It is important to seek medical help as soon as possible following a concussion. If symptoms **persist for 4 weeks**, and your child is **unable to return to full workload** at school or **unable to return to sports**, a family physician may refer them to our BIRT outpatient services for **consultation**. Concussion services offered may include medical follow up, occupational therapy, physiotherapy and social work. Services are individualized and depend on your goals or priorities. We also offer concussion education through **Concussion and You**.

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

- Live in the Greater Toronto Area where similar services are not available
- Is between the ages of 3 months and 18 years
- Has a diagnosis of a concussion
- **Is 4 weeks post-concussion** with persistent concussion symptoms and unable to return to school or sports
- Is willing to participate in setting goals with the support of the rehab team
- Has family members willing to become involved in the therapy process

*The client/family must be aware of the referral*
**PHYSICIAN REFERRAL FORM – OUTPATIENT 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:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Client Name]</td>
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</table>

Date of Birth: ____________________________ ☐ Male ☐ Female

Day / Month / Year

Is an interpreter required? ☐ Yes ☐ No  Language spoken: ______________________

Client Address: ___________________________ City: ___________________________

Province: __________________ Postal Code: _________ Tel.: ____________

Health Card Number: ___________________________ Version Code: ____________

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

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other:

### PARENT(S) OR GUARDIAN(S): (if different from client address)

<table>
<thead>
<tr>
<th>Parent/Guardian:</th>
<th>Address:</th>
<th>Email:</th>
<th>Tel. (home):</th>
<th>Tel. (work):</th>
<th>Tel. (cell):</th>
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### AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

<table>
<thead>
<tr>
<th>Agency (eg. Child Protection, Community)</th>
<th>Professional (eg. OT, SLT, Psychologist)</th>
</tr>
</thead>
<tbody>
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<tr>
<td>2. [ ]</td>
<td>[ ]</td>
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<td>3. [ ]</td>
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</tbody>
</table>

September 2017
MEDICAL INFORMATION:

Primary Diagnosis: 

____________________________________________________________________________________

Other Diagnoses: 

____________________________________________________________________________________

Does this client require any special infectious disease precautions?  Yes  No

If yes, what for: _______________________________________________________________________

Medical History/Allergies: 

______________________________________________________________________________________

Taking Medication: ☐ Yes  ☐ No

Risks (i.e. frequent falls) 

______________________________________________________________________________________

Reason for Referral/Concern/Goals: 

______________________________________________________________________________________

Use check box for referral:

☐ Query Autism
☐ Acquired Brain Injury Rehabilitation
☐ Concussion Clinic
☐ Cleft Lip & Palate Speech Language Pathology
☐ Infant Development Services
☐ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
☐ Psychopharmacology* (additional forms required)
☐ Neuromuscular (e.g. muscular dystrophy)
☐ Feeding* (additional forms required)
☐ Spina Bifida

☐ Spinal Cord Injury
☐ Augmentative & Alternative Communication (AAC)
☐ Writing Aids
☐ Orthotics (including protective headwear)
☐ Prosthetics (including myoelectric & cosmetic)
☐ Clinical Seating

Dental Services: 

☐ Cleft Lip & Palate (general anesthesia available for qualifying clients)
☐ Special Needs Dentistry (general anesthesia available for qualifying clients)

*Dental Services: 

Orthodontics
☐ Oral Health Education
☐ Prosthodontic services
☐ Root Canals
☐ Wisdom tooth extractions

*Pre-assessment forms are required with the referral. Click here:

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: _____________________________________________________________

OHIP Billing Number: __________________________

Hospital: ____________________________________________________

Telephone: ___________________________  Fax: ___________________________

Email: ________________________________________________

Signature: _______________________________________________________

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