ADVANCE CONCUSSION CLINIC Play Hard. Play Safe.™

Affix Patient Label Here

# REFERRAL FOR V-CNS/ADVANCE CONCUSSION CLINIC

**Injury History** **Date of Injury:** _____

1. **Injury Description** _____

_____

2. Was there evidence of injury? ___ Yes ___ No ___ Unknown
3. Was there imaging (i.e. CT, MRI) done? If so, please attach reports/imaging.

**Cause:** __ MVA __ MVA v. Pedestrian __ Fall __ Assault ___ Sports or Other (*specify)* _____

**Loss of Consciousness:** ☐ Yes ☐ No ☐ Unknown If yes, duration _____

**Seizures:** Were seizures observed? ___ Yes ___ No If yes, details _____

**Patient's Primary Complaint:** _____

**Risk Factors:**

| **Concussion History?** *(circle one)* **Y** **N** | **Developmental History** |
|---|---|
| If yes, specify #: _____ | Learning disabilities |
| **Headache History?** *(circle one)* **Y** **N** | ADHD |
| History of migraine headache<br>Patient _____ Family History_____ | Other developmental disorder<br>_____ |
| **Psychiatric History** *(circle one)* **Y** **N** | **Sleep Disorder?** *(circle one)* **Y** **N** |
| Anxiety | Please specify |
| Depression | If yes, what treatment if any |
| Other _____ | |

List other medical conditions and all current medications (e.g., hypothyroid, diabetes) _____

**Physician Comments/Referral Specific Questions:**

**Physician Signature:** _____

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