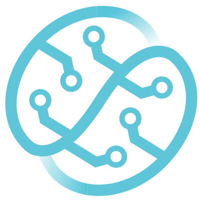

iScope Concussion & Pain Clinics - Neurology Requisition

Virtual Clinic + Locations across Greater Vancouver & Fraser Valley
www.myiscope.com
Toll-free: 1-888-550-5508
Send forms to intake@myiscope.com or fax 604-900-7676

Multidisciplinary Concussion & Pain Clinic (Early and Chronic Intervention for MTBI)

CLIENT INFORMATION:

NAME: ______________________________ PHN: ______________
Last First Middle

DATE OF BIRTH: ______________ • client must be > 16 years of age Male ☐ Female ☐
dd/mm/yy

CURRENT ADDRESS: ______________________________

PHONE NUMBER: ______________ FAMILY DOCTOR: ______________
Phone #

DATE OF INJURY: ______________________________
dd/mm/yy

HAS THIS CLIENT SUSTAINED A CONCUSSION: Y N

NATURE/CAUSE OF CONCUSSION INJURY (Please describe): ______________

____

____

____

____

DIAGNOSTIC CRITERIA: One or more of the following should be present. Please circle.

LOSS OF CONSCIOUSNESS ≤ 30 mins	Y	N
DAZED OR CONFUSED	Y	N
POST TRAUMATIC AMNESIA ≤ 24 hrs	Y	N

ADDITIONAL DIAGNOSTIC INFORMATION:

CT SCAN COMPLETED	Y	N
DEPRESSED &/OR PENETRATING SKULL FRACTURE	Y	N

RESULTS: ______________

REFERRING PROVIDER:

NAME/TITLE: ______________________________
(Please print first and last name) Billing #

HOSPITAL & CONTACT INFORMATION: ______________________________

HAS CLIENT BEEN INFORMED OF REFERRAL: Y N

SIGNATURE (Person completing form): ______________ DATE: ______________