

**Appendix 1 (as submitted by the authors): Physician Evaluation Form, 2002-2003.**

**Please Fax Completed Forms to: 412-432-3686**

NHL Concussion Program 2002-2003

**Physician Evaluation Form**

Player Name: \_\_\_\_\_ Team: \_\_\_\_\_ Man Number: \_\_\_\_\_ Date of Injury \_\_\_\_\_ (mm/dd/yy)  
 Practice  Game  Period: 1st  2nd  3rd  OT  Time of injury during game: \_\_\_\_\_ (minute)

<p><b>Was the Player:</b> (check one)</p> <p>Returned to play immediately? <input type="checkbox"/></p> <p>Evaluated and returned to play? <input type="checkbox"/></p> <p>Evaluated and removed from play? <input type="checkbox"/></p> <p>Hospitalized? <input type="checkbox"/></p> <hr/> <p><b>Memory Loss</b> Yes No</p> <p>Does the player remember the hit/impact? <input type="checkbox"/> <input type="checkbox"/></p> <p>Was there memory loss for events prior to the hit? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how long? (minutes): _____</p> <p>Was there memory loss for events after the hit? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how long? (minutes): _____</p>	<p><b>Loss of Consciousness (LOC)</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">Yes</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">Observed/ Documented</td> <td style="text-align: center;">Reported/ Suspected</td> </tr> <tr> <td>Was there loss of consciousness?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">Observed/ Documented</td> <td style="text-align: center;">Reported/ Suspected</td> </tr> <tr> <td>If yes, estimate length/duration of LOC:</td> <td></td> <td style="text-align: center;">_____ min:sec</td> <td style="text-align: center;">_____ min:sec</td> </tr> <tr> <td>Person documenting LOC?:</td> <td colspan="3">_____</td> </tr> </table>		No	Yes	Yes			Observed/ Documented	Reported/ Suspected	Was there loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			Observed/ Documented	Reported/ Suspected	If yes, estimate length/duration of LOC:		_____ min:sec	_____ min:sec	Person documenting LOC?:	_____		
	No	Yes	Yes																						
		Observed/ Documented	Reported/ Suspected																						
Was there loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
		Observed/ Documented	Reported/ Suspected																						
If yes, estimate length/duration of LOC:		_____ min:sec	_____ min:sec																						
Person documenting LOC?:	_____																								

Concussion is defined as a pathophysiologic process affecting the brain, induced by traumatic biomechanical forces. Concussion results in a graded set of clinical syndromes that may or may not involve loss of consciousness or memory dysfunction. Concussion typically results in a functional disturbance with the rapid onset of short-lived impairment of neurological function that resolves spontaneously.

**Neurocognitive Evaluation**

Modified from the McGill Abbreviated Concussion Evaluation (ACE)

**Symptom Self-Rating**

Ask the player to rate themselves on the scale below, with "0" being no symptom and "6" being the most severe level of symptom.

Symptom	Scale						
	(none)						(severe)
"Don't feel right"	0	1	2	3	4	5	6
Headache	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Low Energy	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6
Nervous/Anxious	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Numbness/Tingling	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Feeling "pressure in head"	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Other: _____	0	1	2	3	4	5	6

**Immediate Memory**

Choose 5 words from the list provided. Place a check mark beside each choice. Avoid choosing related words such as "dark" and "moon" which can be recalled by means of word association. Read each word at the rate of one word per second. Upon completion, ask the candidate to repeat each word. Record correct answers with a check mark. To be considered correct, the word must be repeated, but not necessarily in the order that it was given. Inform candidates that they will be asked to repeat the same 5 words in approximately 5 minutes.

	Immediate	Delayed
___ Bread	___	___
___ Candle	___	___
___ Hard	___	___
___ Dark	___	___
___ Moon	___	___
___ Bottle	___	___
___ Music	___	___
___ Salt	___	___
___ Hand	___	___
___ River	___	___
___ Road	___	___
___ Window	___	___
___ Cheese	___	___
___ Book	___	___
___ Ocean	___	___

**Reverse Digits**

Instruct the candidate to repeat a string of digits in reverse order. Give an example before beginning the test such as "If I say 7-5-2, you say 2-5-7". Read each number at the rate of one number per second.

	Pass	Fail
5-1	___	___
4-9-3	___	___
3-8-1-4	___	___
6-2-9-7-2	___	___
7-1-5-2-8-6	___	___
4-7-3-9-1-2-8	___	___

**Neurologic Examination**

	Pass	Fail
Eye Motion	___	___
Gen.Facial Expression	___	___
Tandem Gait	___	___
Pronator Drift	___	___
Visual Field	___	___
Finger-Nose-Finger	___	___
Rhomberg	___	___
General Strength	___	___

**NHL Concussion Hotline**

Have you called the Concussion Hotline? **416-981-2782** Yes No

Physician's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

When the player has been cleared to return to full unrestricted participation, record the date and fax this form to 412-432-3686 again:

Date Cleared : \_\_\_\_\_  
mm / dd / yy

Physician's Name: \_\_\_\_\_

Signature: \_\_\_\_\_