Newfoundland Balance & Dizziness Rehab Inc.
60 Elizabeth Ave, St. John', NL A1A 1W4
Phone/Fax: 709-700-1474
Email: info@nlbalance.com Website: www.nlbalance.com

Concussion Clinic Referral Form

Please fax completed form to NL Balance & Dizziness Centre at (709) 700-1474.

Patient Information			
Name:			
Address:			
Phone:		Date of Birth:	
MCP #:		MCP Exp Date:	
Family Physician:		Address/Tel:	

Has the client been diagnosed with a concussion? _____ Yes _____ No
Date of brain injury: _____ / _____ / _____
year month day

Cause (select below):
_____ Motor Vehicle Accident _____ Fall _____ Workplace Injury _____ Other

If workplace injury or car collision, include the following contact information:
Claim Number: _____ Case Manager/Adjuster: _____ Tel: _____ Fax: _____
Lawyer: _____ Tel: _____ Fax: _____

Responsibility for payment:	_____ Auto Insurance _____ Private Insurance _____ WCB _____ Self Pay
Investigations to date:	_____ CT Scan _____ MRI ____ Other: _____

Past medical history: _____
Medications: _____
Treatment to date: _____

Referring Physician Information/Comments		
Name:		
MCP Provider #:		
Address:		
Phone:		Fax:

Comments:

Referred for:

☐ Physiotherapy ☐ Occupational Therapy ☐ Counselling ☐ Psychology ☐ Speech Therapy ☐ Sports Medicine

Signature: Date: