



### Referral Form

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) YYYY MM DD

**Male:**  **Female:**  **Health card #:** \_\_\_\_\_ **Version:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Alternate Contact:** \_\_\_\_\_  
(Name) (Relationship) (Phone #)

**Referral Source:** \_\_\_\_\_ **Physician Billing #:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship to client:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

**Date of Injury/Event (if applicable):** \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

**Diagnosis:** \_\_\_\_\_

**Brief Description of Presenting Problem / Injury:**

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**Nature of Service(s) Requested:**

- |  |  |
|--|--|
| <input type="checkbox"/> Neuropsychological Assessment   | <input type="checkbox"/> Cognitive Rehabilitation  |
| <input type="checkbox"/> Memory Screen (older adults)  | <input type="checkbox"/> Psychological Assessment  |
| <input type="checkbox"/> Concussion Management/Education   | <input type="checkbox"/> Psychological Therapy     |
| <input type="checkbox"/> Neurological Consultation ( <i>brain injury only; no WSIB/ MVA /medical legal referrals</i> ) | <input type="checkbox"/> Vestibular Rehabilitation |

**Reports Included** (*Underlined documents, if already attained, are required for neurological consultation*):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <u>GP problem list</u>   | <input type="checkbox"/> <u>Initial documents post-injury (EMS, ER, GP)</u> | <input type="checkbox"/> Consult/ Discharge Note(s) |
| <input type="checkbox"/> <u>Head imaging (CT, MRI)</u>                                      | <input type="checkbox"/> <u>Medication list</u>                             | <input type="checkbox"/> Physiotherapy              |
| <input type="checkbox"/> <u>Cervical spine imaging</u>                                      | <input type="checkbox"/> <u>ENT</u>   | <input type="checkbox"/> Neuro/Psychology           |
| <input type="checkbox"/> <u>Neurology/Neurosurgery</u>                                      | <input type="checkbox"/> Occupational Therapy                               | <input type="checkbox"/> Speech language pathology  |
| <input type="checkbox"/> <u>Neuro-Optometry/Optometry/Ophthalmology/Neuro-ophthalmology</u> |   | <input type="checkbox"/> Social work                |

**CURRENT SYMPTOMS**

**PHYSICAL:** (please check all that apply)

- |   |                                   |   |                                    |
|---|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Paresis/paralysis                        | <input type="checkbox"/> Pain     | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Balance   |
| <input type="checkbox"/> Mobility                                 | <input type="checkbox"/> Headache | <input type="checkbox"/> Photo/phono phobia | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Vision issues (blurred or double vision) | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Sensory issues     | <input type="checkbox"/> Vertigo   |

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PSYCHOLOGICAL/ BEHAVIOURAL:** (please check all that apply)

- |   |                                     |   |   |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> OCD        | <input type="checkbox"/> Post-concussive syndrome | <input type="checkbox"/> Trauma/PTSD              |
| <input type="checkbox"/> Low Mood           | <input type="checkbox"/> Adjustment | <input type="checkbox"/> Sleep difficulties       | <input type="checkbox"/> Suicide Risk             |
| <input type="checkbox"/> Anger/irritability | <input type="checkbox"/> Psychosis  | <input type="checkbox"/> Alcohol/substance abuse  | <input type="checkbox"/> Sexual Inappropriateness |

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**COGNITIVE STATUS:**

Please comment on any presenting cognitive difficulties (e.g., memory, attention, problem solving):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_