iScope Concussion and Pain Clinics
Surrey - 9639 137A Street - Suite 301
Langley - 8837 201 Street - Suite 200
North Vancouver - 1111 Lonsdale Ave - Suite 301

Please send referrals by email or fax to: intake@myiscope.com or (604) 900-7676

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 ☐
dd/mm/yy

CURRENT ADDRESS: _____

PHONE NUMBER: _____ FAMILY DOCTOR: _____
Phone #

DATE OF INJURY: _____

HAS THIS CLIENT SUSTAINED A CONCUSSION: Y N

NATURE/CAUSE OF CONCUSSION (Please describe): _____

_____

EXPEDITED TREATMENT:

REFER FOR PHYSIOTHERAPY ASSESSMENT: Y N REFER FOR CLINICAL COUNSELLING: Y N

REFER FOR OCCUPATIONAL THERAPY: Y N

DIAGNOSTIC CRITERIA:

LOSS OF CONSCIOUSNESS ≤ 30 min	Y	N
DAZED OR CONFUSED	Y	N
POST TRAUMATIC AMNESIA ≤ 24 hrs	Y	N

ADDITIONAL DIAGNOSTIC INFORMATION:

CT SCAN COMPLETED Y N RESULTS: _____

DEPRESSED &/OR PENETRATING SKULL FRACTURE Y N

PERSON MAKING REFERRAL:

NAME/TITLE: _____
(Please print first and last name) Billing #

HOSPITAL & CONTACT INFORMATION: _____

HAS CLIENT BEEN INFORMED OF REFERRAL: Y N

SIGNATURE (Person completing form): _____ DATE: _____