Medical & Rehabilitation Information

Date form completed:	Revised:	Initials:
By whom:	Revised:	Initials:

In this section of the notebook, be sure to include copies of the following documents:

- ☐ Medical documentation of the brain injury
- ☐ Hospital/rehabilitation discharge summaries
- ☐ Hospital and/or rehabilitation discharge recommendations
- ☐ Reports from specialists (e.g., psychiatrists, ophthalmologists, neurologists)
- ☐ List of current medications and dosages

Fill in the items below and print out this form for your notebook.

Name of child:	Birth date:
Home address:	Phone:
Parent/Guardian:	Home/Work phone:

Injury

Date of injury:	Length of coma:
Cause of injury:	Date returned home after injury:

Describe all injuries:

Current condition & therapies

Medications:

Special equipment:

Seizure history:

Supervision/Assistance needed:

Specialty:

© 2006, Oregon Center for Applied Science. Permission is granted to use and print this form for non-commercial purposes.

Medical care & rehabilitation

Location	Date Admitted	Date Discharged
Hospitalization(s):		
Inpatient rehabilitation:		
Outpatient rehabilitation:		

People involved in medical care and rehabilitation

Hospital	Telephone	Family has reports?
Primary doctor:		☐ Yes ☐ No
Neurologist or Neurosurgeon: Head nurse:		☐ Yes ☐ No ☐ Yes ☐ No
Physical therapist:		☐ Yes ☐ No

© 2006, Oregon Center for Applied Science. Permission is granted to use and print this form for non-commercial purposes.

Occupational therapist:		☐ Yes ☐ No
Speech/Language therapist:		☐ Yes ☐ No
Social worker/Discharge planner:		☐ Yes ☐ No
Others:		☐ Yes ☐ No

Inpatient rehabilitation program	**Telephone**	**Family has reports?**
Primary doctor:		☐ Yes ☐ No
Head nurse:		☐ Yes ☐ No
Physical therapist:		☐ Yes ☐ No
Occupational therapist:		☐ Yes ☐ No
Speech/Language therapist: Social worker/Discharge planner:		☐ Yes ☐ No ☐ Yes ☐ No
Psychologist/Neuropsychologist:		☐ Yes ☐ No

© 2006, Oregon Center for Applied Science. Permission is granted to use and print this form for non-commercial purposes.

Others:		☐ Yes ☐ No
Out-patient rehabilitation program	**Telephone**	**Family has reports?**
Physical therapist:		☐ Yes ☐ No
Occupational therapist:		☐ Yes ☐ No
Speech/Language therapist:		☐ Yes ☐ No
Psychologist/Neuropsychologist:		☐ Yes ☐ No
Social worker:		☐ Yes ☐ No
Others:		☐ Yes ☐ No
Community agencies	**Telephone**	**Family has reports?**
Home health/Visiting nurse:		☐ Yes ☐ No
Vocational rehab:		☐ Yes ☐ No
Counseling:		☐ Yes ☐ No
Other:		☐ Yes ☐ No

© 2006, Oregon Center for Applied Science. Permission is granted to use and print this form for non-commercial purposes.