Physiatry Outpatient Acquired Brain Injury Referral Form

Parkwood Institute
550 Wellington Rd London N6C 0A7
Phone: 519-685-4579
Fax: 519-685-4075

Patient Name:	Referring Physician:
DOB (YY/MM/DD):	Phone:
OHIP #:	Fax:
Address:	Billing Number:
	Referral Date:
Contact phone:	Physician's Signature:

REASON FOR CONSULTATION: Please include if any loss of consciousness? date of injury, any history of seizures? Please include reason for referral:

ABI – **Please Circle** MILD MODERATE SEVERE

CURRENT MEDICATIONS:

MVA or other Injury? WSIB if applicable:

Present treatments/therapies to date:

PLEASE ATTACH: Any relevant E.R. Reports , MRI / CT Reports, X-Rays, Bloodwork, consult reports

Please circle urgency of request.

0 1 2 3 4 5

Non Urgent Very Urgent

If form is incomplete we will return it for you to complete.

Should your patient be transported by Ambulance (or any other medical transportation company), please ensure that there is an attendant or family member with the patient as wait times for return pick-up can be lengthy.

If the patient is not able to provide pertinent information or give informed consent for any potential medical procedures, please ensure they are accompanied by someone who has been designated to do this for them.

Please fax completed form to 519-685-4075 Questions (519) 685-4579

☐ Referral declined, not appropriate for this clinic.