

FUNCTIONAL INFORMATION – ABI or Neuro

To be completed by Allied Health Team

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Patient's Name: _____	Date of injury/event: ____/____/____ year month day
Nature/type of injury/event: <input type="checkbox"/> MVC <input type="checkbox"/> MVC (motorcycle) <input type="checkbox"/> MVC (on bicycle/pedestrian) <input type="checkbox"/> Fall <input type="checkbox"/> Assault <input type="checkbox"/> Sporting <input type="checkbox"/> Trauma-other (specify) _____ <input type="checkbox"/> unknown <input type="checkbox"/> Non-trauma (specify) _____	
Glasgow Coma Score on admission (if available): _____	
Previous history of ABI: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes Dates: _____ Describe: _____ Loss of consciousness: <input type="checkbox"/> No <input type="checkbox"/> Yes Coma length: _____ Post Traumatic Amnesia: <input type="checkbox"/> No <input type="checkbox"/> Yes Duration: _____	
Pre-Injury History of Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> History not available Status on admission: _____ Current Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known Substance Abuse Treatment Recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuro-ophthalmology consult conducted: <input type="checkbox"/> Yes <input type="checkbox"/> No Visual field testing completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Visual acuity testing completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Include Results: _____	
Premorbid function: <input type="checkbox"/> Independent in ADL <input type="checkbox"/> Dependent in ADL _____	
Self Care: Dressing: <input type="checkbox"/> Independent <input type="checkbox"/> Total assistance <input type="checkbox"/> Partial assistance <input type="checkbox"/> Supervision only Bathing: <input type="checkbox"/> Independent <input type="checkbox"/> Total assistance <input type="checkbox"/> Partial assistance <input type="checkbox"/> Supervision only	
Swallowing: <input type="checkbox"/> Intact, regular diet <input type="checkbox"/> Dental soft diet <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet <input type="checkbox"/> Thickened fluids	
Feeding: <input type="checkbox"/> Independent <input type="checkbox"/> Total assistance <input type="checkbox"/> Needs partial assistance <input type="checkbox"/> Supervision required <input type="checkbox"/> Tube feed (specify) _____	
Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Mechanical lift <input type="checkbox"/> 2 person <input type="checkbox"/> 1 person <input type="checkbox"/> Supervision only <input type="checkbox"/> On bed rest	
Transfer aide: <input type="checkbox"/> Standard Walker <input type="checkbox"/> Rollator <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> 2 Wheeled Walker <input type="checkbox"/> Other (specify) _____	
Ambulation: <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> 2 person <input type="checkbox"/> 1 person <input type="checkbox"/> Supervision only <input type="checkbox"/> Independent <input type="checkbox"/> Distance (specify) _____	
Limbs: <input type="checkbox"/> Normal <input type="checkbox"/> Left sided impairment <input type="checkbox"/> Right sided impairment <input type="checkbox"/> Bilateral impairment <input type="checkbox"/> U/E impairment <input type="checkbox"/> L/E impairment <input type="checkbox"/> Impaired coordination <input type="checkbox"/> Reduced strength <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Carry-Over/New Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Frustration Tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (<i>specify</i>):

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)