PABICOP Supplementary Form

Name: _____

D.O.B(yyyy-mm-dd):_____

Reason for Referral/Goal for Referral:

_____

Diagnosis:

Concussion/Mild TBI ☐ Moderate-Severe TBI ☐

☐ Acquired brain injury due to: _____

If TBI, what was the mechanism of injury? _____

Date of injury/illness (yyyy-mm-dd): _____

Date of diagnosis of injury, if different from date of injury (yyyy-mm-dd): _____

If applicable: Lowest GCS: _____Duration of post-traumatic amnesia: _____

Associated injuries or complications (please list):

School:

Is this child/youth currently attending school? Yes ☐ No ☐

If no, how long have they been off school? _____

Is there an anticipated return date? No ☐

If yes, how long were they away from school post-injury/illness? _____

Comments:

779 Base Line Rd. E. | London ON N6C 5Y6 | **www.tvcc.on.ca**

Tel: 519.685.8700 | **Toll:** 1.866.590.8822 | **Fax:** 519.685.8705

Risk Factors

Are there any risk factors that may complicate recovery? (check all that apply)

☐ Prior ABI or TBI: Total prior ABI/TBI: _____

Interval since last injury: _____

☐ Prior developmental diagnosis: GDD ☐ ADHD ☐ LD ☐ ID ☐ ASD ☐

Other: _____

☐ Prior psychiatric diagnosis: anxiety ☐ depression ☐ OCD ☐

Other: _____

☐ Substance abuse: alcohol ☐ cannabis ☐ vaping ☐

Other: _____

☐ Family stressors: _____

Comments:

Additional Information:

For children with headaches, how many days/weeks is the child using analgesia? N/A ☐

Comment: _____

If there is frequent analgesia intake (>=3x/week for 3 months or more) please consider risk of Medication Overuse Headache and recommend a 1 month medication holiday then reassess headache pattern. If significant nausea with headaches, anti-emetics can still be recommended.

Has a medication holiday been completed?

No ☐ ☐ Yes - outcome: _____

What medications (include dose) have been tried for headaches (please list): N/A ☐

Comment:

Have the following been completed? If not, please consider arranging, especially if child is having problems with headaches, concentration and/or return to school:

☐ Optometry/ophthalmology exam; results: _____

☐ Audiology; results: _____

What symptoms are currently impacting the child/youth's function? (Check all that apply)

Headache ☐
Vision disruption ☐
Dizziness ☐
Balance concerns ☐
Fatigue ☐
Sleep disruption ☐
Noise/light sensitivity ☐
Other:

Poor concentration ☐
Problems with memory or recall ☐
Problems with word finding or communication ☐
Anxiety/stress ☐
Low mood/depression ☐
Anger/irritability ☐

Were any of these symptoms a concern prior to illness/injury?

☐ Unsure ☐ No

☐ Yes, please list:

Has neuroimaging been completed: Yes ☐ No ☐

If yes: ☐ CT Date (yyyy-mm-dd): _____ Location: _____

☐ MRI Date (yyyy-mm-dd): _____ Location: _____

☐ Report attached or Results:

*Note: new or actionable incidental findings should be referred to Neurology/Neurosurgery as indicated, as we do not have those services within our program

For children with sleep disruption, what recommendations have been made/tried so far:

Methods	Tried	Recommended
Sleep hygiene:	☐	☐
Melatonin - dose:	☐	☐
Magnesium supplement	☐	☐
Other supplement/herbal product (e.g., L-Theanine):	☐	☐
Pre-bed screen time limits (including smart phone)	☐	☐
Caffeine elimination/reduction	☐	☐
Prescription medication (please list):	☐	☐

Please list therapies or supports child is accessing or has accessed (e.g., mental health, OT, PT, private rehabilitation team, etc.):

Name: _____

DOB (yyyy-mm-dd): _____

Referees Name: _____

Please submit this form along with the TVCC Physician Referral Form to https://www.tvcc.on.ca/intake-referrals

Incomplete forms may require follow up, resulting in a delay in our ability to accept a referral and begin service.

Thank you, PABICOP Team