BRAIN INJURY RESOURCE CENTER of Wisconsin

FILE # _____

Resource Facilitation – Survivors

Today's Date _____ RF Database Updated ☐

Brain Injury Survivor Information

First and Last Name: _____

Date of Injury: (MM/YY)____/_____ Date of Birth: (MM/DD/YY)_____/_____/_____ BDay Card added ☐

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

Email Address: _____

For Office Use Only: BI-INSIDE Email added ☐ - EVENTS Notification Eligible? No ☐ / Yes ☐ added ☐

We do not sell email addresses –the email notifies them when we have EVENTS and when the BI-INSIDE Magazine is ready for viewing on our website

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) – Required for Brain Injury Wallet Card Issuance

First and Last Name: _____

Relationship to Survivor: _____ Are you the Guardian? ☐ YES ☐ NO

Are you the POA? ☐ YES ☐ NO

Email Address: _____

For Office Use Only: BI-INSIDE Email added ☐ - EVENTS Notification Eligible? No ☐ / Yes ☐ added ☐

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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? _____

Are you being assisted by the following or have you contacted them?

Wisconsin Residents: **ADRC ☐ Yes or ☐ No (If yes Case Managers Name_____)**
Are you on Family Care or IRIS ☐ Yes or ☐ No

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**

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

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

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How can we assist you today?

If asking for Work Related Assistance:

ASK: **Have you worked with the Department of Vocational Rehabilitation (DVR)**

☐ **Yes (If yes Contact Persons Name and Phone Number _____**

☐ **No**