



iScope Concussion and Pain Clinics
 CC2 building (across from Surrey Memorial Hospital)
 9639 137A Street - Suite 301, Surrey, BC
Toll-free: 1-888-550-5508

Please send referrals by email or fax to: intake@myscope.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:** _____