TALL TREE
INTEGRATED HEALTH CENTRE

CONCUSSION PROGRAM
REFERRAL FORM

Patient Information

Patient Name:		**Date of birth:**	
Contact information:			

Referral Source

Referred by:		**Discipline:**	
Contact:			

Injury Information

Description:	Date: ☐ Trauma ☐ LOC - duration:_____ ☐ Amnesia - pre/post - duration:_____ ☐ Red Flags:
Type:	☐ Sport ☐ MVI ☐ Fall ☐ Assault ☐ Other:
Primary Issues:	☐ Cognitive issues ☐ WAD Grade: Other: ☐ Visual issues ☐ Cervical injury ☐ Balance/gait issues ☐ Cranial nerve injury ☐ Dizziness issues ☐ Depression ☐ Headache issues ☐ Anxiety ☐ Fatigue issues ☐ PTSD ☐ Exertional issues ☐ Endocrine issues

Relevant Medical History

☐ None	☐ Sleep disorder	☐ ADHD
☐ Previous Concussions(#):	☐ Headache/migraine	☐ Reading difficulties
☐ Anxiety	☐ Vision Issue	☐ Learning differences
☐ Depression	☐ MSK injury:	☐ Other:
☐ PTSD	☐ Neck injury	

Current Management

Seen by:	☐ Emergency medicine ☐ GP/Family Med ☐ Physiotherapy ☐ Chiropractic ☐ Neurologist ☐ Other:
Diagnostics:	☐ X-Ray ☐ CT ☐ MRI ☐ Other: Results:
Assessments:	☐ Acute Evaluation ☐ SCAT ☐ Other: Assessment findings:

Additional Notes/ Requests:

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Signature Date

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