MINDS
Mississauga Institute of Neurological Disorders and Stroke

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Concussion Clinic Referral & Intake

PATIENT INFORMATION	
Last Name:	First Name:
Date of Birth (DD/MM/YYYY):	Gender: ☐ Male ☐ Female
Home Phone:	Cell Phone:
Health Card Number:	

Cause of Injury: (Check all that apply)

☐ Motor Vehicle Accident ☐ Sports ☐ Assault ☐ Hit by Object ☐ Bike accident ☐ Other.

Date Of Injury: _____

Did the patient Lose consciousness? ☐ YES ☐ NO

Approximate length of time Unconscious_____

Symptoms and Ancillary Testing Requested (check all that apply)

SYMPTOMS REPORTED

☐ Headaches ☐ Dizziness ☐ Nausea/Vomiting ☐ Noise Sensitivity ☐ Light Sensitivity V Blurred Vision ☐ Sleep disturbance ☐ Fatigue/easily tired ☐ Irritable mood ☐ Feeling Depressed ☐ Feeling frustrated/impatient ☐ Forgetfulness. ☐ Poor Concentration ☐ Radicular Pain ☐ Other

TESTING REQUESTED

☐ Vestibular Testing ☐ Cognitive Evaluation ☐ Home Sleep Study ☐ EMG/ Nerve conduction Studies ☐ EEG

Referring Physician/ Np Information

Name:	Billing Number:
Phone:	Fax:
Copies to:	