OBIA
ONTARIO BRAIN INJURY ASSOCIATION
education • awareness • support

Peer Support Mentoring Program for People Living with ABI
Referral Form

Check one:

_____ The following person is interested in being matched with a mentor.
_____ The following person is interested in becoming a mentor.

Mentor/Partner Contact Information:

Name:_____
Address:_____
Phone #: (home)_____ (work)_____
Email: _____
Best method and time of contact:_____

What is the relationship of the person you are referring to the person with a brain injury?

_____

Referral Source:

Your Name:_____
Organization:_____
Address:_____
Telephone #:_____ Fax #:_____
Email:_____

Consent of Individual:

I _____ have given my consent for _____ to provide the Brain Injury Association of _____with my contact information in order that the Peer Support Coordinator can contact me to discuss my participation in their Peer Support Mentoring (PSM)Program.

_____
Signature of Person Being Referred to the PSM Program

Please email or fax this form to: ***Hamilton Brain Injury Association***
Lindsay Bright – Peer Support Coordinator
Email: *peersupport@hbia.ca*
Fax: 905-390-3649