

Traumatic Brain Injury Registry Referral Form

Arkansas Statute 20-14-703 requires that every public and private health agency, public and private social agency, and attending physician report persons who have sustained a Moderate-to-Severe brain injury to the Brain Injury Alliance of Arkansas (BIAA) within five (5) days of injury identification or diagnosis. The BIAA has signed an agreement with the Arkansas Spinal Cord Commission (ASCC) Trauma Rehabilitation Program to assume responsibility for the Traumatic Brain Injury Registry. **Send referrals by email to atrp.referral@arkansas.gov or fax to (501) 296-1787.**

PATIENT / CLIENT REFERRAL INFORMATION

REPORT ALL INFORMATION BELOW WITHIN FIVE (5) DAYS OF INJURY IDENTIFICATION OR DIAGNOSIS

TBI Registry Referral Date: _____ SURVIVE TO ACUTE: YES NO
Trauma Band Number: _____ Payor Source: _____
Last Name: _____ First Name: _____ M. I.: _____
Address: _____ City, State: _____
Zip Code: _____ County: _____ Phone: _____
Date of Birth: _____ Gender: _____ Race: _____ Hispanic: _____
Primary Contact/Legal Guardian: _____ P.C. Phone: _____
Relationship: _____ Date TBI Packet Given: _____
Reporting Facility: _____ Reporter Name: _____
Reporter Phone: _____ Reporter E-mail: _____
Date of Injury: _____ Time: _____ E-Code Location: _____
Injury County: _____ ETOH/Drug: _____ Etiology/Cause: _____
Injury (Check all that apply): Accidental Intentional Self-Inflicted Inflicted By Other
Position: _____ Protection: _____
Date of Admission: _____ Date Brain Injury Identified: _____

ALL INFORMATION BELOW MUST BE COMPLETED BY DATE OF DISCHARGE.

BRAIN INJURY INFORMATION A BRAIN INJURY MUST BE REPORTED TO THE TBI REGISTRY IF GLASGOW COMA SCORE IS 12 OR BELOW FOR ADULTS OR 13 OR BELOW FOR PEDIATRIC PATIENTS. DO NOT REPORT IF THE (ADULT) GLASGOW SCORE IS 13 OR ABOVE, THE PATIENT IS NOT AN ARKANSAS RESIDENT, OR THE INJURY IS NOT THE RESULT OF A TRAUMATIC INJURY.

Glasgow Coma Scale Scores at admit (or lowest): ____ at discharge: ____ TBI: Open Closed
ICD-10: S02.0 S02.1 S02.7 S02.8 S02.9 S06.0 S06.1 S06.2 S06.3
 S06.4 S06.5 S06.6 S06.8 S06.9 Altered Sensorium Ventilator
Discharge Disposition: _____ Discharge Date: _____
If discharged to another acute or rehab, please specify the facility: _____

SPINAL CORD INJURY INFORMATION COMPLETE THIS PORTION ONLY IF THE INDIVIDUAL ALSO SUSTAINED A SPINAL CORD INJURY. THAT INJURY MUST BE REPORTED IF 3 OUT OF 4 OF THE FOLLOWING DEFICITS ARE PRESENT.

Deficits: Sensory Motor Bowel Bladder Para/Quad Level: _____
ICD-10: G81.0 G81.1 G81.9 G82.2 G82.5 G83.1 S14.1 S24.1 S34.1
Loss of motor and/or sensory function below zone of injury: Complete Incomplete Unknown