Toronto Brain Health

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

Referral Form

Client Name: _____ _____
(Last) *(First)*

Date:_____ **Male:** □ **Female**: □ **Date of Birth:**_____/_____/ _____
year month day

Home Address:

_____

Postal Code:_____ **Telephone: ( ) _____**

Alternate Contact: _____ _____
(Name) *(Relationship)*

Alternate Contact: Telephone: ( ) _____

Form completed by: _____ _____
(print name) *(signature)*

Address:_____**Telephone**: ( )_____

_____ _____/_____/ _____
Relationship to referee *year month day*

Date of Injury/Event (if applicable):_____/_____/ _____
Year Month Day

Diagnosis:

_____

Brief Description of Presenting Problem / Injury:

_____
_____
_____
_____
_____
_____
_____
_____

Additional copies of this form can be found on our website.

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Nature of Service(s) Requested:

□ Neuropsychological Assessment
□ Memory Screen (older adults)
□ Concussion Management/Education
□ Neurological Consultation (*brain injury only; no WSIB/ MVA /medical legal referrals*)
□ Cognitive Rehabilitation
□ Psychological Assessment
□ Psychological Therapy
□ Vestibular Rehabilitation

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

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

CURRENT SYMPTOMS

PHYSICAL: (please check all that apply)

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

Comments:_____

PSYCHOLOGICAL/ BEHAVIOURAL: (please check all that apply)

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

Comments:_____

COGNITIVE STATUS:

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