Vancouver Coastal Health
G.F. Strong Rehab Centre

GF Strong Rehabilitation Centre
4255 Laurel Street
Vancouver, BC V5Z 2G9

Adolescent Complex Concussion Clinic (ACCC)
Phone: 604-737-6291 ext. 0
Fax: 604-730-7904

Adolescent Complex Concussion Clinic (ACCC) Referral Form

- o 12-17 year-old or 18 year-old in high school diagnosed with a concussion in the last 18 months.
- o Is either **MORE than1 month** post-concussion with persistent symptoms **OR LESS than 1 month** with **ONE** of the following risk factor(s): prior concussion(s), history of learning disability, diagnosis of ADHD or other developmental disability, history of migraine/headaches, history of depression/mood disorders/anxiety, and/or sleep disorder.
- o Must have been seen by the local general physician, pediatrician, and/or concussion clinic but now needs specialized provincial service due to the unresolved complex persistent concussion symptoms
- o Exclusion: severe/untreated substance use disorder and mental health condition
- o Physician referrals only.

****FAX REFERRAL FORM TO: 604.730.7904****

****INCOMPLETE REFERRALS WILL NOT BE PROCESSED AND WILL BE RETURNED****

Client Name/Address(street#, street name, city, postal code):	DOB: (Day) / (Month) / (Year)	Gender: ☐ M ☐ F
	PHN#:	
Clients contact #/e-mail: Parents contact #/e-mail:	Referred by: Tel.#: Fax #:	
Ministry of Children and Family Development: ☐ Yes, contact info: ☐ No	Family Physician Name: Tel.#: Fax#:	
School Name: Grade Level: School concerns:	Affiliated Third Payer Funding: ☐ Yes, name of organization and contact info: _____ ☐ No	
Speaks & Understands English? ☐ Yes ☐ Minimal ☐ No	Interpreter Required: ☐ No ☐ Yes, language: _____	

MEDICAL STATUS

Date of Concussion: **Total # of Concussions:**	**Mechanism:**
GCS(at scene): **Emergency Department (if seen):**	**LOC**: ☐ Yes (time)_____ ☐ No ☐ Unsure
Imaging results : ☐ Yes(please attach) ☐ No	**Neuropsych Assx :** ☐ Yes(please attach) ☐ No
List Top Three Most Problematic Symptoms to be addressed: **1)** **2)** **3)**	**Current Medications:**
Risk Factor(s): □ Prior concussion □ History of learning disability/ ADHD/developmental disability □ Depression, mood disorder, &/or anxiety □ History of migraines/headaches □ Sleep disorder □ Other:	
Current Health Care Provider(s) Involved/Contact Info: ex. Concussion Clinic, GP, Pediatrician	