Toronto Brain Health

20 De Boers Drive, Suite 535, Toronto, ON, M3J 0H1
Phone: 416-258-2367 | Fax: 416-342-1968
contact@torontobrainhealth.com

Referral Form

Client Name: _____ _____ **Date of Birth:** _____/_____/ ____
(Last) (First) YYYY MM DD

Male: □ Female: □ Health card #: _____ **Version:** _____

Home Address: _____ **Phone #:** _____

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

Referral Source: _____ **Physician Billing #:** _____ **Signature:** _____

Address: _____ **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
- □ Memory Screen (older adults)
- □ Concussion Management/Education
- □ Neurological Consultation (*brain injury only; no WSIB/medicolegal referrals*)
- □ Cognitive Rehabilitation
- □ Psychological Assessment
- □ Psychological Therapy
- □ Vestibular Rehabilitation

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Reports Included (*Underlined documents, if already attained, are required for neurological consultation*)**:**

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

CURRENT SYMPTOMS

PHYSICAL: (please check all that apply)

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

Comments:_____

PSYCHOLOGICAL/ BEHAVIOURAL: (please check all that apply)

□ Anxiety
□ OCD
□ Post-concussive syndrome
□ Trauma/PTSD
□ Low Mood
□ Adjustment
□ Sleep difficulties
□ Suicide Risk
□ Anger/irritability
□ Psychosis
□ Alcohol/substance abuse
□ Sexual Inappropriateness

Comments:_____

COGNITIVE STATUS:

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