WCH
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: ❑ Yes ❑ 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

Mood/Behavior symptoms:

- ❑ Depression/Sadness
- ❑ Anxiety
- ❑ Irritability
- ❑ Nervousness

Vestibular symptoms:

- ❑ Vision problems
- ❑ Hearing problems
- ❑ Balance problems

Cognitive symptoms:

- ❑ Feeling in a "fog"
- ❑ Memory problems
- ❑ Poor focus/ concentration

Sleep symptoms:

- ❑ Difficulty falling asleep
- ❑ Drowsiness
- ❑ Increased fatigue/low energy
- ❑ 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: ______________________________

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