Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CUH
Ospidéal Ollscoile Chorcaí
Cork University Hospital

Adult Mild Traumatic Brain Injury (TBI) Referral Form
Emergency Department
(Fill in this form only if Post Trauma Amnesia is present)

Patient Details (Addressograph Label)
Name:

DOB:
MRN:
Consultant:

G.P. Name: _____
G.P. Contact No.: _____

Date of Admission to ED: _____
Date of Discharge from ED: _____

Clinical Details & Assessment

- **Date of TBI:**
- **GCS:** On Admission: /15 On Discharge: /15
- **Mechanism of Brain Injury:**
  Fall Assault RTA Road User Other: _____
- **Brain Imaging:**
  CT Scan Other: _____
  Report attached *(please make every effort to do so)*
- **Brain Pathology** *(tick as many as appropriate)*
  DAI Skull Fracture Extradural Haematoma
  Subdural Haematoma Subdural Haemorrhage
  Intra-Cranial Haemorrhage Brain Contusion

Potential Complicating Factors

Prolonged Post Traumatic Amnesia *(A-WPTAS <18/18)*
History of previous TBI
Drug or alcohol intoxication *(at presentation or history)*
Previous Neurological/Psychiatric condition
Co-morbidities _____
Age >65
Multi-system trauma
Peri-trauma seizure
Focal Neuro-deficits

Post Concussion Symptom Observation

Headache
Sleep Disturbance
Anxiety/Mood
Others: _____
Tinnitus
Dizziness/Balance Problems
Difficulty with Attention/Concentration

Management

Total Period of Observation = _____hrs
Analgesia
Education & Advice
Information Leaflet

Completed By:

_____ __ __ __ __ __ __ __
Health professional name Day Month Year

Please send completed form to:
Consultant in Rehabilitation Medicine, Mercy University Hospital Tel: 021 4935256

A-WPTAS for completion overleaf
www.psy.mq.edu.au/GCS