

I'm not robot!

ACUTE CONCUSSION EVALUATION (ACE)

PHYSICIAN/CLINICIAN OFFICE VERSION
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Patient Name: _____
DOB: _____ Age: _____
Date: _____ IDMR# _____

A. Injury Characteristics Date/Time of injury: _____ Reporter: Patient Parent Spouse Other _____

1. Injury Description _____

1A. Is there evidence of a forceful blow to the head (direct or indirect)? Yes No Unknown
1B. Is there evidence of intracranial injury or skull fracture? Yes No Unknown
1C. Location of impact: Frontal Left Temporal Right Temporal Left Parietal Right Parietal Occipital Neck Indirect Force
2. Cause: MVC Pedestrian-MVC Fall Assault Sports (Specify) _____ Other _____
3. Antecedent Events (Pre-Event) Are there any events just BEFORE the injury that your person has no memory of (given brief)? Yes No Duration _____
4. Antecedent Events (Post-Event) Are there any events just AFTER the injury that your person has no memory of (given brief)? Yes No Duration _____
5. Loss of Consciousness: Did your person lose consciousness? Yes No Duration _____
6. EARLY SIGNS: Appears dazed or stunned Is confused about events Answers questions slowly Repeats Questions Forgetful (recent info)
7. Seizures: Were seizures observed? No Yes Detail _____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?
Indicate presence of each symptom (0=No, 1=Yes). Lowell & Collins, 1998, JGIM

PHYSICAL (10)	COGNITIVE (4)	SLEEP (6)
Headache 0 1	Feeling mentally foggy 0 1	Drowsiness 0 1
Nausea 0 1	Feeling slowed down 0 1	Sleeping less than usual 0 1 N/A
Vomiting 0 1	Difficulty concentrating 0 1	Sleeping more than usual 0 1 N/A
Balance problems 0 1	Difficulty remembering 0 1	Trouble falling asleep 0 1 N/A
Dizziness 0 1	COGNITIVE Total (0-4) _____	SLEEP Total (0-6) _____
Visual problems 0 1	EMOTIONAL (4)	Caution: Do these symptoms occur with: Physical Activity Yes No N/A Cognitive Activity Yes No N/A Overall Rating: How different is the person acting compared to his/her usual self? (score) Normal 0 1 2 3 4 5 6 Very Different
Fatigue 0 1	Irritability 0 1	
Sensitivity to light 0 1	Sadness 0 1	
Sensitivity to noise 0 1	More emotional 0 1	
Numbness/tingling 0 1	Nervousness 0 1	
PHYSICAL Total (0-10) _____	EMOTIONAL Total (0-4) _____	
(Add Physical, Cognitive, Emotion, Sleep Subtotal Total Symptoms Score (0-22) _____)		

C. Risk Factors for Prolonged Recovery (check all that apply)

Concussion History Y N	Headache History Y N	Developmental History	Psychiatric History
Previous # 1 2 3 4 5 6+	Prior treatment for headache	Learning disabilities	Anxiety
Longest symptom duration (Days, Weeks, Months, Years)	History of migraine headache (Personal, Family)	Attention-Deficit/Hyperactivity Disorder	Depression
If multiple concussions, less force caused injury? Yes No		Other developmental disorder	Other psychiatric disorder

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures).

D. RED FLAGS for acute emergency management: Refer to the emergency department with urgent onset of any of the following:
* Headaches that worsen * Looks very drowsy/can't be awakened * Can't recognize people or places * Neck pain
* Seizures * Repeated vomiting * Increasing confusion or irritability * Unusual behavioral change
* Equal pupil size * Slurred speech * Weakness or numbness in arms/legs * Change in state of consciousness

E. Diagnosis (ICD): Concussion w/ LOC 850.0 Concussion w/ LOC 850.1 Concussion (unspecified) 850.9 Other (854) _____
No diagnosis _____

F. Follow-Up Action Plan Complete ACE Care Plan and provide copy to patient/family.
No Follow-up Needed
Physician/Clinician Office Monitoring: Date of next follow-up: _____
Referral:
Neuropsychological Testing
Physician: Neurology Sports Medicine Physiatrist Psychiatrist Other _____
Emergency Department

ACE Completed by: _____ © Copyright G. Glick & M. Collins, 2008
This form is part of the "Treat Up, Don't Sign Up in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).

STUDENT MEDICAL EXAMINATION FORM
Niva International School
35 5th Ave East York, E. Kingston, Ontario, Canada K0G 1S0 Telephone: 613 546-8557 ext 100

Entering grade: _____ Admission date: _____ Registration no. _____

Name of Student Last, First, Middle Initials: _____ Nick name: _____
Gender: Male Female Birth date: _____ Nationality: _____
Parent's Name: Father Last, First, Middle Initials: _____ Mother Last, First, Middle Initials: _____ Home Address in Thailand: _____ Home Tel: _____

Medical History:
1. Significant illness, accidents, operations, congenital defects, family history, etc.
2. Significant factors in home education setting, well-being and academic performance.
3. To be completed by the parent/guardian only for the student's parent/guardian to be advised of the student's medical condition and to advise the school health authorities on his/her behalf. It is necessary for the school to have a report of the health examination. This report will be held in confidence and used only for the protection and well-being of the student in the school. Thank you.

A. Are there abnormalities of the following systems? Yes No
1. Heart, Lungs, Nose, or Throat
2. Hearing
3. Eyes, Vision, Ears
4. Cardiovascular System
5. Blood Pressure
6. Pulse Rate
7. Gastrointestinal System
8. Urinary System
9. Musculoskeletal System
10. Male: Endocrine System

B. Weight, Height, BMI
C. Any significant weight changes in the last year?
D. Is there any serious physical defect?
E. Is the student ever treated for any medical or emotional condition?
F. Recommended for physical activity (e.g., intramurals, etc.)
G. Occupational, School, Explain
H. Recommended stress test and labor test (Obstructed, Unobstructed)
I. Allergies
J. General Comments (Medication, food, and for other)

4. These examinations are required and must be completed in full and signed by physician before student can be accepted. An official record of all medical and dental examinations must accompany school file. Please attach to this form.

5. To be completed by the physician.
6. PLEASE CONDUCT THESE TESTS IF APPROPRIATE AND ATTACH INFORMATION ABOUT TESTS GIVEN AND THE RESULTS.
7. If there is evidence of the following conditions, please refer for and attach information:
Neuropsychiatric Learning Disabilities Dyslexia Attention Deficit Disorder (ADD) Appetitability Underachievement Characteristics

8. Physician's Name & Signature
9. Date of Examination (month/year)
10. I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any YES answers and potential hazards of medications including over-the-counter medications while driving. Should additional medical documentation from a treating physician be warranted prior to determining if the driver meets the minimum requirements, said documentation should become a part of his/her medical file which is maintained in your office.) (Discussion with driver should be documented below.)

- (iv) The students of Kibaoni Secondary school conducted a study tour to volcanic regions and when they reach the area they were wondering the way hot water was forcefully emitted into the atmosphere from the ground due to volcanic eruptions. What feature is that?
A. Hot spring
B. Crater lake
C. Geyser
D. Water falls
E. Volcanic plug
- (v) The forest officer of Iringa is about to explain the importance of reserved forest resource. Identify the economic activity expected to be discussed among the following
A. Lumbering
B. Mining
C. Agriculture
D. Tourism
E. Forestry
- (vi) Mwandizi was a great farmer in Mbeya. He used to cultivate a certain piece of land and leave it to regain its fertility for sometimes. Which among the following farming system did Mwandizi used?
A. Subsistence
B. Crop rotation
C. Bush fallowing
D. Mixed farming
E. Shifting cultivation
- (vii) River Kagers underwent undercutting and rock breaking by boulders, pebbles and sand being hurled against the base of cliff by breaking waves. Which process involved in this marine erosion?
A. Attrition
B. Corrosion
C. Solution
D. Abrasion
E. Hydraulic action
- (viii) The form four students studied the topic of population and were able to define the term dependence ratio. What does the term mean?
A. Number of males to females
B. Composition of population
C. Number of people in working ages and non working ages.
D. Number of people per unit area
E. Total number of people in relation to the area occupied.

Louisiana Department of Public Safety & Corrections
Office of Motor Vehicles
CDL PHYSICAL EXAMINATION FORM
State Department of Transportation Inspection

Date of Examination: _____ New Certification [] Re-certification [] Follow-up []

1. DRIVER'S INFORMATION: Driver completes this section.
Driver's Name: _____
Address: _____
Sex: Male Female Date of Birth: _____ Age: _____ Race/Eth: _____
Driver's License No. _____ Class: _____ State: _____ Telephone: _____

2. HEALTH HISTORY: Driver completes this section, but medical examiner is encouraged to discuss with driver.
Yes No
[] Any illness or injury in last 5 years? [] Diabetes or elevated blood sugar controlled by []
[] Heart/brain/spine, disorders or diseases []
[] Seizures, epilepsy []
[] If yes, specify medication []
[] Eye disorders or impaired vision (except corrective lenses) []
[] Ear disorders, loss of hearing or balance []
[] Heart disease or heart attack, other cardiovascular condition []
[] If yes, specify medication []
[] Hearing/ear (tube replacement/typanitis, otitis, etc.) []
[] High blood pressure []
[] If yes, specify medication []
[] Shortness of breath []
[] Lung disease, emphysema, asthma, chronic bronchitis []
[] Kidney disease, dialysis []
[] Liver disease []
[] Digestive problems []

3. MEDICAL EXAMINER'S COMMENTS: Medical examiner must review and discuss with the driver any YES answers and potential hazards of medications including over-the-counter medications while driving. Should additional medical documentation from a treating physician be warranted prior to determining if the driver meets the minimum requirements, said documentation should become a part of his/her medical file which is maintained in your office.) (Discussion with driver should be documented below.)

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature: _____ Date: _____

Medical Examiner's Signature: _____ Date: _____

Is the condition(s) likely to hamper the driver's ability to control and/or safely operate a commercial motor vehicle? Yes [] No []

Does treatment/medication utilized cause any side effects that are likely to hamper the ability to control and/or safely operate a commercial motor vehicle? Yes [] No []

