UNIVERSITY OF ALBERTA
GLEN SATHER SPORTS MEDICINE CLINIC

Kaye Edmonton Clinic, Level 2
11400 University Avenue
Edmonton, Alberta T6G 1Z1
Tel: 780-407-5160
Fax: 780-407-5667

Complex Concussion Clinic Referral

The GSSMC Complex Concussion Clinic an interdisciplinary assessment clinic consisting of a neurologist, a sports medicine physician, a neuropsychologist and a physiotherapist.

The Clinic is intended for patients with prolonged concussion symptoms (i.e. **1-12 months**) directly related to sport concussion/injury.

There is a charge of $375.00 to the patient for services not covered by Alberta Health (Physical Therapy Assessment, Neuropsychology).

****This clinic will *not* accept active MVA, WCB or medical-legal adjudication requests.**

Patient Demographics

Name: _____	**Address:** _____
Date of Birth (Y/M/D):_____/_____/_____	**PHN:** _____
Telephone: Home: _____	**Mobile:** _____

Concussion Details

Date of concussion (Y/M/D): _____/_____/_____			
What is the primary reason for referring this patient? _____			
Is this a sport related concussion?	**Yes** ☐ **No** ☐	**Is this related to a WCB incident?**	**Yes** ☐ **No** ☐
Is a headache waking the patient up at night?	**Yes** ☐ **No** ☐	**Is this related to an MVA?**	**Yes** ☐ **No** ☐
Has the patient been treated for an acute mental illness within the last 3-6 months?			**Yes** ☐ **No** ☐
Details:			
Is there any evidence of current substance abuse?			**Yes** ☐ **No** ☐
Details:			

Please describe the mechanism of injury in detail:

_____

_____

_____

Please see other side

Current school and/or work status (e.g. full time, part time, not attending):

_____

Current level of physical activity (e.g. normal, reduced contact, reduced intensity, none):

_____

What other health care providers and treatments have been attempted (PT, chiro, massage, optometry)? How often were these treatments?

_____

_____

What medications have been tried (dosage, frequency)?

_____

_____

Past concussion history (when, details):

_____

_____

Other pertinent medical history (including surgery, hospitalizations):

_____

_____

Referring Health Professional Details (Affix Label if available):

Name: _____	**Phone Number: _____**
PRACID: _____	**Fax Number: _____**
Address: _____	**Referral Date: (Y/M/D): _____/_____/_____**

Please complete and return this form by fax to 780-407-5667