UNIVERSITY OF ALBERTA

**Glen Sather Sports Medicine Clinic**

# Complex Concussion Referral Request Form

**An assembled expert team of concussion rehabilitation professionals in one place.**

**Please complete and return this form by fax 780-407-5167 or email psoriano@ualberta.ca**

**Please Note: This clinic will not see any WCB or MVA cases.**

## Referral Guidelines

This clinic is a multi-disciplinary clinic that takes place once a month for patients with prolonged concussion symptoms of **1-12 months directly related to Sport Concussion**. There is a charge of $695.00 to the patient for services not covered by Alberta Health (Physical Therapy Assessment, Neuropsychology).

***This clinic excludes medical-legal opinions: the focus of this group is to assess and establish a patient centered plan for post-concussion rehabilitation.**

## Patient Details

| | |
|---|---|
| Name: | Address: |
| Date of Birth: | Telephone<br>Home:<br>Cell: |
| PHN: | Referring MD<br>Telephone<br>Fax: |

## Reason for Referral:

What is the primary reason you are referring this patient:

Date of Concussion: _____

## Sport Caused Concussion

Is this a Sport Related Concussion? Yes ☐ No ☐

Is this related to WCB? Yes ☐ No ☐

Is this related to a Motor Vehicle Collision? Yes ☐ No ☐

Is a headache waking them up during the night? Yes ☐ No ☐

Has this patient been treated for acute mental illness within the last 3-6 months? Yes ☐ No ☐

Details: _____

Any current substance abuse? Yes ☐ No ☐

Details: _____

**Please see other side**

Describe this mechanism of injury in detail:

_____
_____
_____
_____

## Interventions completed at time of referral:

**Current level of physical activity:**

_____

**Current level of mental activity (Work or School – Part- time/ Full-time):**

_____

**Medications:**

_____
_____
_____

**Physical treatments (frequency and type):**

_____
_____
_____

**Past Concussion History:**

_____
_____
_____

**Other Medical History:**
**(Please include surgeries and hospitalizations)**

_____
_____
_____

## Referring Health Professional Information:

Name (Print) _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

PRAC ID: _____

Date: _____

Signature: _____

**Please Note: We do not accept any referrals without this form.**