KIVALLIQ INTIMATE PARTNER VIOLENCE TRAUMATIC BRAIN INJURY PILOT PROGRAM REFERRAL FORM

Patient Name: _____(last),_____(first)

DOB(DD/MM/YYYY): _____ Nunavut health #:_____

Address: _____

Preferred telephone number: _____

Does patient require language interpretation services? No ☐ Yes ☐, (if yes, specify preferred language and dialect): _____

Has patient been recently transferred to Winnipeg for emergency medical care? Yes ☐ No ☐

Is patient appropriate to undergo elective out-patient clinical appointment at the Kivalliq Health Centre in Rankin Inlet? Yes ☐ No ☐

Patient age: _____ Patient sex: Male ☐ Female ☐

Date of Injury: _____

Clinical History and Present Symptoms:

_____

_____

Past Medical History:

_____

_____

Current Medications:

_____

Previous Investigations and Results (x-ray, CT, blood work etc.):

_____

_____

Referring healthcare provider:

_____(print);_____(signature)

This referral form is only to be used by healthcare providers caring for patients who meet strict referral criteria for the Kivalliq Intimate Partner Violence Traumatic Brain Injury Pilot Program. It is not to be used for patients living outside the Kivalliq region of Nunavut and those who require emergency medical care. Please visit www.panamclinic.org/departments/concussion-program/ for more information.