HealthNOW

FAX TO: 416-572-3110
Or
Email To: careteam@healthnow.health

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Referral to Concussion Physician

Reason for Referral: Patient requires concussion clinic follow-up.

PATIENT INFORMATION:

FIRST NAME:	LAST NAME:	DOB:
STREET ADDRESS:	CITY:	POSTAL CODE:
CELL PHONE NUMBER:	ALT PHONE NUMBER:	EMAIL ADDRESS:
HEALTH CARD NUMBER & VERSION CODE:		

INJURY:

Mechanism of Injury:	**Rehabilitation:**	**Description/Additional Information:**
☐ MVC ☐ Slip & Fall ☐ Assault ☐ Sports ☐ Other:	☐ Physiotherapy ☐ Chiropractic ☐ Chiropody (Foot Care) ☐ Sports Injury Assessment ☐ Post-Accident Assessment (specify) ☐ Physiotherapy ☐ Motor Vehicle Accident (MVA) ☐ Work Accident (WSIB) ☐ Other	

REFERRING PHYSICIAN:

PHYSICIAN NAME:	BILLING NUMBER:
DATE:	SIGNATURE:

Please fax or email completed form with medical chart and/or any relevant investigations to
Phone: 416-859-4400 Fax: 416-572-3110. Email: careteam@healthnow.health
Patient will be contacted post-discharge for appointment scheduling.

Thank you for your referral.