It is important to seek medical assessment as soon as possible following a suspected concussion in order to rule out a more severe head injury and obtain a concussion diagnosis.

In order to be eligible for this service a **Physician or Nurse Practitioner referral is required** and the client must meet **all of** the following criteria:

- Client must have received a **diagnosis of a concussion**
- Referral must be made **within 4 weeks of injury**
- For questions or concerns please contact 416-425-6220 Ext. 3119
- Please use fax number located on referral form below to fax completed referral
- Once referral is received the client will be contacted as soon as possible

*The client/family must be aware of the referral.*
PHYSICIAN REFERRAL FORM – EARLY CARE CONCUSSION SERVICES

Please complete all sections of this form as incomplete forms will result in processing delays.

NOTE: This information will be shared with Holland Bloorview staff as required.

Family is aware of this referral: Yes □ (must be checked) Referral Date: ________________________(dd/mm/yy)

CLIENT INFORMATION:

Client Name: ________________________________________________________________

Last Name                             First Name                             Middle Initial

Date of Birth: ____________________________  o  Male  o  Female

Day / Month / Year

Client Address: ______________________________________________________________

City: ______________________________________________________________

Province: _______________________  Postal Code: _______________________  Tel.: _______________________

Health Card Number: __________________________________________________________

Version Code: _______________________________________________________________

o  Interim Federal Health Program (IFHP)  o  Health Card In Process

PARENT(S) OR GUARDIAN(S):

Name(s): ________________________________

Address (if different from client):

Email: ______________________________________________________________

Tel. (home): __________________________Tel. (work): __________________________Tel. (cell): __________

MEDICAL INFORMATION:

Primary Diagnosis: ______________________________

Date of Injury: ______________________________

Medical History/Allergies:

____________________________________________________________________________________

Concussion History:

____________________________________________________________________________________

REFERRING PHYSICIAN INFORMATION:

Name: ______________________________________________________________

OHIP Billing Number: _______________________________________________________  

Hospital: ________________________________________________________________

Telephone: ___________________________ Fax: ___________________________

Signature: ______________________________

Primary Care Physician (if different from referring physician): ___________________________

Please fax your completed Referral Form to Appointment Services: (416) 422-7036