iScope
CONCUSSION & PAIN CLINICS
myiscope.ca

iScope Concussion and Pain Clinics
Toll-free: 1-888-550-5508
Please send referrals by email or fax to: intake@myiscope.com or (604) 900-7676

CONCUSSION CLINIC (EARLY INTERVENTION FOR MTBI) - REFERRAL FORM

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: _____

HAS THIS CLIENT SUSTAINED A CONCUSSION: Y N

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

_____

_____

_____

_____

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

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

ADDITIONAL DIAGNOSTIC INFORMATION:

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

PERSON MAKING REFERRAL:

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: _____