|  |  |  |  |  |  |  |  |
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| **Initial Multidisciplinary Traumatic Brain Injury Assessment** | | | | | | | |
| **Date: Time:**  Notes reviewed **□ Present and role explained:**   * Occupational Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Physiotherapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Speech Language Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Additional people present: | | | | | | | **Consent**   * Verbal * Non-verbal * Seen in best interest |
| **Past Medical History** | | | | **Previous Function** | | | |
|  | | | |  | | | |
| Previous head injury or concussion: Yes/No Details: | | | | | | | |
| Known psychiatric history: Yes/No Details: | | | | | | | |
| Visual impairment (glasses): Yes/No Hearing impairment (hearing aids): Yes/No Handedness: Left / Right/ ambidextrous | | | | | | | |
| **Injury Characteristics** | | | | | | | |
| Date of injury: | | Date of admission: | | | ACC number: | | |
| Loss of consciousness: Yes / No / Unknown Duration: | | | | | | | |
| Intubation: Yes / No Details: | | | | | | | |
| Tracheostomy: Yes/No Details: See Tracheostomy Weaning Checklist (template CR4758) and/or weaning plan in clinical notes | | | | | | | |
| Substance/ Alcohol involvement: Yes / No Details: | | | | | | | |
| GCS | At Scene: /15 | | in ED: / 15 | | | Current: /15 | |
| Injury Description/ Mechanism:  CTH/MRI findings:  Other injuries (including management plans i.e. weight bearing status, safety parameters):  Neurosurgical intervention: | | | | | | | |
| **Social and Occupational Profile** | | | | | | | |
| Social history  Family and friend questionnaire provided:  No / Yes – refer to attached form | | | | | | | |
| **Swallowing & Nutrition** | | | | | | | |
| Dysphagia screening completed: Yes / No Details: Dentition:  Oral hygiene:   Current feeding:  □ NBM Date NBM commenced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □NG □PEG □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Oral intake Current consistency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Neurological assessment**  Observations as charted □ Attachments:  Cognition: ( level of alertness, orientation, attention, information processing):   |  |  |  |  |  | | --- | --- | --- | --- | --- | | The Rivermead Post-Concussion Symptoms Questionnaire | Westmead PTA Scale | Wessex Head Injury Matrix | Coma Recovery Scale | Rancho Los Amigos levels of cognitive functioning scale | | Refer to attached form | | | | |   Affective/ Behaviour:  Medications to manage behaviour:  Fatigue, endurance, activity tolerance:  Other observations (e.g. skin integrity, pressure injuries, pain, subluxation):  Range of Motion:  Tone:  Function Neurological Observations (Power/sensation/co-ordination):  Speech/Language assessment and observations: | | | | | | | |
| **Problems/Occupational Performance issues** | | | | **Therapy plan**  Family education provided (include details/topics and any resources provided):  □ Orientation board provided and explained  Referrals to other disciplines (e.g. orthotics)  ACC Early cover □ | | | |
| **Recommendations:**  Seating and transfer plan:  Positioning plan:  Fatigue and behaviour management plan:  Feeding plan:   Communication strategies:  **MDT recommendations:** Likely discharge destination:  □ ABI □ Domicile DHB :□ Home   □ Training for independence □ Concussion clinic □ Other  Date referral completed:  Medical team follow-up requests:  Occupational Therapist (NZROT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physiotherapist (NZRPT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech Language Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |