Greenbank Acute Concussion Clinic
Referral Form

189 Hughson Street South, Hamilton, ON L8N 2B6
Telephone – Voicemail Line Only (905) 574-8630 Line 4 Fax (905) 383-3958

Please note that referrals are only accepted within 72 hours of the injury.

Patient Information:

Name:	**Health Card #:**	
Address:	**City:**	**Postal Code:**
Phone:	**DOB:**	**Gender:**
Speaks/Understands English ☐ Yes ☐ No (patient must provide interpreter)		
Contact person:		

Admission Criteria at least one of the following:

- ☐ Any period of loss of consciousness;
- ☐ Any loss of memory for events immediately before or after the accident;
- ☐ Any alteration in mental state at the time of the accident (confusion or disorientation);
- ☐ Focal neurological deficits that may or may not be transient.

The injury does not exceed:

_____

- ☐ Loss of consciousness greater than 30 minutes;
- ☐ GCS below 13-15 after 30 minutes;
- ☐ Posttraumatic amnesia greater than 24 hours.

Imaging completed (please attach to referral):

☐ CT ☐ MRI ☐ Other: _____

Date and mechanism of injury: _____

- ☐ Motor vehicle accident
- ☐ Sports-related injury
- ☐ Slip and fall
- ☐ Assault
- ☐ Workplace injury
- ☐ Other: _____

Referral date: _____
Name of referring Physician/Nurse Practitioner/Physician Assistant: _____
Signature: _____
Billing number: _____