NL BALANCE & DIZZINESS CENTRE

Newfoundland Balance & Dizziness Rehab Inc.
60 Elizabeth Ave, St. John', NL A1A 1W4
Phone/Fax: 709-700-1474
Email: info@nlbalance.com Website: www.nlbalance.com

Concussion Clinic Referral Form

Please fax completed form to NL Balance & Dizziness Centre at (709) 700-1474.

Patient Information		
Name		
Address		
Phone		Date of Birth:
MCP#		Exp Date:
Family Physician		Address/Tel:

Has this client been diagnosed with a concussion? _____Yes _____No
Date of brain injury: ____ / _____ / _____
year month day
Cause (select below):
___ Motor Vehicle Accident ____ Fall _____ Assault _____Work Related _____Other

If workplace or car collision, include the following contact information:
Claim Number: _____Case Manager/Adjuster_____ Tel: _____Fax:_____
Lawyer: _____Tel: _____Fax:_____

Responsibility for payment	___Auto Insurance ____Private Insurance ____WCB ____Self Pay
Investigations to date:	_____ CTScan _____MRI _____Other

List other medical history and medications:

Referring Physician Information/Comments		
Name:		
MCP Provider #:		
Address:		
Phone:		Fax:

Upcoming medication investigations:

Best practice is interdisciplinary treatment for concussion. Please check below.
_____ Referral to multi-disciplinary assessment program (Physio, Occupational, Psychol/Counselling)
_____ Neurology

Signature: Date: