iScope Concussion and Pain Clinics

Mississauga - 89 Queensway W - Suite 500 .

Ph: 1-888-550-5508

Please send referrals by fax to: (416) 900-7006

CONCUSSION & REHABILITATION CLINIC (Early Intervention for mTBI & Pain Management)

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 VESTIBULAR THERAPY: Y N

PAIN? Y N LOCATION: _____

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 #

PRACTICE & CONTACT INFORMATION: _____

HAS CLIENT BEEN INFORMED OF REFERRAL: Y N

SIGNATURE (Person completing form): _____ DATE: _____