Traumatic Brain Injury - Patient Case Presentation Form

PLEASE FILL OUT THIS FORM ON YOUR COMPUTER

Please do not include any patient identifying data.
This case form is the only document used for your ECHO case. Please complete this form to the best of your ability; fields may be left blank if you are missing information. Do not send any supplementary materials or share documents from your screen during the case presentation.

Presenter: Site: Date:

TBI Type / Category: Mild TBI/ Concussion Moderate-Severe TBI Other (Acquired)

How long have you been seeing the patient?

How many visits have you had with the patient?

Brief Patient Demographics

Age Sex and gender Ethnic background

Current employment/ Academic

Occupation

Employment prior to injury

Living arrangement and circumstances (lives alone, with significant other/ family, stability of housing)

Injury Details

Date of presenting injury Injury severity

Details of presenting injury (description of event, including cause and circumstances of injury, whether they received inpatient/outpatient rehabilitation)

Loss of consciousness | Post-traumatic amnesia

CT | MRI | Glasgow Coma Scale

Current Symptom/Impairment Profile: Primary **current** complaints

Check all that apply

	No complaint	Minor complaint	Moderate complaint *(interfering with daily activities*	Severe complaint *cannot complete daily activities*
Light sensitivity				
Sound sensitivity				
Headache				
Dizziness				
Balance/motor coordination				
Sleep changes and/or fatigue				
Attention/concentration				
Processing speed				
Memory				
Visuospatial abilities				
Executive function (e.g., reduced initiation, apathy)				
Behavioural dysregulation				
Language/communication				
Depression				
Anxiety/stress				
Emotional dysregulation (e.g., anger, overly tearful)				
Activities of daily living				

Please list any other physical, cognitive, and/or emotional symptoms

Treatments/Consultations: List history of pertinent treatments/consultations for TBI (include referrals to neurologists, psychologists, chiropractors, OTs, PTs, etc; indicate if in past or current)

Medical History: List any past medical, psychiatric, neurological history and/or conditions

Medication History: Medication pertinent to TBI-related symptoms

Substance Use: List alcohol or nicotine or non-prescription drugs(e.g.,cannabinoids); including any substance abuse history

Your main questions concerning your patient (please list top 3 main questions).

**Once the form saves, the information can't be modified*

****IMPORTANT* PLEASE SAVE THIS DOCUMENT AS A PDF BEFORE CLOSING TO AVOID LOSING INFORMATION***

ECHO Staff Use:

SIGNATURE:

DATE:

SIGNATURE:

DATE:

Save Case Form