fraserhealth

CONCUSSION SERVICES REFERRAL
(Early Intervention for Mild Traumatic Brain Injury)

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Concussion Services: 201-9440 202 Street, Langley, BC V1M 4A6 Office: 604-514-7431 Email: Concussion@fraserhealth.ca

Please fax completed referral form to 604-528-5454

A. DEMOGRAPHIC		
Last Name:	First Name:	Preferred Name:
Date of Birth (DD/MM/YYYY):	Personal Health Number:	Preferred Language:
Pronouns: ☐ He/His/Him ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other, please specify: _____		
Gender: ☐ Male ☐ Female ☐ Identify As:_____		
Address (City, Province, Postal Code):		
Home Telephone:	Cell:	Email:
Do you wish to identify as an Aboriginal / Indigenous person? ☐ Yes ☐ No ☐ Prefer not to answer If **yes,** select **ALL** that apply: ☐ First Nations ☐ Inuit ☐ Metis ☐ Status Non-Status ☐ Other, please specify:_____		
B. REFERRAL SOURCE		
Referring Person Name:	Occupation:	Phone Number:
Primary Health Care Provider:	Telephone:	Fax Number:
C. CONCUSSION INFORMATION ***** Referrals accepted within 12 months of injury ***** *If TBI is moderate to severe as indicated on imaging consider referral for FH Acquired Brain Injury Services*		
Date of Injury:		
Mechanism of Injury:		
Reason for Referral ***** If eligible for services with ICBC or WorkSafeBC, referral will not be accepted ***** _____ _____		
D. DIAGNOSTIC CRITERIA ****** Client must have a diagnosis of concussion prior to receiving service *****		

1. Any loss of consciousness?	☐ Yes ☐ No Duration: _____ minutes
2. At 30 minutes post injury, was the GCS score greater than or equal to 13 out of 15?	☐ Yes ☐ No
3. Any loss of memory of events immediately before or after the injury (not to exceed a 24 hours span of time)	☐ Yes ☐ No
4. Any alteration in mental state at the time of the injury (e.g. feeling dazed, disoriented or confused)	☐ Yes ☐ No

Any other relevant diagnosis: (prior concussions, mental health history, substance use, learning difficulties, brain injuries or any other injuries sustained at the same time as the concussion):

_____

_____

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