Rehabilitation Referral Form

Youth Sports Concussion PROGRAM

Patient Name: _____ Date of Visit: _____

School: _____ Date of Birth: _____

Diagnosis:

- ❑ Concussion
- ❑ Post-concussion syndrome
- ❑ Cervicalgia
- ❑ Other

Impairments:

Date of Injury: _____

Prescription: Physiotherapy Massage Therapy Mental Health

Precautions (if any): _____

Instructions:

- Vestibular Rehabilitation
- Cervical Rehabilitation
- Exercise Rx (please see Appendix H)
- Return To Play Protocol (please see Appendix J)
- Support Group
- Individual Therapy
- Other

_____ _____

Name of Health Care Provider *Signature*

_____

Date