HEAD INJURY REFERRAL

To Be Completed By Designated School Representative And Signed By Parent/Guardian

Date: _____

To: California-licensed Healthcare Provider

From: Staff member making referral: _____

Position: ☐ Nurse ☐Coach ☐Athletic Trainer ☐Health Tech ☐Principal ☐Other_____

RE: Student Name: _____ **Birthdate:** _____

School _____ Grade: ___ Teacher or Room: _____

I the parent/guardian authorize release of information about concussion and management, between this school and student's physicians:

Name:_____ _____

(Signature of Parent or Guardian) (Printed Name of Parent or Guardian)

Dear Licensed Healthcare Provider,

This student was noted to have these symptoms or signs after an injury (immediately or within hours):

☐Dizziness	☐Seeing stars	☐Temporary loss of consciousness	☐Confusion/foggy feeling
☐Nausea	☐Vomiting	☐Amnesia around event	☐Light or noise sensitive
☐Ringing in ears	☐ Fatigue	☐Slurred speech	☐ Delayed response to questions
☐Appeared dazed		☐Concentration/memory problem	☐Irritability or personality change

☐*Headache/pressure feeling in head (**if attributable to cut, bruise, then inadequate alone to diagnose concussion).*

OR: ☐Standardized Concussion Assessment attached to this form (e.g., SCAT)

The injury occurred on _____ **(*date*) at approximately** _____ **(*time*).**

Details of injury that occurred are (i.e., *which sport/activity, part of head or body hit or jolted, nature of object, force etc.*):

_____

_____

Students suspected of having a concussion must have a graduated Return to Play protocol of no less than seven days in duration under supervision of a licensed healthcare provider (MD or DO). Input regarding the medical examination today and medical management plans are requested by this school.

Attached is a: ☐Return to Learn and/or ☐Return to Play form for you (or another physician) to complete.

☐Head Injury Report form (provides warning signs of subdural hematoma)

To Be Completed By Licensed Healthcare Provider

I have reviewed the above history of concussion symptoms and my diagnosis is:

A: ☐ No concussion; student may immediately resume all activities without restriction. *or*

B: ☐Yes, a concussion occurred or is likely to have occurred and I prescribe the following:

☐ Recommended standard for initial treatment: First day after injury, stay home, cognitive rest, no physical activity. Once student tolerates a 15 minute walk without symptoms, can begin school with a half-day the first day back, and full days as tolerated thereafter.

Attached, see completed: ☐ Return to Learn Instructions ☐ Return to Play Instructions ☐ Return to Play Clearance

☐ I will see this patient again (date): _____

Signature of Examining Clinician _____ **Date:** _____

Printed Name of Examining Clinician _____ **Phone**: _____

Name of Clinic/Address of Clinician _____

PLEASE return this form to: Name _____

School or Address _____

Phone:_____ **Fax** _____

Schools to retain a copy of completed form before sending to licensed healthcare provider.