Holland Bloorview
Kids Rehabilitation Hospital

150 Kilgour Road, Toronto ON, M4G 1R8
T: 416-425-6220 1-800-363-2440

Name: _____

Date of Birth: _____

Pronoun (she/he/they/other): _____

Concussion Service Pre-Assessment Form

Injury Characteristics

***Date/Time of Injury:**_____

Referral ≥ 4 weeks post-injury: ___ Yes ___ No

Injury Description: _____
_____
_____
_____
_____
_____

***Is there evidence of intracranial injury or skull fracture?** ___Yes___No___Unknown

Location of Impact: ___Front of head (forehead area) ___Left side ___ Right side ___Back of head ___Neck ___Did not hit head directly

Amnesia Before: Are there any events just **BEFORE** the injury that the client has no memory of (even brief)? ___Yes ___No Duration: _____

Amnesia After: Are there any events just **AFTER** the injury that the client has no memory of (even brief)? ___Yes ___No Duration: _____

Loss of Consciousness: Did the client lose consciousness? ___Yes ___No Duration: _____

Seizures: Were seizures observed? ___Yes ___No

Details: _____

Please circle the symptoms experienced immediately after the injury:

Headache	Vision Changes	Dizziness	Balance Problems
Nausea	Vomiting	Ringing in the Ears	Dazed or stunned
Personality Changes	Forgetful	Confusion	Fatigue

REF OUTP

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Clinical Risk for Persistent Post-Concussive Symptoms

- ☐ Screen completed ≤48 hours from concussion injury
- ☐ Screen completed >48 hours from concussion injury

Please circle the applicable response based on the client's CURRENT status:

	0	1	2
Primary Indicators (5P – CHEO Research Institute)			
Age of Client	5 to < 8 years	8 to < 13 years	13 to < 18 years
Sex of Client	Male		Female
How long did client's previous concussion Last?	No previous concussion or recovery in less than 1 week	Recovery took 1 week or longer	
Does the client have a history of migraines?	No	Yes	
Did the client answer questions more slowly than normal as compared to before the injury?	No	Yes	
On the BESS Tandem stance balance testing, how many errors did the client have in 20 seconds	0-3 errors	4 or more errors, or could not complete the balance testing	
Does the client have a headache?	No	Yes	
Does the client have sensitivity to noise?	No	Yes	
Is the client more fatigued?	No		Yes
***Total Risk Score:**			
Additional Indicators: Please list all applicable			
Mental Health Diagnoses:			
Diagnosed Learning Disabilities:			
Behavioural Diagnoses:			
Neurodevelopmental Diagnoses:			

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Additional Information

Headaches: Is the client experiencing ongoing headaches? ___ Yes ___ No Frequency: _____

Is the client taking one or more prophylactic headache medications ___Yes ___No

Details: _____

Activity Tolerance: Do the client's symptoms worsen with:

Physical Activity ___ Yes ___ No ___Unknown

Cognitive Activity ___ Yes ___ No ___Unknown

Return to School: Has the client returned to school / class? ___ Yes ___ No

Is the client attending school 2 or more days per week? ___ Yes ___ No

Has the client returned to full academic workloads / assessments? ___ Yes ___ No

Is the client experiencing symptoms during school programming? ___ Yes ___ No

Details: _____

Legal: Is there a legal case associated with this injury? ___ Yes ___No ___Unknown

CAS: Is there Children's Aid Society (CAS) involvement? ___Yes ___ No__ Unknown

Additional Comments

_____

_____

Is the client seeing any other physicians/clinicians for concussion symptoms (If yes, please explain)

_____

_____

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How many concussions has the client had in the past? 0 1 2 3 4 5 6+

How many of these were diagnosed by a physician / NP? 0 1 2 3 4 5 6+

If applicable, please provide the date of injury and duration for the concussion with **the longest recovery time**. Also list the symptoms the client had during this recovery.

_____

_____

***Please attach all relevant imaging and consult notes.**

* R E F O U T P *