Emergency Department and Trauma Programs

BRAIN INJURY EVALUATION FORM

PATIENT INFORMATION

Date: AAYY/MM/JD Time of assessment: 00:00

Brought by: ☐ parents ☐ ambulance ☐ other _____________
Brought from: ☐ accident site ☐ home ☐ doctor’s office ☐ other hospital: _____________
Cause of injury: ☐ fall ☐ sports ☐ MVC ☐ non-accidental ☐ other _____________

Past medical history:

Medication & Allergies: ____________________ Vaccination: _____________

Injury description: _______________________________________________________

AT TIME OF INJURY (☒ for positive findings)

Loss of consciousness ☐ duration:
Disoriented, confused ☐ ☐ person ☐ place ☐ time
Post-traumatic seizure ☐ duration:
Retrograde amnesia (events before accident) ☐
Anterograde amnesia (events after accident) ☐
Vomiting ☐
Headaches ☐
Dizziness ☐
Other: ____________________ ☐

IN THE EMERGENCY DEPARTMENT (☒ for positive findings)

| LEVEL OF CONSCIOUSNESS – PAEDIATRIC GLASGOW COMA SCALE (range: 3 to 15): |
|---------------------------------|--------------|----------------|-----------------|
| EYE OPENING | VERBAL RESPONSE | MOTOR RESPONSE |
| Age: > 2 yrs | Age: > 2 yrs | Age: > 2 yrs |
| ≤ 2 yrs | ≤ 2 yrs | ≤ 2 yrs |
| Spontaneous | Oriented | Coos, babbles | Obeys commands | Normal, spontaneous |
| To voice | Confused | Irritable, cries | Localizes pain | Withdraws to touch |
| 3 | 4 | 5 | 6 | |
| To pain | Inappropriate | Cries to pain | Withdraws to pain | Withdraws to pain |
| 2 | 3 | 4 | 5 | |
| None | Incomprehensible | Moans to pain | Flexion to pain | Abnormal flexion |
| 1 | 2 | 3 | 4 | |
| None | None | None | Extension to pain | 2 Abnormal extension |
| 1 | 1 | 1 | 5 | |

Eye opening = ________ Verbal = ________ Motor = ________

PAEDIATRIC GLASGOW COMA SCALE TOTAL = ________/15

Headache ☐ location:
Nausea ☐
Vomiting ☐ # ________ time of last episode:
Drowsiness ☐
Dizziness ☐
Altered vision (i.e. diplopia, blurry vision, photophobia) ☐
Altered hearing (i.e. tinnitus) ☐
Altered speech (i.e. dysphasia, difficulty finding words) ☐
Exam affected by suspected alcohol/drug use ☐
NEUROLOGICAL EXAMINATION (☐ for positive findings)

- Depressed skull fracture
- Bulging fontanel
- Tenderness on palpation
- Signs of basal skull fracture
- Hematoma
- Laceration
- Mental status, oriented x 3:
  -☐ person
  -☐ place
  -☐ time

Motor: ☐ for abnormal findings

- C-spine clearance
- Ocular exam
- Visual tracking
- Facial asymmetries
- Coordination (finger nose, arm extended, 10 x)
- Strength (grip, major muscle groups)
- Sensation (numbness, tingling)
- Toe walk/heel lifts
- Heel walk
- Balance (tandem gait, 10 steps)
- Gait
- Reflexes: ☐ clonus R L Babinski ↑ ↓ R L ☐ deep tendon R L

Other:

Physical systems exam:

________________________________________

PLAN

☐ Skull and other X-ray: __________________________
☐ Blood work: __________________________

☐ CT Scan: __________________________
☐ Urinalysis: __________________________

☐ Admission: Patient meets admission criteria; patient admitted to ward ______________ Follow-up by Neurotrauma Program as in-patient (Criteria is available on desktop under “Protocols”)

☐ Neurosurgery consulted; patient to be seen in Emergency Department

☐ Other consultants (ex: Ortho, Ophth, ENT, etc) specify: __________________________

NOTE: if an assault case, consult Social Services

☐ Discharge package given with explanation

☐ Activity restrictions (specified time if needed): ______________ Must be symptom free at rest for 1 week prior to gradual return to physical activity

☐ Discharge home, follow-up PRN

☐ Discharge home with out-patient referral to Neurotrauma Program

Criteria for referral to Neurotrauma Program

one or more of the following:

- Delayed emergency department visit with a confirmed skull fracture
- Any patient given a Miami-J collar to rule out a neck injury
- Prolonged LOC (> 1 minute) at time of injury
- Multiple concussions (> 2 in the same year) or occurring with less impact forces
- Persistent symptoms with no improvement lasting greater than one week
- Persistent deficits or cognitive impairments
- Elite athlete (> 8 hours/week in a competitive sport)

Diagnosis/Comments: ______________

______________________________

______________________________

Physician’s Signature: __________________________
Physician’s Name: __________________________
Physician’s license number: __________________________

(REV 06/2006, 01/2009)