



FILE # \_\_\_\_\_

### Resource Facilitation – Survivors

Today's Date \_\_\_\_\_

Brain Injury Survivor Information

RF Database Updated

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: \_\_\_\_\_

*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)

\*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

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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? \_\_\_\_\_

### 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

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

**Resource Facilitation – Survivors**

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

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

***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: \_\_\_\_\_

