**Dr. John Doe**

**Concussion Diagnosis Consultation Request**

**Date:**

**Patient Name:**

**DOB:**

**DOI:**

**To: Dr.**

**Please provide the following:**

Concussion diagnosis consultation Assume case management

Results of EEG ERP test attached  Results of attached

**Brief description of the injury:** (include if driver, how accident happened, body parts struck, etc.?)

**Loss of Consciousness**

There was loss of consciousness for minutes seconds

There was NO loss of consciousness

**Amnesia:**

­­­­­­­­­­­­­  The patient demonstrated symptoms of amnesia following the injury

­­­­­­­­­­­­­  The patient did NOT demonstrate symptoms of amnesia following the injury

**The following were used in the evaluation of this patient:**

CDC ACE / Rivermead Questionnaires  positive  Psychological Questionnaires  positive  Neurological Exam  positive  Physical/Ortho Exam  positive  Gaze Deviation or Nystagmus  positive  Neurocognitive testing  positive  BESS balance test  positive  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Post Injury Symptoms:**

Headaches  Neck Pain  Cognitive impairment

Memory impairment  Seizure  Sleep disorder

Anxiety  Depression  Diagnosed Whiplash (CAD)

Seizures post-injury  Concussion symptoms for \_\_\_day(s)/week(s)

Dizziness/ Poor Balance/Vertigo

Symptoms worsen with physical and/or cognitive exertion

Changes in cognition, emotion, sleep and/or physical status post trauma as reported by patient and/or family  Other:

**Previous History of:**

Head Trauma

Concussion

Headaches

Cognitive impairment

Memory Impairment

Dementia/Alzheimer's

Anxiety

Depression

Other psychiatric disorders

Sleep disorder

**Cranial Nerve Testing Results:**

Cranial Nerve 1 (Olfactory) Abnormality

Cranial Nerve 4 (Trochlear) Abnormality

Cranial Nerve 5 (Trigeminal) Abnormality

Cranial Nerve 8 (Vestibulocochlear) Abnormality

Other Cranial Nerve

No Cranial Nerve Abnormalities found

Did not perform

**Focal Neurological Symptoms (Weakness, Loss of Sensation, Impaired Coordination, Gait Impairment)**

Yes  No

**The following air bag(s) deployed\*:**

Front air bag

Side air bag

None

Unknown

\**Deployed air bags have been shown to double the incidence of mTBI.*

I understand that any unchecked box above is an indication of absence of that condition.

Physician Name