GTA REHAB Network

FUNCTIONAL INFORMATION – ABI or Neuro

To be completed by Allied Health Team

Patient's Name:

Date of injury/event: _____ / _____ / _____
year month day

Nature/type of injury/event: ☐ MVC ☐ MVC *(motorcycle)* ☐ MVC *(on bicycle/pedestrian)* ☐ Fall ☐ Assault ☐ Sporting ☐ unknown
☐ Trauma-other *(specify)* _____
☐ Non-trauma *(specify)* _____

Glasgow Coma Score on admission *(if available)*: _____

Previous history of ABI: ☐ No ☐ Yes Describe: _____

Seizures: ☐ No ☐ Yes Dates: _____ Describe: _____

Loss of consciousness: ☐ No ☐ Yes Coma length: _____

Post Traumatic Amnesia: ☐ No ☐ Yes Duration: _____

Pre-Injury History of Substance Abuse: ☐ Yes ☐ No ☐ History not available Status on admission: _____

Current Substance Abuse: ☐ Yes ☐ No ☐ Not known

Substance Abuse Treatment Recommended: ☐ Yes ☐ No

Neuro-ophthalmology consult conducted: ☐ Yes ☐ No Visual field testing completed: ☐ Yes ☐ No

Visual acuity testing completed: ☐ Yes ☐ No Include Results: _____

Premorbid function: ☐ Independent in ADL ☐ Dependent in ADL _____

Self Care:

Dressing:	☐ Independent	☐ Total assistance	☐ Partial assistance	☐ Supervision only
Bathing:	☐ Independent	☐ Total assistance	☐ Partial assistance	☐ Supervision only

Swallowing: ☐ Intact, regular diet ☐ Dental soft diet ☐ Minced diet ☐ Pureed diet
☐ Thickened fluids

Feeding: ☐ Independent ☐ Total assistance ☐ Needs partial assistance ☐ Supervision required
☐ Tube feed *(specify)* _____

Transfers: ☐ Independent ☐ Mechanical lift ☐ 2 person ☐ 1 person ☐ Supervision only
☐ On bed rest

Transfer aide: ☐ Standard Walker ☐ Rollator ☐ Wheelchair ☐ Cane ☐ Crutches
☐ 2 Wheeled Walker ☐ Other (specify)

Ambulation: ☐ Non-ambulatory ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent
☐ Distance *(specify)* _____

Limbs: ☐ Normal ☐ Left sided impairment ☐ Right sided impairment ☐ Bilateral impairment
☐ U/E impairment ☐ L/E impairment ☐ Impaired coordination ☐ Reduced strength
☐ Other _____

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Chair Sitting Tolerance: Specify minutes: _____

Participation Level:

Specify: On average, patient is able to participate in _____ therapy sessions / day, _____times / week for _____minutes / session.

Rancho Los Amigos Cognitive Scale at present: _____

Behavioural Issues: ☐ No ☐ Yes (If yes, please check where applicable and describe, listing interventions used):

☐ Physical aggression ☐ Verbal aggression ☐ Self abuse ☐ Inappropriate sexual behaviour ☐ Wandering ☐ Other *(specify)*

_____

_____

_____

Communication:

Language expression: ☐ Intact ☐ Dysarthria ☐ Only able to express basic needs ☐ Uses gesturing ☐ Completely impaired

Language comprehension: ☐ Intact ☐ Follows basic instructions ☐ Impaired _____

Other comments: _____

Cognitive Status:	Not Tested	Intact	Impaired
Orientation	☐	☐	☐ *(specify):*
Attention	☐	☐	☐ *(specify):*
Memory (short term)	☐	☐	☐ *(specify):*
Memory (long term)	☐	☐	☐ *(specify):*
Carry-Over/New Learning	☐	☐	☐ *(specify):*
Judgment	☐	☐	☐ *(specify):*
Insight	☐	☐	☐ *(specify):*
Frustration Tolerance	☐	☐	☐ *(specify):*
Other	☐	☐	☐ *(specify):*

Briefly describe the rehabilitation goals *(Be specific — e.g. increased mobility, speech, community living skills, etc.)*

PT Progress & Plan

OT Progress & Plan

SLP Progress & Plan

Form completed by: (Include name/telephone/date)