Toronto Brain Health

5700 Yonge St., Suite 200, Toronto, ON, M2M 4K2
Phone: (416) 646-2194; Fax: (416) 342-1968
Email: contact@torontobrainhealth.com

Referral Form

Client Name: _____ _____
(Last) *(First)*

Date: _____ Male: □ Female: □ **Date of Birth:** _____ / _____ / _____
year month day

Home Address:

_____

Postal Code: _____ **Telephone: ( ) _____**

Alternate Contact: _____ _____
(Name) *(Relationship)*

Alternate Contact: Telephone: ( ) _____

Form completed by: _____ _____
(print name) *(signature)*
Address: _____ **Telephone**: ( )_____

_____ _____ / _____ / _____
Relationship to referee *year month day*

Date of Injury/Event (if applicable): _____/ _____/ _____
Year Month Day

Diagnosis:

_____

Brief Description of Presenting Problem / Injury :

_____
_____
_____
_____
_____
_____
_____
_____

Additional copies of this form can be found on our website.

Toronto Brain Health
5700 Yonge St., Suite 200, Toronto, ON, M2M 4K2
Phone: (416) 646-2194; Fax: (416) 342-1968
Email: contact@torontobrainhealth.com

Nature of Service(s) Requested:

□ Neuropsychological Assessment
□ Memory Screen (older adults)
□ Concussion Management/Education
□ Cognitive Rehabilitation
□ Psychological Assessment
□ Psychological Therapy

Reports Included:

□ MRI
□ CT Scan
□ X-ray
□ Occupational therapy
□ Physiotherapy
□ Social Work
□ Consult/ Discharge Note
□ Speech Language Pathology
□ Neuro/Psychology
□ Other _____

CURRENT SYMPTOMS

PHYSICAL: (please check all that apply)

□ Paresis/paralysis
□ Pain
□ Fatigue
□ Balance
□ Mobility
□ Headache
□ photo/phono phobia
□ Dizziness

Comments:_____
_____
_____
_____

PSYCHOLOGICAL/ BEHAVIOURAL: (please check all that apply)

□ Anxiety
□ OCD
□ Post-concussive syndrome
□ Trauma/PTSD
□ Low Mood
□ Adjustment
□ Sleep difficulties
□ Suicide Risk
□ Anger/irritability
□ Psychosis
□ Alcohol/substance abuse
□ Sexual Inappropriateness

Comments:_____
_____
_____
_____

COGNITIVE STATUS:

Please comment on any presenting cognitive difficulties (e.g., memory, attention, problem solving):

Comments:_____
_____
_____
_____