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Review form

Patient's encounter number

_____

Record

_____

Patient's age at the time of admission to the emergency department (in years)

_____

Patient's sex

◯ Male
◯ Female
◯ Unknown

Admission date

_____

Injury event

(Definition: Any external strike, force of acceleration/ deceleration, or explosive force/shock wave)

◯ No
◯ Yes, known
◯ Yes, suspected
◯ No documentation

Injury due to abuse
(Definition: Documentation indicates the injury was secondary to abuse)

◯ No
◯ Yes, known
◯ Yes, suspected
◯ No documentation

Date of injury

_____
(The date the injury event occurred, if known. Please use mmddyyyy format. If the exact date of injury is not documented, please type "UKN")

Time of injury

_____
(The time the injury event occurred, if known. Please use military time format. If the time of injury is not documented, type "UKN")

The number of hours between the injury event and the time of ED admission

◯ < 1 hour
◯ 1-11 hours
◯ 12-23 hours
◯ 24-48 hours
◯ >48 hours
◯ Unknown

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Within the medical record, was there mention of the following signs and/or symptoms by anyone?				
	No	Yes, known	Yes, suspected	No documentation
Change in the child's normal pattern of eating, drinking or nursing	○	○	○	○
Change in the child's normal interest in enjoyable activities	○	○	○	○
Dazed, foggy, confused, disoriented, or not able to think clearly	○	○	○	○
Difficulty remembering what happened just before or after the injury event, difficulty recognizing people or places or learning new things	○	○	○	○
Loss of consciousness (also referred to as syncope or fainting)	○	○	○	○
Nausea or vomiting that occurred early on following the injury event	○	○	○	○
Headache including pain or feeling pressure in the head subsequent to injury event	○	○	○	○
Dizzy, uncoordinated, had poor balance, was stumbling around, was moving more slowly than usual, or had imbalance on gait testing (e.g., tandem walk ability normal/able vs abnormal; speed normal vs decreased)	○	○	○	○
Blurred vision, double vision, or decreased vision as compared to pre-injury state	○	○	○	○
Difficulty concentrating or easily distractable	○	○	○	○
Sensitivity to noise or light (Noise or light are disturbing or painful to the patient)	○	○	○	○
Change in mood or personality such as irritability, nervousness, anxiety, feeling more or less emotional or sad, or feeling more bothered by things	○	○	○	○

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Difficulty falling asleep, more drowsy than usual, or sleep quantity is noticeably more or less than usual	◯	◯	◯	◯
Slurred speech, inability to speak (aphasia) or other speech problem	◯	◯	◯	◯
Ringing in the ears (tinnitus) or other change in hearing	◯	◯	◯	◯
Motor or sensory loss including weakness, numbness or tingling	◯	◯	◯	◯

Any signs of alcohol or drug intoxication noted

◯ No: No signs of alcohol/drug use or intoxication are report or observed
◯ Yes, known: Documentation indicates alcohol/drug use associated with event, either by observation or positive laboratory testing
◯ Yes, suspected: Documentation indicates suspicion of alcohol/drug use associated with event but not confirmed
◯ No documentation: No documentation of alcohol/drug use associated with event

Any documentation in the record regarding alcohol/drug use or intoxication
(Free text field for documentation of blood alcohol level, toxicology screen, alcohol on the breath, needle track marks, etc)

Dementia listed in patient history or by caregiver/family member report

◯ No: Patient/informant denies any form of dementia
◯ Yes, known: Documentation or report of dementia in some form
◯ Yes, suspected: Documentation or report of suspicion of dementia
◯ No documentation: No documentation of dementia in any form

Any documentation in the record regarding dementia
(Free text field for documentation of dementia)

Documentation of whether or not CT imaging of head was performed	◯ Yes ◯ No
Documentation of whether or not contrast medium was used with CT imaging	◯ Yes ◯ No
Documentation of whether or not MRI imaging of head was performed	◯ Yes ◯ No
Documentation of whether or not contrast medium was used with MRI imaging	◯ Yes ◯ No

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Documentation of whether or not x-ray of head was performed
◯ Yes
◯ No

If positive results are noted on imaging, document the radiologist's impression verbatim
(If imaging was normal, leave blank. If more than one imaging technique was used, document which technique the radiologist's impression addresses)

Documentation of any other potential TBI-related signs or symptoms
◯ Yes
◯ No

Specify other TBI-related symptoms
(Other symptoms include objective findings documented by physician and might include, but are not limited to restlessness, combativeness, biting, dilation of one or both pupils, clear fluids draining from the nose or ears, penetrating brain injury, seizures/convulsions, paralysis)

Documentation of an assessment of TBI with any type of symptom inventory
(Do not count review of systems (ROS) or Glasgow Coma Scale (GCS) as symptom inventories. Inventories may include but are not limited to: Post-Concussion Symptom Scale (PCSS), Health and Behavior Inventory (HBI), Post-Concussion Symptom Inventory (PCSI), Acute Concussion Evaluation (ACE))

◯ Yes ◯ No

List the symptom inventories used
(Inventories may include but are not limited to: Post-Concussion Symptom Scale (PCSS), Health and Behavior Inventory (HBI), Post-Concussion Symptom Inventory (PCSI), Acute Concussion Evaluation (ACE))

TBI, concussion or similar diagnosis documented in the ED physician's note
◯ No
◯ Yes, known
◯ Yes, suspected

Document verbatim how this was described in the ED physician's note

Based on complete record review, reviewer's assessment is

◯ TBI
◯ Probable TBI
◯ Possible TBI
◯ No TBI

Reviewer comments
(List any other concerns that the reviewer discovers during the review process)

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Date of review