Concussion Consultation Request

Requesting Physician/ATC ____
Date of Request ______________________________

Patient Name ________________________________ Date of Birth _______________
Patient's School ______________________________
Patient's Primary Care Physician______________________________
Sport_______________________________________ Date of Injury _______________
Previous Concussions Y / N Please explain ___________________________________
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Loss of Consciousness Y / N Seizure Y / N Balance Problem Y / N
Retrograde Amnesia Y / N Antegrade Amnesia Y / N
Mouth Piece Y / N Type______________________
Other Symptoms Y / N Please explain _______________________________________
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Date of Appointment_______________________
Time of Appointment_______________________

TO THE PATIENT-

Please arrive 15 minutes before your appointment time, as there may be some extra paperwork that may need to be completed prior to your appointment. Bring your insurance card(s), all medications that you are currently taking, and including any nutritional supplements.

PLEASE PROVIDE 24 HOURS NOTICE of CANCELATION as your appointment is set aside for 30-45 minutes for the initial evaluation. IF you do not provide such notice YOU WILL BE BILLED FOR THAT TIME.

For Office Site and Directions please visit our website at www.lvismm.org

Athletic Trainer- Please fax this form to our office at 610-691-8420 with copies of the athletes insurance card(s) and a copy of any school insurance claim that may be filed. Also, please provide the athlete's parent(s) with this request as it will serve as their appointment card. Our office will fax or email a copy of the report to you if you so desire. Please provide us with the fax or email and we will keep it on file.

If you should have any questions, please do not hesitate to contact us as we look forward to working with you and your athletes.