Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

G. F. Strong Rehab Centre

# Early Response Concussion Service Referral Form

**4255 Laurel Street**
**Vancouver, BC V5Z 2G9**

**Phone: 604-714-4186**
**Fax: 604-730-7904**

## Client must meet the following inclusion criteria:

- ○ **Lives within Vancouver Coastal Health** (Vancouver, North/West Vancouver, Richmond, Sea to Sky, Sunshine Coast, Powell River & Central Coast)
- ○ **19+ years old** (18 if graduated high school)
- ○ **6 months or less post-injury**

## CLIENT DEMOGRAPHICS

| Client Name: (Last) (First) | DOB: (Day) / (Month) / (Year) | Gender: ☐ M ☐ F |
|---|---|---|
| Home Address (street #, street name, city, postal code): | | |
| Home/Cell Tel.#: | PHN#: | |
| Referred by:<br>Tel.#:<br>Fax #: | Family Physician:<br>Tel.#:<br>Fax#: | |
| Speaks & Understands English? ☐ Yes ☐ Minimal ☐ No<br>Interpreter Required: ☐ No ☐ Yes - Language: | | |

## MEDICAL STATUS

Date of Injury:

Mechanism of Injury:

Loss of Consciousness: yes (time)______ no unsure

Emergency Department at:________________ CT scan results:_______________________

Current Health Status (Physical, Cognitive and Emotional):

Social History and Supports:

Pre-Injury Health Issues/Medications:

Current Follow-up Plans/Additional Data:

Referring Clinician Signature: