CONCUSSION CARE KELOWNA

201-3030 Pandosy Street, Kelowna, BC V1Y 0C4
Phone: 236-420-1154
Fax: 236-420-1159
www.concussioncarekelowna.com

Patient Information: Please fax completed referral to 236-420-1159

Patient Name *(First, Middle, Last)*			Birth Date *(mm-dd-yyyy)*
Patient Email			Gender: ☐ Male ☐ Female ☐ Other
Address			City
Province	Postal Code		Primary Care Provider:
Home Phone	Alternate Phone	Mobile Work Other	Parent Name (if minor)

Insurance information (Must complete all that is applicable)

Personal Health Insurance Number:	Issuing Province:
ICBC Claim Number:	Date of Injury:
Work Safe Claim Number:	Date of Injury:

Referring Provider Information:

Referring Practitioner Name:	Referral Date *(mm-dd-yyyy)*
Phone:	Fax:
Physician Signature:	Practitioner Billing Number:

Injury Information: **MUST BE COMPLETED** **If not complete – referral will be returned**

This referral is to: **(must select)**

____ **Concussion Specialist consult** **(Neurologist / Psychiatrist / Physiatrist)** **n/c referral MSP# 64654**

____ **Rehabilitation / Counselling only** **(refer to website for rehab options provided)**

Injury Date: mm-dd-yyy: ________________________

Cause: ____ Motor Vehicle Accident ____ MVA vs Pedestrian ____ WorkSafe ____ Fall ____ Assault ____Stroke
___ Sports Injury (type of sport):___________________ Other (specify): _____________________

Diagnosis: ☐ Concussion with LOC ☐ Concussion w/o LOC ☐ Concussion (unspecified)

Loss of consciousness: Duration: _____________ Dazed and confused: Duration: ____________

Post Traumatic Amnesia: Duration: _____________ Other: ___________________________________

Has the patient previously been seen by a specialist / neurologist? Yes / No (attach consults/supporting documents)

Was Imaging done? Yes / No ____ X-ray ____ Ultrasound ____ CT ____ MRI **(attach imaging records to referral)**