Seekers Centre

Healing the brain and body

MVA High Risk Pain Clinic Referral Form

Fax to: 613-727-7247

Date of Referral: _____

Patient Information: **(Affix patient label if available)**

Patient Name: _____ Phone #: _____

Date of Birth: _____

Patient has risk factors for: **(Check all that apply)**

Concussion	Chronic Pain	Anxiety or PTSD
☐ LOC	☐ High-speed Injury	☐ Prior mood disorder
☐ Amnesia	☐ Catastrophizing	☐ Traumatic event
☐ Dizziness	☐ Immediate onset of pain	☐ Fear or anger on scene
☐ Confusion	☐ Decreased ROM	☐ Young child in vehicle
☐ Mood Disorder	☐ Prior pain syndrome	
☐ ADHD or learning disorder		

Clinical History

Referring Physician: _____ Billing #: _____

Referring Clinic/Hospital: _____

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