Vancouver CoastalHealth
Promoting wellness. Ensuring care.

G. F. Strong Rehab Centre

Early Response Concussion Service Referral Form

4255 Laurel Street
Vancouver, BC V5Z 2G9
Phone: 604-714-4186
Fax: 604-730-7904

Attention: Early Response Concussion Service Coordinator

CLIENT DEMOGRAPHICS

Client Name: (Last) (First)	DOB: (Day) / (Month) / (Year)	Gender: ☐ M ☐ F
Home Address (street #, street name, city, postal code):		
Home/Cell Tel.#:	PHN#:	
Referred by: Tel.#: Date: Fax #:	Family Physician: Tel.#: Fax#:	
Speaks & Understands English? ☐ Yes ☐ Minimal ☐ No Interpreter Required: ☐ No ☐ Yes - Language:		

MEDICAL STATUS

Mechanism and Date of Injury:

Details:

GCS(at scene): _____ LOC: yes (time)_____ no unsure

Emergency Department at:_____

CT scan results:_____

Current Health Status (Physical, Cognitive and Emotional):

Social History and Supports:

Pre-Injury Health Issues/Medications:

Current Follow-up Plans:

Additional Data: