Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Early Care Concussion Services

It is important to seek a medical assessment as soon as possible following a suspected concussion in order to rule out a more severe head injury.

Is your client currently enrolled in the baseline testing and early care program at Holland Bloorview?

In order to be eligible for this service a **Physician referral is required** and the client must meet **all of** the following criteria.

- Client must have already completed a baseline test and currently enrolled in the **Holland Bloorview Baseline Testing and Early Care program**
- Has a **diagnosis of a concussion**
- For questions or concerns please contact 416-425-6220 Ext. 3239
- Please use fax number located on referral form below to fax in completed referral
- Once referral is received the client will be contacted as soon as possible directly

The client/family must be aware of the referral

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Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN REFERRAL FORM – EARLY CARE CONCUSSION SERVICES

Please complete all sections of this form as incomplete forms will result in processing delays.
NOTE: This information will be shared with Holland Bloorview staff as required.

Family is aware of this referral: Yes ☐ (must be checked) Referral Date: _____(dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ ☐Male ☐Female
Day / Month / Year

Client Address: _____City:_____

Province: _____ Postal Code: _____ Tel.:_____

Health Card Number: _____ Version Code: _____

☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process

PARENT(S) OR GUARDIAN(S):

Name(s): _____

Address (if different from client)

Email:_____

Tel. (home): _____Tel. (work):_____Tel. (cell): _____

MEDICAL INFORMATION:

Primary Diagnosis: **Date of Injury: _____**

_____

Medical History/Allergies:

_____

Concussion History:

_____

Did the client have a baseline concussion test at Holland Bloorview within the last year? ☐Yes ☐No

REFERRING PHYSICIAN INFORMATION:

Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ Fax: _____

Signature: _____

Primary Care Physician (if different from referring physician): _____

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