Toronto Brain Health

20 De Boers Drive, Suite 535, Toronto, ON, M3J 0H1
P (416) 258-2367 **F** (416) 342-1968
contact@torontobrainhealth.com
www.torontobrainhealth.com

Referral Form

Client Name: _____ _____
(Last) (First)

Date of Birth: _____/_____/ ____ **Male:** □ **Female:** □ **Other:** □ **Phone #**: _____
YYYY MM DD

Home Address: _____

Alternate contact: _____ _____ _____
(Name) (Relationship) (Phone #)

Referral Source: _____ **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:

_____
_____
_____
_____
_____
_____
_____
_____

Nature of Service(s) Requested:

□ Neuropsychological Assessment
□ Psychological Assessment
□ Concussion Management/Education
□ Cognitive Rehabilitation
□ Psychological Therapy

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Reports Included:

- ☐ GP problem list
- ☐ Head imaging (CT, MRI)
- ☐ Cervical spine imaging
- ☐ Neurology/Neurosurgery
- ☐ Neuro-/ Optometry / Neuro-/Ophthalmology
- ☐ Initial documents post-injury (EMS, ER, GP)
- ☐ Medication list
- ☐ ENT
- ☐ Occupational therapy
- ☐ Consult/Discharge Note(s)
- ☐ Physiotherapy
- ☐ Neuro/Psychology
- ☐ Speech language pathology
- ☐ Social work

CURRENT SYMPTOMS

PHYSICAL: (please check all that apply)

- ☐ Paresis/paralysis
- ☐ Mobility
- ☐ Vision issues (blurred or double vision)
- ☐ Pain
- ☐ Headache
- ☐ Tinnitus
- ☐ Fatigue
- ☐ Photo/phono phobia
- ☐ Sensory issues
- ☐ Balance
- ☐ Dizziness
- ☐ Vertigo

Comments:_____
_____
_____

PSYCHOLOGICAL/BEHAVIOURAL: (please check all that apply)

- ☐ Anxiety
- ☐ Low mood
- ☐ Anger/irritability
- ☐ OCD
- ☐ Adjustment
- ☐ Psychosis
- ☐ Post-concussion syndrome
- ☐ Sleep difficulties
- ☐ Alcohol/substance misuse
- ☐ Trauma/PTSD
- ☐ Suicide Risk
- ☐ Sexual Inappropriateness

Comments:_____
_____
_____

COGNITIVE STATUS:

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

_____
_____
_____
_____