Vancouver Coastal Health
G. F. Strong Rehab Centre

GF Strong Adult Concussion Services (GFACS)
Email: gfsadultconcussionservices@vch.ca
Ph: 604.737.6458; Fax: 604.730.7904

GFS Adult Concussion Services (GFACS): GROUP EDUCATION SESSION Referral Form

CLIENT INFORMATION

NAME: _____ **PHN:** _____
Last First Middle

DATE OF BIRTH: _____ **GENDER:** ☐ M ☐ F ☐ Other
(Must be ≥ 18y) (MMM/DD/YYYY)

CURRENT ADDRESS: _____ **PHONE:** _____
(*must reside in Vancouver Coastal Health authority: Vancouver, North Van, Richmond, Sunshine Coast)

EMAIL ADDRESS: _____

Please indicate if the injury involves: ☐ ICBC ☐ Worksafe BC ☐ Crime Victims

Interpreter Required: ☐ Y ☐ N **Language:** _____

DATE OF INJURY: _____ **Referrals only accepted within 12 months of injury*
(MMM/DD/YYYY)

DIAGNOSIS OF CONCUSSION? ☐ Y ☐ N **CAUSE OF INJURY:** _____

DIAGNOSTIC CRITERIA:		**Concussion criteria:**	**Moderate TBI criteria:**
Glasgow Coma Scale	☐ Never <15	☐ 13-14 at any time	☐ <13 for 30+ minutes
Loss of consciousness	☐ No	☐ Yes, <30 minutes	☐ Yes, >30 minutes
Post-traumatic amnesia	☐ No	☐ Yes, <24 hours	☐ Yes, >24 hours
Confusion or disorientation	☐ No	☐ Yes, <24 hours	☐ Yes, >24 hours
Positive neuroimaging	☐ No		☐ Yes, midline shift or basal cistern compression

For Moderate TBI, Refer to GFS ABI OP program

ANY OTHER RELEVANT DIAGNOSES / INFORMATION: (prior concussions, mental health history, substance use, learning difficulties, brain injuries, dementia, other injuries sustained concurrent with concussion):

_____
_____

REFERRED BY: *(must be referred by a physician or nurse practitioner)*

NAME / TITLE: _____ **HOSPITAL/CLINIC:** _____

PHONE: _____ **FAX:** _____

FAMILY DOCTOR: _____ **PHONE & FAX:** _____

HAS CLIENT BEEN INFORMED OF REFERRAL? ☐ Y ☐ N

SIGNATURE: _____ **DATE:** _____

COMPLETED REFERRALS MAY BE EMAILED (**gfsadultconcussionservices@vch.ca**) OR FAXED (604.730.7904)

*****INCOMPLETE REFERRALS WILL BE RETURNED UNPROCESSED*****