Fraser Health Concussion Clinic
#104 – 218 Blue Mountain Street
Coquitlam, BC V3K 4H2
Ph: 604-528-5387 Fx: 604-936-0955

CONCUSSION CLINIC (EARLY INTERVENTION FOR MTBI) – REFERRAL FORM

CLIENT INFORMATION:

NAME:_____ **PHN:**_____
Last First Middle

DATE OF BIRTH: _____*client must be ≥16 years of age ☐MALE ☐FEMALE

MARITAL STATUS: ☐MARRIED ☐COMMON LAW ☐SINGLE ☐UNKNOWN

CURRENT ADDRESS: _____

PHONE NUMBER: _____ **FAMILY DOCTOR:**_____

Please indicate if the injury involves: ☐ICBC ☐WCB ☐Criminal Injuries

ESL: Y☐ N☐ **Interpreter required:** Y☐ N☐ **Language spoken**:_____

DATE OF INJURY:_____ ***Referrals accepted only within 6 months of injury***

HAS THIS CLIENT BEEN DIAGNOSED WITH A CONCUSSION: Y☐ N☐

NATURE/CAUSE OF CONCUSSION INJURY:_____

_____

REASON FOR REFERRAL: _____

_____

DIAGNOSTIC CRITERIA: *One or more must be present at the time of injury. Please circle:

GLASGOW COMA SCALE SCORE *no less than 13/15	Y☐	N☐	GCS Score: _____
LOSS OF CONSCIOUSNESS *no more than 30 minutes	Y☐	N☐	Duration:_____
DAZED OR CONFUSED	Y☐	N☐	Duration:_____
POST TRAUMATIC AMNESIA *no more than 24 hours	Y☐	N☐	Duration:_____

ADDITIONAL DIAGNOSTIC CRITERIA:

CT HEAD SCAN COMPLETED?	Y☐	N☐	RESULTS:_____
DEPRESSION OR PENETRATING SKULL FRACTURE?	Y☐	N☐	

ANY OTHER RELEVANT DIAGNOSES: (prior concussions, mental health history, substance use, learning difficulties, brain injuries or any other injuries sustained at the same time as the concussion):_____

_____

PERSON MAKING REFERRAL:

NAME/TITLE:_____

HOSPITAL & CONTACT INFORMATION_____

HAS CLIENT BEEN INFORMED OF REFFERAL? Y☐ N☐

SIGNATURE (person completing referral)_____ DATE:_____

PLEASE NOTE – THE CLIENT IS REQUIRED TO CALL OUR OFFICE TO SCHEDULE THE APPOINTMENT