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
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** **Private insurance** (please specify insurer) **Exchange Policy** (please specify insurer) **Not insured** **Worker’s Compensation**
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 *only* 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

Ethnicity	Enter one of the following: **1** – if the individual **is** of Hispanic origin. **2** – if the individual **is not** of Hispanic origin.
Primary Language	Indicate if the individual's primary language is **English**, **Spanish**, or **Other** (please specify).
Military Status	Please indicate if the patient is an **Active Duty** or **Veteran** member of the U.S. Armed Forces.
Employment Status	Enter the selection that best describes the patient's employment status prior to his or her injury: **Employed Full-Time** **Retired** **Employed Part-Time** **Unemployed (Working Age)** **Student** **Child/Infant (Not Working Age)** **Homemaker** **Other** **Disabled** **Unknown**
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. This person may need to be contacted by Trauma Rehabilitation Program with requests for missing or additional information. If a private citizen is making the referral, enter **N/A. If entering information by hand, 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. This person may need to be contacted by Arkansas Trauma Rehabilitation Program with requests for missing or additional information. 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 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: **Home** **Farm** **Mine and Quarry** **Industrial Place or Premises** **Place for Recreation or Sport** **Street or Highway** **Public Building** **Residential Institution** **Other Specified Place** **Unspecified Place**
Injury County	Enter the **county** where the injury occurred. If unknown, leave blank.
ETOH/Drug (Alcohol)	Enter the selection that best describes if alcohol or drug use was involved at the time of the injury: **1** – Not alcohol or drug related **2** – Alcohol related **3** – Drug related **4** – Alcohol and drug related **5** – Unknown
Etiology (Circumstances)	Enter the selection that best describes the cause of the individual's injury: **11** – Auto/Truck Accident **12** – Motorcycle Accident **13** – ATV/Moped/Dirt bike/Go cart **14** – Bicycle/Auto collision **15** – Bicycle/Not-auto collision **16** – Fall from Auto/Truck **17** – Boating/Jet Ski **18** – Heavy Equipment (farm/construction) **20** – Pedestrian/Auto collision **21** – Pedestrian/Bicycle collision **29** – Pedestrian unknown **31** – Stabbing **32** – Firearms **40** – Swimming **41** – Diving into a pool **42** – Diving into a natural body of water **44** – Football/Soccer/Hockey **45** – Skating/Skateboard/Scooter **49** – Other Sport **50** – Jump/Fall **55** – Falling Object **60** – Medical Complication **65** – Airplane/Train Crash **70** – Altercation/Assault **71** – Suspected Abuse **72** – Domestic Violence **73** – Car Surfing **74** – War Injury **98** – Other **99** – Unknown
Injury	Please indicate if the injury was **Accidental** or **Intentional**, **Self-Inflicted** or **Caused by another person or circumstance**, **Work Related**, or **Military Service Related**. Please check all that apply.
Position	Enter the selection that best describes the position of the individual if the injury involved a motor vehicle: **1** – Driver/Operator **2** – Passenger **4** – Pedestrian **5** – Motorcycle Driver **6** – Motorcycle Passenger **7** – Other Specified **8** – Other/Cyclist **9** – Riding on Animal **10** – Streetcar Occupant **11** – Not Available
Protection	Enter the selection that best describes if safety devices were being used at the time of injury: **20** – 2 point belt (lap belt only) **21** – 3 point belt (shoulder and lap belt only) **22** – Airbags (air bag only) **23** – Airbags & Belt (airbag and seatbelt) **24** – Airbag deployed **25** – Car seat (infant/child car seat) **26** – Eye protection **27** – Hard hat **28** – Helmet **29** – None **30** – Padding **31** – Protective clothing **32** – Seatbelt (seatbelt only) **33** – Not recorded (default) **34** – Not performed **35** – Not available
Ejected from Vehicle/Rollover	Please indicate if the individual was ejected from the vehicle and/or the vehicle rolled over.

Type of Vehicle	Please indicate the type of vehicle the individual was occupying at the time of the accident: **1-Passenger Car** **2-Pick-up Truck** **3-Van/Mini-van** **4-Sport Utility Vehicle (SUV)** **5-Commercial Truck or Bus** **6-Motorcycle or Moped** **7- All-Terrain Vehicle or go-cart** **8-Other** **9-Unknown**
Number of Vehicles	Please indicate the number of vehicles involved in the accident.
Road Conditions	Please indicate the road conditions at the time of the accident: **1-Dry, hard (Pavement)** **2-Dry, loose gravel** **3-Mist/Fog** **4-Wet** **5-Ice** **6-Snow** **7- Off-Road** **8-Other** **9-Unknown**
Date of Admission	Date Individual was admitted to the facility, if applicable. Date format: **MM/DD/YYYY**
Date Brain Injury Identified	Date the individual's brain injury was identified or diagnosed. This date may differ from the Date of Admission. Date format: **MM/DD/YYYY**

BRAIN INJURY INFORMATION

Glasgow Score To be collected: • Upon admission (or lowest) • At discharge.	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.
TBI Open / Closed	Indicate if the individual's brain injury was **open** or **closed**.
ICD-10 Codes	Enter the codes that best describe the individual's brain (head) injury: **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
Altered Sensorium	Check to indicate if the individual's senses (taste, touch, sight, hearing, or smell) have been affected by the brain injury.
Ventilator	Check to indicate if the individual required assistance from a ventilator to breathe.
Discharge Date	Indicate the date the individual was discharged or transferred
Discharge Disposition (Please record the date of all discharge dispositions, including death.)	**Another Acute Care Facility** **Home, Self Care** **Home, Non-Skilled Assistance** **Home, With Skilled Care** **Residential Facility Without Skilled Care** **Residential Facility With Skilled Care** **Law Enforcement** **Inpatient Rehabilitation Care** **AMA (Against Medical Advice)** **Step-Down Care** **Long Term Acute Care (LTAC)** **Inpatient Psychiatric Care** **Hospice Care** **Deceased** **Other (please specify)** **Unknown**
Discharge Facility	If the patient is transferred or discharged to another acute care facility or rehabilitation unit at another hospital, please indicate that facility.
Suitable for Acute Rehabilitation	Please indicate if the individual meets the following criteria to participate in acute rehabilitation: **Medically Stable**, **Vent Independent**, **Insurance Coverage**, and/or **Able to Take Part in Three Hours of Therapy Daily**.
Reason for Discharge Destination	Please indicate the primary reason the individual was discharged or transferred to destination indicated above: **Insurance** **Specialty/Higher level of care** **Resources unavailable** (beds, equipment, staff, MD) **Patient Request** **Patient Physician** **Family Request** **Law Enforcement** **Online Medical Direction** **Lower Level of Care** **Not Applicable** **Unknown**

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:	