



iScope

CONCUSSION & PAIN CLINICS

iScope Concussion & Pain Clinics - Neurology Requisition

Virtual Clinic + Locations across the Greater Toronto Area

www.myscope.com

Toll-free: 1-888-550-5508

Send forms to intake@myscope.com or fax 416-900-7006

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: _____