Note: For patients <20 years of age only

PAN AM CONCUSSION PROGRAM REFERRAL FORM

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

DOB(DD/MM/YYYY): _____ PHIN/MHSC#:_____

Address (street, town, prov/territory, postal code):_____
_____

Telephone #: _____ (home);_____(cell)

Patient age: _____ Sex: Male ☐ Female ☐ Gender: (Please specify)_____

Clinical History and Present Symptoms:
_____
_____

Past Medical History:
_____
_____

Current Medications:
_____

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

Previous Consultations/Treatments:
_____

*Requesting physician:*_____(print);_____(signature)

Billing #: _____

Address (street, town, prov/territory):_____

Telephone:_____ Fax:_____

Important: All patients will be seen at the Pan Am Concussion Program located on the **2nd floor of the Bell-MTS Iceplex, 3969 Portage Avenue** (just west of the perimeter highway). Please forward all diagnostic imaging studies, neuropsychology results and consultation records along with the referral. **Please fax referrals to 204-927-2768**