Brain Care Centre®
Defy Limitations!

#305, Hys Centre, 11010 101 Street NW Edmonton, AB T5H 4B9
Tel. (780) 477-7575 Fax (780) 474-4415 www.braincarecentre.com

Referral for Brain Care Centre Concussion Service Program

Completed referral form is required for all new referrals.

Individual with Concussion/Mild Traumatic Brain Injury/Post-Concussion Syndrome Information

First Name	Last Name		Date of Birth
Address	City/Province		Postal Code
Phone - Home	Cell		Health Care Number
Email			
Alternate Contact Name	Emergency/Family/Other	Phone (Home) (Cell)	Comments

History of Concussions

Date of most recent concussion **(must be at least 3 months and less than 5 years post-injury to be eligible for services):**	
Event description & current symptoms	
Dates and brief descriptions of other past concussions	
Hospital of Admission	Rehabilitation Supports Received

Describe service currently provided (please include discharge summary/service plan if relevant)
Discharge date:
Please list any other relevant referral/treatment services <u>in place</u>:

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Please comment on family and/or natural supports

Medical Support

Family Doctor	Phone	Fax	Email
Medical Practitioner/Specialty	Phone	Fax	Email
Other	Phone	Fax	Email
Please comment on any other medical or health concerns (e.g. diabetes, heart condition, seizures, mental health, etc.)			

Is there a history of:	**If any of these boxes are checked, further information *must* be provided. Attach additional documents if required.***
☐ Substance use	
☐ Criminal charges	
☐ Violent behaviour	
☐ Mental illness	
☐ Learning disability	

*This information is collected to ensure the safety of our staff and the best outcome for our clients.

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Service Plan

Reason for referral – Please note if individual is involved in litigation or insurance claim for this injury.
Before an individual is eligible for service, BCC requires medical documentation of the concussion. As Brain Care Centre does not have access to Netcare, please send all medical documentation on file. This can include: a neuropsychological assessment, discharge summary, hospital records, chart notes, CT scan or MRI with interpretation of results, diagnosis from medical doctor, records from emergency room visit, summaries from rehabilitation professionals, etc.

Referral Completed By	Date	Relationship
Phone	Fax	Email

*This referral form must be completed by a licensed medical professional (e.g. physician, psychiatrist, neuropsychologist, LPN, RN). All areas of referral form **must** be completed or the referral will be deemed incomplete and sent back to the referral source.*

Mail to address at the top of the form or fax referrals to 780-474-4415
Attention: New Referral or email info@braincarecentre.com

By submitting this form, you agree that we may keep confidential and secure files with your information, both in paper form and in electronic form on a secure database.