

Instructions for completing the 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.

Criteria for Referral: A brain injury must be reported to the TBI registry if the patient's Glasgow Coma Scale score is 12 or below for adults or 13 or below for pediatric patients at the time of admission to the Emergency Department or at any time during acute care stay. 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.

Due to a patient's unstable medical status, some information may not be obtainable immediately. However, it is still the responsibility of the reporting person/facility to provide the missing information as soon as possible.

Note to Hospital and Rehabilitation facility personnel completing this form: Please use the boldface responses recommended in the "Response(s) Needed" section. All categories must be completed.

If you have any questions while completing this form, please call or email the Arkansas Trauma Rehabilitation Program Health Educator at (501) 683-3435 or atrp.info@arkansas.gov.

| PATIENT/CLIENT REFERRAL INFORMATION | RESPONSE(S) NEEDED |
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| TBI Registry Referral Date | Enter the date the referral is faxed or sent to the TBI Registry. Date format MM/DD/YYYY . |
| Survive To Acute | Was the individual admitted to acute care? Check either Yes or No . |
| Trauma Band Number | Enter the individual's Arkansas Trauma System trauma band number . |
| Payor Source | Enter the form of payment by the individual using the following terms: Medicaid Medicare Medicaid/Medicare Not insured Worker's Compensation Private insurance (please specify insurer) |
| Last Name First Name M.I. | Enter last name , first name , and middle initial . Suffixes such as Jr. or III should be entered with the last name, separated by a comma (for example, Smith, Jr.). |
| Address | Enter the individual's residential street address . Use Post Office Box addresses <i>only</i> when the residential street address is unknown. |
| City | Enter the name of the city where the individual resides. If the individual resides in another state, do not refer to the registry . |
| Zip Code | Enter the Zip Code of the individual's residence. |
| County | Enter the county where the individual resides. |
| Phone | Enter the area code and phone number for the individual. |
| Date of Birth | Date format MM/DD/YYYY . |
| Gender | Enter M for male or F for female. |
| Race | Enter one of the following: A -Asian B -African American/Black I -American Indian/Alaskan Native L -Hispanic/Latino O -Other P -Native Hawaiian/Pacific Islander U -Unknown W -White |

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| Hispanic | Enter one of the following: 1 – if the individual is of Hispanic origin. 2 – if the individual is not of Hispanic origin. | | | | | | | | | | |
| Primary Contact / Legal Guardian Name | Enter the name of the responsible party / legal guardian who can be contacted in the daytime regarding the individual. When unknown, enter “None.” | | | | | | | | | | |
| Phone (Primary Contact / Legal Guardian Phone Number) | Enter the area code and phone number where the primary contact or legal guardian can be reached during business hours. | | | | | | | | | | |
| Relationship | Enter the selection that best describes the relationship between the Primary Contact or Legal Guardian and the individual: Aunt, Brother, Brother-in-law, Daughter, Daughter-in-law, Ex-spouse, Facility contact, Father-in-law, Foster parent, Friend, Granddaughter, Grandparent, Grandson, Insurance agent, Legal guardian, Mother-in-law, Niece, Neighbor, Nephew, Other family member, Other official, Parent, Physician, School contact, Significant other, Sister, Sister-in-law, Social worker, Son, Son-in-law, Spouse, Spouse-separated from, Teacher, Uncle, Unknown | | | | | | | | | | |
| TBI Resource Packet | Enter the date the Primary Contact is provided with the TBI Resource Packet. Date format MM/DD/YYYY . Please distribute TBI Referral Packets ONLY to patients who meet the medical criteria for referral. | | | | | | | | | | |
| Reporting Facility | Enter the name of the facility (if applicable) reporting to the TBI Registry. Spell out the name of the facility as much as is possible (for example, UAMS Medical Center). | | | | | | | | | | |
| Reporter Name | Enter the name of the person in the facility that is responsible for making referrals to the TBI Registry. <u>This person may need to be contacted by Trauma Rehabilitation Program with requests for missing or additional information.</u> If a private citizen is making the referral, enter N/A . Please write legibly. | | | | | | | | | | |
| Reporter's Phone and Email Address | Enter the area code, phone number, and extension (if applicable) , and email address of the person in the facility that is responsible for making referrals to the TBI Registry. <u>This person may need to be contacted by Arkansas Trauma Rehabilitation Program with requests for missing or additional information.</u> If a private citizen is making the referral, enter N/A . | | | | | | | | | | |
| Date of Injury | Enter the date the injury to the individual occurred. Date format MM/DD/YYYY | | | | | | | | | | |
| Time | Enter the approximate time the injury occurred, or when the individual was admitted to the facility. Hospital/rehab facility personnel completing this form should enter a number 01 through 12 to indicate the approximate hour of injury or admission if it occurred at or before noon . Enter a number 13 through 23 if the approximate hour of injury or admission occurred between 1:00 p.m. and 11:59 p.m. Enter 00 if the approximate hour of injury or admission occurred between 12:00 a.m. to 12:59 a.m. (Midnight.) | | | | | | | | | | |
| E-Code Location | Select the approximate location of where the injury occurred. If unknown, leave blank: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Home</td> <td style="width: 50%;">Street or Highway</td> </tr> <tr> <td>Farm</td> <td>Public Building</td> </tr> <tr> <td>Mine and Quarry</td> <td>Residential Institution</td> </tr> <tr> <td>Industrial Place or Premises</td> <td>Other Specified Place</td> </tr> <tr> <td>Place for Recreation or Sport</td> <td>Unspecified Place</td> </tr> </table> | Home | Street or Highway | Farm | Public Building | Mine and Quarry | Residential Institution | Industrial Place or Premises | Other Specified Place | Place for Recreation or Sport | Unspecified Place |
| Home | Street or Highway | | | | | | | | | | |
| Farm | Public Building | | | | | | | | | | |
| Mine and Quarry | Residential Institution | | | | | | | | | | |
| Industrial Place or Premises | Other Specified Place | | | | | | | | | | |
| Place for Recreation or Sport | Unspecified Place | | | | | | | | | | |
| Injury County | Enter the county where the injury occurred. If unknown, leave blank. | | | | | | | | | | |

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| ETOH/Drug (Alcohol) | <p>Enter the selection that best describes if alcohol or drug use was involved at the time of the injury:</p> <p>1 – Not alcohol or drug related 4 – Alcohol and drug related 2 – Alcohol related 5 – Unknown 3 – Drug related</p> |
| Protection | <p>Enter the selection that best describes if safety devices were being used at the time of injury:</p> <p>20 – 2 point belt (lap belt only) 28 – Helmet 21 – 3 point belt (shoulder and lap belt only) 29 – None 22 – Airbags (air bag only) 30 – Padding 23 – Airbags & Belt (airbag and seatbelt) 31 – Protective clothing 24 – Airbag deployed 32 – Seatbelt (seatbelt only) 25 – Car seat (infant/child car seat) 33 – Not recorded (default) 26 – Eye protection 34 – Not performed 27 – Hard hat 35 – Not available</p> |
| Position | <p>Enter the selection that best describes the position of the individual if the injury involved a motor vehicle:</p> <p>1 – Driver/Operator 7 – Other Specified 2 – Passenger 8 – Other/Cyclist 4 – Pedestrian 9 – Riding on Animal 5 – Motorcycle Driver 10 – Streetcar Occupant 6 – Motorcycle Passenger 11 – Not Available</p> |
| Etiology (Circumstances) | <p>Enter the selection that best describes the cause of the individual's injury:</p> <p>11 – Auto/Truck Accident 42 – Diving into a natural body of water 12 – Motorcycle Accident 44 – Football/Soccer/Hockey 13 – ATV/Moped/Dirt bike/Go cart 45 – Skating/Skateboard/Scooter 14 – Bicycle/Auto collision 49 – Other Sport 15 – Bicycle/Not-auto collision 50 – Jump/Fall 16 – Fall from Auto/Truck 55 – Falling Object 17 – Boating/Jet Ski 60 – Medical Complication 18 – Heavy Equipment (farm/construction) 65 – Airplane/Train Crash 20 – Pedestrian/Auto collision 70 – Altercation/Assault 21 – Pedestrian/Bicycle collision 71 – Suspected Abuse 29 – Pedestrian unknown 72 – Domestic Violence 31 – Stabbing 73 – Car Surfing 32 – Firearms 74 – War Injury 40 – Swimming 98 – Other 41 – Diving into a pool 99 – Unknown</p> |
| Injury | <p>Please indicate if the injury was Accidental or Intentional, Self-Inflicted or Caused by another person or circumstance. Please check all that apply.</p> |
| Date of Admission | <p>Date Individual was admitted to the facility, if applicable. Date format: MM/DD/YYYY</p> |
| Date Brain Injury and/or Spinal Cord Injury Identified | <p>Date the individual's brain injury was identified or diagnosed. This date may differ from the Date of Admission. Date format: MM/DD/YYYY</p> |

BRAIN INJURY INFORMATION

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|--|--|--|--|----------------------------|---|---|--|------------------------------------|-------------------------|--|----------------------|---|------------------------------------|--|---------------------|
| <p>Glasgow Score To be collected:</p> <ul style="list-style-type: none"> • Upon admission (or lowest) • At discharge. | <p>The Glasgow Coma Score is vital information that must be on the form in order for the referral to be properly entered into the TBI Registry. Enter a number from 03 to 15 that best describes the individual's ability to respond. If the Glasgow Score is unknown or unavailable, it can be calculated using the included Glasgow Coma Scale Worksheet. If the individual's Glasgow Score is not medically eligible for referral at admission (see Criteria for Referral on page 1), but drops to 12 or below (13 or below for pediatrics) during acute care, make the referral using the lowest Glasgow Score.</p> | | | | | | | | | | | | | | |
| <p>TBI Open / Closed</p> | <p>Indicate if the individual's brain injury was open or closed.</p> | | | | | | | | | | | | | | |
| <p>Altered Sensorium</p> | <p>Indicate if the individual's senses (taste, touch, sight, hearing, or smell) have been affected by the brain injury by checking Yes or No.</p> | | | | | | | | | | | | | | |
| <p>Ventilator</p> | <p>Indicate if the individual required a ventilator to breathe by checking Yes or No.</p> | | | | | | | | | | | | | | |
| <p>ICD-10 Codes</p> | <p>Enter the codes that best describe the individual's brain (head) injury:</p> <p>S02.0 Fractures of the vault of the skull, including frontal parietal bones. S02.1 Fractures of the base of the skull. S02.7 Multiple fractures of the skull. S02.8 Fractures of other specified skull and facial bones. S02.9 Unspecified fracture of the skull. S06.0 Concussion with loss of consciousness S06.1 Traumatic cerebral edema S06.2 Diffuse traumatic brain injury S06.3 Cerebral laceration & contusion S06.4 Epidural hemorrhage S06.5 Traumatic subdural hematoma S06.6 Subarachnoid, subdural, and extradural hemorrhage following injury S06.8 Other specified intracranial injuries S06.9 Intracranial injury of other and unspecified nature</p> | | | | | | | | | | | | | | |
| <p>Discharge Disposition (Please record the date of all discharge dispositions, including death.)</p> | <table border="0"> <tr> <td>0 – Another Acute Care Facility</td> <td>6 – Inpatient Rehabilitation Facility</td> </tr> <tr> <td>1 – Home, Self Care</td> <td>7 – AMA (Against Medical Advice)</td> </tr> <tr> <td>2 – Home, Non-Skilled Assistance</td> <td>8 – Long Term Acute Care (LTAC)</td> </tr> <tr> <td>3 – Home, With Skilled Care</td> <td>9 – Hospice Care</td> </tr> <tr> <td>4 – Residential Facility Without Skilled Care</td> <td>10 – Deceased</td> </tr> <tr> <td>5 – Residential Facility With Skilled Care</td> <td>11 – Other (please specify)</td> </tr> <tr> <td></td> <td>12 – Unknown</td> </tr> </table> | 0 – Another Acute Care Facility | 6 – Inpatient Rehabilitation Facility | 1 – Home, Self Care | 7 – AMA (Against Medical Advice) | 2 – Home, Non-Skilled Assistance | 8 – Long Term Acute Care (LTAC) | 3 – Home, With Skilled Care | 9 – Hospice Care | 4 – Residential Facility Without Skilled Care | 10 – Deceased | 5 – Residential Facility With Skilled Care | 11 – Other (please specify) | | 12 – Unknown |
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| 4 – Residential Facility Without Skilled Care | 10 – Deceased | | | | | | | | | | | | | | |
| 5 – Residential Facility With Skilled Care | 11 – Other (please specify) | | | | | | | | | | | | | | |
| | 12 – Unknown | | | | | | | | | | | | | | |
| <p>Discharge Facility</p> | <p>If the patient is transferred or discharged to another acute care facility or rehabilitation unit at another hospital, please indicate that facility.</p> | | | | | | | | | | | | | | |

SPINAL CORD INJURY INFORMATION

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| Para/Quad Level | Enter the level that best describes the individual's spinal cord injury: Cervical: C1, C2, C3, C4, C5, C6, C7, or C8 Thoracic: T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, or T12 Lumbar: L1, L2, L3, L4, or L5 Sacral: S1, S2, S3, S4, or S5 |
| Extent of Lesion | Check the appropriate response that best describes the individual's spinal cord injury: <ul style="list-style-type: none"> • Complete loss of motor and/or sensory functions below the zone of injury. • Incomplete loss of motor and/or sensory functions below the zone of injury (includes sacral sensory sparing). • Unknown loss of motor and/or sensory functions below the zone of injury. |
| Ventilator | Check to indicate if the individual requires a ventilator to breathe. |
| Sensory Deficit | Check to indicate if the individual is experiencing sensory deficits as a result of the spinal cord injury. |
| Motor Deficit | Check to indicate if the individual is experiencing motor deficits as a result of the spinal cord injury. |
| Bowel Deficit (Loss of control) | Check to indicate if the individual is experiencing a loss of bowel control as a result of the spinal cord injury. |
| Bladder Deficit (Loss of control) | Check to indicate if the individual is experiencing a loss of bladder control as a result of the spinal cord injury. |
| ICD-10 Codes | G81.0 Flaccid hemiplegia affecting either side. G81.1 Spastic hemiplegia affecting either side G81.9 Unspecified hemiplegia affecting either side G82.2 Unspecified quadriplegia G82.5 Quadriplegia of C1-C4 or C5-C7, complete or incomplete G83.1 Other paralytic syndromes S14.1 Injury at C1-to-C7 level of cervical spinal cord S24.1 Injury at T1-to-T6 level of thoracic spinal cord S34.1 Injury to sacral spinal cord |

GLASGOW COMA SCALE

(Recommended for Age 4 to Adult)

| Eye Opening | Points | Best Verbal Response | Points | Best Motor Response | Points |
|--|--------|---|--------|---|--------|
| Spontaneous Indicates arousal mechanisms in brainstem are active. | 4 | Oriented Patient knows who and where he or she is, and the year, season and month. | 5 | Obeys Commands *Note: a gasp reflex or a change in posture does not count as a response. | 6 |
| To Sound Eyes open to any sound stimulus. | 3 | Confused Responses to questions indicate varying degrees of confusion and disorientation. | 4 | Localized Moves a limb to attempt to remove a painful stimulus. | 5 |
| To Pain Apply stimulus to limbs, not face. | 2 | Inappropriate Speech is intelligible, but sustained conversation is not possible. | 3 | Flexor: Normal Entire shoulder or arm is flexed in response to painful stimuli. | 4 |
| No Response | 1 | Incomprehensible Unintelligible sounds such as moans and groans are made. | 2 | Flexion: Abnormal The patient is rigidly still with arms flexed, fists clenched, and legs extended. | 3 |
| Choose the number from the column above that best describes patient's response. Enter here: | | No Response | 1 | Extension Abnormal turning and rotation of the arms and shoulders. | 2 |
| | | Choose the number from the column above that best describes patient's response. Enter here: | | No Response | 1 |
| | | | | Choose the number from the column above that best describes patient's response. Enter here: | |
| The Glasgow Score is the total of the three numbers chosen above. Enter total here: | | | | | |