CONCUSSION
Medical Assessment Letter

Name of patient	***Date:*** _______ / _______ / ________

To be complete by the Medical Office

Name of the Medical Office	
M.D. / N.P. name[1] (capital letters)	
Medical License #	
Email / Contact #	
Date of concussion	
Date of assessment	

To Whom It May Concern:

Any individual who sustains a blow or impact to the head, face, neck or body and demonstrates any visual signs of concussion or reports any of the symptoms of concussion is recommended to be assessed by a licensed medical professional. Accordingly, I have personally completed a medical assessment on this patient.

RESULTS OF THE MEDICAL ASSESSMENT

☐	This patient has not been diagnosed with a concussion or other injury and can return, with full participation to work, school, or physical activities without restriction.
☐	This patient **HAS** been diagnosed with a concussion. *See below for concussion management protocol.*
☐	This patient has been instructed to avoid all activities that could potentially place them at risk of another concussion or head injury, or activities with implications for the safety of others (e.g., driving, dangerous job duties, and contact sports) until a licensed physician or nurse practitioner provides a Medical Clearance Letter. [1]

Signature: ____ M.D. / N.P. *(please circle appropriate designation [1])*

1. Depending upon physician or nurse practitioner access, the Medical Assessment Letter may be completed by a nurse with access to a licensed physician or nurse practitioner. Forms completed by other health care professionals (e.g., physiotherapists, chiropractors, and other allied health care professionals) should not be accepted. It is recommended that this document be provided to the patient without charge.

Concussion management protocol

Name of patient:	**Date:** _______ / _______ / ________

The goal of concussion management is to allow complete recovery through a safe and gradual return to work, school and physical activities. *Note: a patient's progress through the return to activity stages is unique to the individual.* After Stage 2, if new or worsening symptoms are experienced, he may need to return to the previous stage for 24 hours and consider reassessment by their physician/nurse practitioner. For more detailed information on management and resources, please refer to the Concussion Awareness Training Tool (CATT) at cattonline.com.

Stage 1 – Initial Rest

In the first 24-48 hours the patient has been instructed to have complete physical and cognitive rest prior to initiating a return to work or activity.

☐	*Not yet completed*
☐	*Completed on (dd/mm/yyyy)* _______ / _______ / _________
☐	*Time period has passed*

Stage 2 – Prepare to return to activity at home

The patient can begin the return to activity process at home by undertaking brief familiar tasks until no new or worsening concussion symptoms are experienced.

☐	*Not yet completed*
☐	*Completed on (dd/mm/yyyy)* _______ / _______ / _________
☐	*Time period has passed*

Stage 3 & 4 – Prepare to return to work, school, and physical activity and gradually resume daily activities

The patient can initiate a graduated return to work, school, and physical activities on a part-time basis, by increasing and gradually resuming usual activities (supported with accommodations, modifications, and restrictions as needed) as tolerated and only at a level that does not bring on new or worsening concussion symptoms.

☐	*Not yet completed*
☐	*Completed on (dd/mm/yyyy)* _______ / _______ / _________
☐	*Time period has passed*

1. Depending upon physician or nurse practitioner access, the Medical Assessment Letter may be completed by a nurse with access to a licensed physician or nurse practitioner. Forms completed by other health care professionals (e.g., physiotherapists, chiropractors, and other allied health care professionals) should not be accepted. It is recommended that this document be provided to the patient without charge.

Name of patient:

Restrictions/Accommodations	***Details***	***Timeline***

Stage 5 & 6 – Full return to work, school, and physical activities

The patient can return with full participation to work, school, and physical activities.

☐	*Not yet completed*
☐	*Completed on (dd/mm/yyyy) _______ / _______ / _________*
☐	*Time period has passed*

Restrictions/Accommodations	***Details***	***Timeline***

Signature: _______________________________________ M.D. / N.P. *(please circle appropriate designation [1])*

Name in capital letters: ____

1. Depending upon physician or nurse practitioner access, the Medical Assessment Letter may be completed by a nurse with access to a licensed physician or nurse practitioner. Forms completed by other health care professionals (e.g., physiotherapists, chiropractors, and other allied health care professionals) should not be accepted. It is recommended that this document be provided to the patient without charge.