BRAIN INJURY RESOURCE CENTER of Wisconsin

FILE # _____

# Resource Facilitation – Survivors

**Brain Injury Survivor First and Last Name**: _____

Date of Injury: (MM/YY)____/_____ Date of Birth: (MM/DD/YY)_____/_____/_____

Are you a veteran? ☐Yes or ☐ No Do you have a DD-214? ☐ Yes (If yes, a copy needed for their file)

Email Address: _____

Cell Phone: _____ Home Phone: _____

Mailing Address: _____

**Indicate One**: Home? _____ Apt # _____ Condo # _____ Other # _____

City: _____ State:_____ Zip: _____ - _____ County: _____ (Wisconsin Only)

## EMERGENCY CONTACT PERSON OR RESPONSIBLE PERSON (GUARDIANS OR PARENTS FOR MINORS)

*First and Last Name: _____ ***Required for Brain Injury Wallet Card Issuance**

*Phone Number _____ ***Required for Brain Injury Wallet Card Issuance**

Relationship to Survivor: _____

Are you the Guardian? ☐ YES ☐ NO Are you the POA? ☐ YES and activated ☐ NO

Email Address: _____

Cell Phone: _____ Home Phone: _____

Mailing Address _____

**Indicate One**: Home? _____ Apt # _____ Condo # _____ Other # _____

City : _____ State:_____ Zip: _____ - _____ County: _____ (Wisconsin Only)

**How did you hear about our organization?**

**Is the survivor being assisted by the following or have you contacted them?**

1. ***Wisconsin Residents:*** **ADRC ☐ Yes (if Yes, also answer below) or ☐ No**
   **(If Yes) Case Managers Name AND Phone Number_____**
   **(If Yes) Are you on Family Care or IRIS ☐ Yes or ☐ No**

2. ***Wisconsin and all other States:*** **Are you on SSDI or SSI ☐ Yes or ☐ No**
   **Do you have Medicare ☐ Yes or ☐ No**
   **Do you have Medicaid ☐ Yes or ☐ No**
   **<u>If no to the above, ask:</u> Are you private pay if medical resources are requested ☐ Yes or ☐ No**

**Complete Page 2 – Physician Information Required**

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**What was the cause of the brain injury?** (If more than one injury check each that apply)

| Traumatic Brain Injury<br>*Type of brain injury that is caused by sudden physical damage to the brain* | Acquired Brain Injury<br>*Type of brain damage caused by events after birth, rather than by a congenital disorder* |
|---|---|
| ☐ Bicycle Accident<br>☐ Blow to head<br>→ Accidental, Assault, Object falling on the head<br>☐ Child Abuse<br>☐ Domestic Abuse<br>☐ Gunshot Wound<br>→ Accidental, Assault<br>☐ Fall<br>→ Stairs<br>→ Tree<br>→ Window<br>☐ Farm Vehicle Accident<br>☐ Motorized Vehicle Accident<br>→ Automobile<br>→ Bus<br>→ Motorcycle, Scooter, related<br>→ Truck<br>☐ Pedestrian verses Motorized Vehicle<br>☐ Recreational Vehicle Accident<br>→ ATM<br>→ Boat<br>☐ Sports Related<br>☐ OTHER: _____ | ☐ Aneurysm (Brain)<br>☐ Arteriovenous Malformation (AVM)<br>☐ Bleeding in the brain<br>→ Intracranial surgery<br>→ Hemorrhage<br>→ Hematoma<br>☐ Fluid build-up in the brain<br>☐ Infections in the brain<br>☐ Intentional self-harm<br>→ Drug overdose<br>→ Excessive and prolonged use of drugs and/or alcohol<br>→ Suicide attempt<br>☐ Lack of oxygen to the brain<br>→ Anoxia/hypoxia<br>→ Near-drowning<br>→ Cardiac arrest (heart stops beating)<br>☐ Stroke<br>→ Embolism<br>→ Thrombosis<br>→ Aneurysm<br>☐ Toxic exposure<br>→ Carbon monoxide poisoning<br>→ Inhaling toxic chemicals<br>→ Solvent sniffing<br>☐ Tumors of the brain<br>☐ OTHER: _____ |

***A completed Acquired/Traumatic Brain Injury Verification Statement is needed to take advantage of specific parts of our Programs and Services (such as the Brain Injury Identification Wallet Card and our invitation only Events) We will send this form to your physician for completion.***

Physician's Name: _____

Organization/Facility Name: _____

Mailing Address _____

City _____ State: _____

Zip Code _____-_____ Phone Number: _____