Hamilton Health Sciences

Adult (16 years +) Concussion Clinic
Telephone 905-521-2100 ext 40866 FAX Referral 905-577-8234

Date of Injury:_____

(Referrals outside of the 0-1 year criteria are not accepted into the Concussion Clinic)

Admission criteria for the concussion clinic:

□ ***Referral accepted from Emergency Dept. or Urgent Care of Hamilton Health Sciences and St. Joseph's Healthcare; and family physician/nurse practitioner/medical specialists in the LHIN.***
□ ***Age 16 and up***
□ ***The patient has sustained a concussion***
□ ***Diagnosis of concussion based on (one or more must be present at the time of injury):***
- □ ***Loss of consciousness (30 minutes or less) Duration of LOC_____***
- □ ***Post-traumatic amnesia that is less than 24 hours Duration of amnesia _____***
- □ ***Confusion or disorientation at the time of the injury.***

□ ***GCS no less than 13/15 if known _____***
□ ***Cause of Concussion*** □ *Motor vehicle accident* □ *Fall* □ *Sport/recreation* □ *Assault* □ *Bicycle accident*
- □ *Object hit head (Please indicate what _____*
- □ *Other _____*

Client Information

Name:	**Health Card #**	
Address:	**City:**	**Postal Code:**
Phone:	**Date of Birth (dd/mm/yy)**	**Gender:**

Speaks, Understands English: □ YES □ NO – Interpreter Needed (client must provide)

Responsible for Payment:
□OHIP □ Auto Insurance □ Private Insurance □ WSIB □ Extended Health □ OTHER
_____

The Following Test Have Been Completed (must attach to complete referral):

□ CT Scan □ MRI □ OTHER_____

Relevant past medical/surgical history: (tick off system)

□ Prior concussion(s) – indicate how many
□ Psychiatric history Please indicate: depression, anxiety, PTSD, Other_____
□ Substance Abuse
□ Other injuries sustained at the time of concussion Please indicate:_____
□ History of chronic pain
□ NeuroDevelopmental problems (ADHD, Learning Disability)
□ History of headache/migraine disorder
□ Sleep Disorder (ie obstructive sleep apnea)
□ Neurological Disorder (ie moderate to severe traumatic brain injury, seizure disorder) Please indicate:_____
□ Other:_____

Referral Date:_____ **Referral From: □ GP □ ED □ Other**

Name of Referring Physician: _____ **Signature:** _____

Billing Number:_____