Concussion Clinic Referral Form

To be completed by Physician – Please FAX to 613 260-3897

Patient Information *(Please complete all fields)		
Name:		
Gender: Male Female	**DOB (DD/MM/YYYY):**	
Address: City: Province:	Postal Code:	
Home #:	Alternate #:	
OHIP #:		
Primary Care Physician:		Phone:
Referring Physician Information *(Please complete all fields)		
Name: **Address:**		
Phone:	**Fax:**	**Private Line:**
Parent/Guardian Information *(Please complete all fields)		
Name:		
Relationship to Patient: **Language(s) spoken at home:** **Interpreter Services Required (circle):** **Yes**		**No**
Home #:	Work #:	Cell#:

Medical History *(Please complete all fields)

Pertinent Medical History:

☐ developmental delay ☐ ADHD ☐dyslexia ☐ other learning disability:
☐ headaches ☐ migraine ☐ pain: ☐ chronic pain:
☐ seizures ☐ primary sleep disorder e.g. OSA
☐ chronic fatigue ☐ cervical strain/whiplash disorder

Other:

Mental Health Issues:

☐ depression ☐ major depressive disorder ☐ anxiety
☐substance abuse/polypharmacy ☐ somatoform disorder/factitious disorder

Other:

Date of Injury (day/month/year):

Mechanism of Injury (describe):

☐ LOC

Previous Concussive Injuries:

Primary Symptoms:

Medications:

Interventions to date: