Recommended time for assessment:

	Basic	Intermediate	Advanced
FIMTM: (see attachment 1)			
- Entry to rehab	X	X	X
- Discharge rehab	X	X	X
- 1 month post injury		X	X
- 3 months post injury		X	X
NSI: (see attachment 2)			
- Entry to rehab	X	X	X
- Discharge rehab	X	X	X
- 1 month post injury		X	X
- 3 months post injury		X	X
PTSD checklist: (see attachment 3)			
- Admission to study hospital	X	X	X
- Entry to rehab		X	X
- 1 month outcome		X	X
- 3 months outcome		X	X

POST DISCHARGE / OUTPATIENT CARE

VISIT DATE

Visit date: ☐☐ - ☐☐☐ - ☐☐☐☐

Day Month Year

STATUS

Status:
- ◯ Dead → Please complete section on death information
- ◯ Alive → Please continue
- ◯ Unknown

SOCIOECONOMIC STATUS

Patient's residence:
- ◯ At home
- ◯ Hospital
- ◯ Rehab center
- ◯ Nursing home
- ◯ Other
- ◯ Unknown

Returned to work/school:
- ◯ Returned to previous level
- ◯ Same work/school, reduced level
- ◯ Different work/school
- ◯ Only in sheltered environment
- ◯ No
- ◯ N/A
- ◯ Unknown

Returned to other activities:
- ◯ Full return to previous level
- ◯ Reduced level
- ◯ No
- ◯ Unknown

POST DISCHARGE / OUTPATIENT TREATMENT

Medication:
- ◯ No
- ◯ Yes:
  - ◯ Psycho-stimulants
  - ◯ Anticonvulsants
  - ◯ Pain killers
  - ◯ Antidepressants
  - ◯ Other
- ◯ Unknown

Surgery:

Intracranial	◯ No	◯ Yes	◯ Unknown
Extracranial	◯ No	◯ Yes	◯ Unknown

Rehabilitation:
- ◯ No
- ◯ Out-patient rehabilitation
- ◯ Non-specialised facility (in-patient)
- ◯ Specialised rehab center (in-patient)
- ◯ Unknown

Duration of out-patient rehab: ☐☐☐ days

Duration of in-patient rehab: ☐☐☐ days

POST DISCHARGE / OUTPATIENT CARE

VISIT DATE

Visit date: ☐☐ - ☐☐☐ - ☐☐☐☐

Day Month Year

STATUS

Status:

- ◯ Dead → Please complete section on death information
- ◯ Alive → Please continue
- ◯ Unknown

SOCIOECONOMIC STATUS

Patient's residence:

- ◯ At home
- ◯ Hospital
- ◯ Rehab center
- ◯ Nursing home
- ◯ Other
- ◯ Unknown

Marital status:

- ◯ Never been married
- ◯ Married/Living together/common law
- ◯ Separated
- ◯ Divorced
- ◯ Widowed
- ◯ Other
- ◯ Unknown

Persons living with*:

- ◯ Alone
- ◯ Spouse (including common law partner)
- ◯ Parents
- ◯ Siblings
- ◯ Child/children
- ◯ Significant other partner
- ◯ Other (incl. correctional facility inmates)
- ◯ Unknown

* Multiple entries permitted

Number of people living with:

☐☐ Please enter number

Returned to work/school:

- ◯ Returned to previous level
- ◯ Same work/school, reduced level
- ◯ Different work/school
- ◯ Only in sheltered environment
- ◯ No
- ◯ N/A
- ◯ Unknown

Returned to other activities:

- ◯ Full return to previous level
- ◯ Reduced level
- ◯ No
- ◯ Unknown

POST DISCHARGE / OUTPATIENT TREATMENT

Medication:

- ◯ No
- ◯ Yes:
  - ◯ Psycho-stimulants
  - ◯ Anticonvulsants
  - ◯ Narcotics
  - ◯ Other pain medication
  - ◯ Steroids
  - ◯ Antibiotics
  - ◯ Antidepressants
  - ◯ Antipsychotic agents
  - ◯ Others
- ◯ Unknown

Surgery:

Intracranial

- ◯ No
- ◯ Yes — If yes:
  - ◯ Hydrocephalus
  - ◯ Chronic Subdural Hematoma
  - ◯ Cranioplasty
  - ◯ Other, specify: _____

Date surgery:

		-			-				
Day			Month			Year			

- ◯ Unknown

Extracranial

- ◯ No
- ◯ Yes — If yes: please specify:

Date surgery:

		-			-				
Day			Month			Year			

- ◯ Unknown

Rehabilitation:

- ◯ No
- ◯ Out-patient rehabilitation
- ◯ General rehab unit (in-patient)
- ◯ TBI rehabilitation unit (in-patient)
- ◯ General long term acute care unit (in-patient)
- ◯ Geriatric rehab unit (in-patient)
- ◯ Unknown

If treated as in-patient:

Date admission to rehab: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Date discharge rehab: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Short term rehabilitation interruptions:

First interruption start date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

First interruption end date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Second interruption start date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Second interruption end date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

If treated as outpatient:

Date start outpatient Rehab therapy: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Active rehab therapy ongoing:

- ◯ No — If no, date end outpatient rehab therapy: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)
- ◯ Yes

Type of outpatient therapy*:

- ◯ Physical therapy
- ◯ Occupational therapy
- ◯ Speech therapy
- ◯ Therapeutic recreation
- ◯ Cognitive remediation
- ◯ Vocational services
- ◯ Psychological services
- ◯ Nursing services
- ◯ Comprehensive day treatment
- ◯ Peer mentoring
- ◯ Social work/Case management
- ◯ Independent living training
- ◯ Home health
- ◯ Other: _____
- ◯ Unknown

* Please, mark all that apply.

Advanced

POST DISCHARGE / OUTPATIENT CARE

VISIT DATE

Visit date: ☐☐ - ☐☐☐ - ☐☐☐☐

Day Month Year

STATUS

Status:

- ◯ Dead → Please complete section on death information
- ◯ Alive → Please continue
- ◯ Unknown

SOCIOECONOMIC STATUS

Patient's residence:

- ◯ At home
- ◯ Hospital
- ◯ Rehab center
- ◯ Nursing home
- ◯ Other
- ◯ Unknown

Marital status:

- ◯ Never been married
- ◯ Married/Living together/common law
- ◯ Separated
- ◯ Divorced
- ◯ Widowed
- ◯ Other
- ◯ Unknown

Persons living with*:

- ◯ Alone
- ◯ Spouse (including common law partner)
- ◯ Parents
- ◯ Siblings
- ◯ Child/children
- ◯ Significant other partner
- ◯ Other (incl. correctional facility inmates)
- ◯ Unknown

* Multiple entries permitted

Number of people living with:

☐☐ Please enter number

Returned to work/school:

- ◯ Returned to previous level
- ◯ Same work/school, reduced level
- ◯ Different work/school
- ◯ Only in sheltered environment
- ◯ No
- ◯ N/A
- ◯ Unknown

Returned to other activities:

- ◯ Full return to previous level
- ◯ Reduced level
- ◯ No
- ◯ Unknown

POST DISCHARGE / OUTPATIENT TREATMENT

Medication:

- ◯ No
- ◯ Yes:
  - ◯ Psycho-stimulants
  - ◯ Anticonvulsants
  - ◯ Narcotics
  - ◯ Other pain medication
  - ◯ Steroids
  - ◯ Antibiotics
  - ◯ Antidepressants
  - ◯ Antipsychotic agents
  - ◯ Others
- ◯ Unknown

Surgery:

Intracranial

- ◯ No
- ◯ Yes — If yes:
  - ◯ Hydrocephalus
  - ◯ Chronic Subdural Hematoma
  - ◯ Cranioplasty
  - ◯ Other, specify: _____

Date surgery:

☐☐ - ☐☐☐ - ☐☐☐☐

Day Month Year

- ◯ Unknown

Extracranial

- ◯ No
- ◯ Yes — If yes: please specify:

☐

Date surgery:

☐☐ - ☐☐☐ - ☐☐☐☐

Day Month Year

- ◯ Unknown

Rehabilitation:

- ◯ No
- ◯ Out-patient rehabilitation
- ◯ General rehab unit (in-patient)
- ◯ TBI rehabilitation unit (in-patient)
- ◯ General long term acute care unit (in-patient)
- ◯ Geriatric rehab unit (in-patient)
- ◯ Unknown

If treated as in-patient:

Date admission to rehab: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Date discharge rehab: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Short term rehabilitation interruptions:

First interruption start date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

First interruption end date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Second interruption start date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Second interruption end date: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

If treated as outpatient:

Date start outpatient Rehab therapy: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)

Active rehab therapy ongoing:

- ◯ No — If no, date end outpatient rehab therapy: ☐☐ - ☐☐☐ - ☐☐☐☐ (Day - Month - Year)
- ◯ Yes

Type of outpatient therapy*: **Frequency**, only if marked:**

◯ Physical therapy	☐
◯ Occupational therapy	☐
◯ Speech therapy	☐
◯ Therapeutic recreation	☐
◯ Cognitive remediation	☐
◯ Vocational services	☐
◯ Psychological services	☐
◯ Nursing services	☐
◯ Comprehensive day treatment	☐
◯ Peer mentoring	☐
◯ Social work/Case management	☐
◯ Independent living training	☐
◯ Home health	☐
◯ Other: _____	☐
◯ Unknown	

** 1 = None
2 = Only follow-up, no active treatment
3 = < once per week
4 = weekly
5 = 2-3 times/week
6 = Daily
7 = Unknown

* Please mark all that apply.

Attachment 1

FIMTM

FIMTM Scale: Functional Independence Measure (FIM) Scale		
1. Feeding:	0-7;9	
2. Grooming:	0-7;9	
3. Bathing:	0-7;9	
4. Dressing Upper Body:	0-7;9	
5. Dressing Lower Body:	0-7;9	
6. Toileting:	0-7;9	
8. Bladder Management:	1-7;9	
8a. Bladder Management – LEVEL OF ASSISTANCE:	1-7;9	
8b. Bladder Management – FREQUENCY OF ACCIDENTS:	1-7;9	
9. Bowel Management:	1-7;9	
9a. Bowel Management – LEVEL OF ASSISTANCE:	1-7;9	
9b. Bowel Management- FREQUENCY OF ACCIDENTS:	1-7;9	
10. Bed, Chair, Wheelchair Transfers:	0-7;9	
11. Toilet Transfers:	0-7;9	
12. Tub or Shower Transfers:	0-7;9	
14a. Walking:	0-7;9	
14b. Wheelchair:	0-7;8;9	
15. Stairs:	0-7;9	
17a. Comprehension MODE:	a;v;b;9	
17b. Comprehension:	1-7;9	
18a. Expression MODE:	v;n;b;9	
18b. Expression:	1-7;9	
22. Social Interaction:	1-7;9	
26. Problem Solving:	1-7;9	
27: Memory:	1-7;9	

FIM Codes:		Frequency of Accidents Codes:
Activity does not occur-Admit items 1 through 6 and 10 through 15 only	0	
Total Assistance (pt <25 % of task)	1	Five or more accidents in past 7 days
Maximum Assistance (pt 25-49 % of task)	2	Four accidents in past 7 days
Moderate Assistance (pt 50-74 % of task)	3	Three accidents in past 7 days
Minimal Assistance (pt >75 % of task)	4	Two accidents in past 7 days
Supervision (pt does 100 %)	5	One accident in past 7 days
Modified Independence (extra time, device)	6	No accidents, uses device
Complete Independence (timely, safely)	7	No accidents
N/A pt walking/not using wheelchair – item 14b. only	8	
Unknown or assessed at >72 hours	9	Unknown or assessed at >72 hours

Attachment 2

Neurobehavioral Inventory List

Neurobehavioral Symptom Inventory:		
Rate the following syptoms with regard to how much they have disturbed you *IN THE PAST TWO WEEKS. (ONLY TO BE COMPLETED BY PERSON WITH TBI)*		
1. Feeling dizzy:	0-4;9	
2. Loss of balance	0-4;9	
3. Poor coordination, clumsy:	0-4;9	
4. Headaches:	0-4;9	
5. Nausea:	0-4;9	
6. Vision problems, blurring, trouble seeing:	0-4;9	
7. Sensitivity to light:	1-4;9	
8. Hearing difficulty:	1-4;9	
9. Sensitivity to noise:	0-4;9	
10. Numbness or tingling on parts of my body:	0-4;9	
11. Change in taste and/or smell:	0-4;9	
12. Loss of appetite or increase of appetite:	0-4;9	
13. Poor concentration, can't pay attention, easily distracted:	0-4;9	
14. Forgetfulness, can't remember things:	0-4;9	
15. Difficulty making decisions:	0-4;9	
16. Slowed thinking, difficulty getting organized, can't finish things:	0-4;9	
17. Fatigue, loss of energy, getting tired easily:	0-4;9	
18. Difficulty falling or staying asleep:	0-4;9	
19. Feeling anxious or tense:	0-4;9	
20. Feeling depressed or sad:	0-4;9	
21. Irritability, easily annoyed:	0-4;9	
22. Poor frustration tolerance, feeling easily overwhelmed by things:	0-4;9	

Codes:
0 = None – rarely if ever present; not a problem at all
1 = Mild – Occasionally present, but it does not disrupt activities, I can usually continue what I'm doing; doesn't really concern me.
2 = Moderate – Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.
3 = Severe – Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel like I need help.
4 = Very severe – Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.
9 = Unknown or assessed at >72 hours

Attachment 3

PCL-C

PTS CHECKLIST: Post Traumatic Stress Disorder Checklist – Civilian Version (PCL-C):	
Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please indicate how much you have been bothered by the following IN THE PAST MONTH. *(ONLY TO BE COMPLETED BY PERSON WITH TBI)*	At Admission to PRC
1. Repeated, disturbing memories, thoughts or images of a stressful experience from the past	
2. Repeated, disturbing dreams of a stressful experience from the past	
3. Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)	
4. Feeling very upset when something reminded you of a stressful experience from the past	
5. Having physical reactions (i.e. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past	
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feeling related to it	
7. Avoiding activities or situations because they reminded you of a stressful experience from the past	
8. Trouble remembering important parts of a stressful experience from the past	
9. Loss of interest in activities that you used to enjoy	
10. Feeling distant or cut off from other people	
11. Feeling emotionally numb or being unable to have loving feelings to those close to you	
12. Feeling as if your future will somehow be cut short	
13. Trouble falling or staying asleep	
14. Feeling irritable or having angry outbursts	
15. Having difficulty concentrating	
16. Being super alert or watchful or on guard	
17. Feeling jumpy or easily startled	
1 = not at all 2 = a little bit 3 = moderately 4 = quite a bit 5 = extremely 9 = unknown/not sure	