



WOMEN'S COLLEGE HOSPITAL  
Health care for women | REVOLUTIONIZED

76 Grenville Street, Toronto, Ontario M5S 1B2  
Telephone: 416-323-6136 Fax: 416-323-6007

**CENTRE FOR HEADACHE  
CONCUSSION REFERRAL FORM**

**PATIENT INFORMATION**  
(Affix Patient Label/Identification Here)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
DD/MM/YYYY  
Health Card: \_\_\_\_\_ Version Code: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Referral Date: DD/MM/YYYY Specific Physician  No (first available)  Yes (Dr. \_\_\_\_\_)

ADDITIONAL PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Gender: Allergies: Insurance coverage/self-pay:  Language spoken: Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Address: Telephone: _____ Fax: _____ Alternate report sent to: (name/contact information) Billing number: _____ Signature: _____

1. INJURY DETAILS: Date of injury: DD/MM/YYYY

**Mechanism of injury:**

- Motor vehicular accident
- Sports related
- Work related
- Other (please specify): \_\_\_\_\_

- Neuroimaging  Yes (attach report)  No
- History of previous head injury  Yes  No
- Ongoing litigation regarding the injury  Yes  No

2. SYMPTOMS:

Headache:  Yes If yes, how often \_\_\_\_\_  No

- |  |  |  |  |
|--|--|--|--|
| <b>Mood/Behavior symptoms:</b>   | <b>Vestibular symptoms:</b>  | <b>Cognitive symptoms:</b>   | <b>Sleep symptoms:</b>   |
| <input type="checkbox"/> Depression/Sadness<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Irritability<br><input type="checkbox"/> Nervousness | <input type="checkbox"/> Vision problems<br><input type="checkbox"/> Hearing problems<br><input type="checkbox"/> Balance problems | <input type="checkbox"/> Feeling in a "fog"<br><input type="checkbox"/> Memory problems<br><input type="checkbox"/> Poor focus/<br>concentration | <input type="checkbox"/> Difficulty falling asleep<br><input type="checkbox"/> Drowsiness<br><input type="checkbox"/> Increased fatigue/low energy<br><input type="checkbox"/> Difficulty staying asleep |

3. TREATMENT:

Current medications (List all, prescription and non-prescription):

Medication	Dose	Date started
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

Current Rehabilitation Services/Treatment:

- Physiotherapy  Social Work  Occupational Therapy  Psychiatry/Psychology  Vestibular therapy
- Other: \_\_\_\_\_

4. PAST MEDICAL HISTORY: \_\_\_\_\_

