CONCUSSION CARE
COMMUNITY CLINIC

830 St Mary's Road
Winnipeg, MB R2M 3P4

Phone: 204-415-0784
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REFERRAL FORM

1. CLIENT DETAILS

Client name:	DOB:
Home Address:	POSTAL CODE:
Phone Number – Home:	Date of Injury:
Phone Number – Cell:	Email:
Diagnosis / Injuries:	

2. REFERRAL INFORMATION

Date of Referral:		Phone #:
Referral Agency:		Fax #:
Contact Person:		Email:
Funding Source:	☐ **Self** ☐ **Insurer**	Claim #:

3. MEDICAL INFORMATION

Family Physician:	Phone #:
Address:	Fax #:
	# of years with Doctor:
List any other medical specialists involved: (i.e. Neurologist, Psychologist, Orthopedics, Psychiatrist, etc.)	

4. INJURY DESCRIPTION

Briefly describe how the injury occurred:

Was there loss of consciousness? ☐ **Yes** Length of time _____ ☐ **No**

Were any formal tests done (CT, MRI, etc.): ☐ **Yes** ☐ **No**

If yes, what were the results:

5. SYMPTOMS

Since the injury, are any of the following symptoms occurring more than usual. If so, please check any that apply:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fatigue
- ☐ Sleep Changes
- ☐ Visual Problems
- ☐ Nausea / Vomiting
- ☐ Worry / Anxious
- ☐ Depression
- ☐ Irritability
- ☐ Memory
- ☐ Concentration
- ☐ Sensitivity to Light / Noise
- ☐ Balance Problems
- ☐ Foggy / Sluggish

6. RISK FACTORS

Are there any past pre-existing health issues (i.e. previous concussions, learning disabilities, mental health diagnosis, drug/alcohol use): ☐ **Yes** ☐ **No**

If so, please explain:

7. EXPECTED GOALS AND OUTCOMES OF PROGRAM

Please explain:

8. ADDITIONAL DATA / COMMENTS: