

Brain Injury Coalition Request for Case Review Form

Instructions:

Once this form is complete return to Marcie Moss Helfgott or Theodore J. DeCarlo by either email, fax or regular mail. You will receive notification of scheduled date of case review.

Marcie Moss Helfgott, Theodore J. DeCarlo

2801 Martin Luther King Drive / CR 11

Cleveland, Ohio 44104-3865

Phone: (216) 448-6283

Fax: (216) 791-1012

helfgom@ccf.org or DECARLT@ccf.org

Date: _____

Referring Agency/Person: _____ Contact Phone Number: _____ Email Address: _____
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Name of Individual to be Reviewed: _____
D.O.B.: _____ Age: _____
Address: _____ Apt./Suite: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Educational Level: _____ School(s) Attended: _____
Employer at time of injury: _____ Position: _____ Years Employed: _____
Summary of job responsibilities: _____ _____ _____

Date of Injury: _____
Nature of Injury: _____ Acquired Brain Injury _____ Traumatic Injury
How did the injury occur?

Was there a loss of consciousness? If yes, for how long? _____

Was rehabilitation provided? _____ Yes _____ No

Name of Facility _____

_____ Inpatient _____ Outpatient

Duration of Rehab: _____

Therapy Provided:

_____ PT _____ OT _____ Speech

_____ Psychology _____ Neuropsychology

Did he/she complete a Neuropsychological evaluation? _____ Yes _____ No

Current Medications: (Include name, dose and frequency)

Name of Family/Support Person: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: _____ (Home)

_____ (Cell)

Current Concerns: Identify the person's concerns, you may not have to use all subject areas below.

Behavior:

Mood/Emotional State:

Physical Functioning:

Daily Activity Pattern:

Medical Issues:

Hygiene/Cleanliness:

Appetite:

Sleep:

Sexuality:

Medications:

Employment Issues:

How did you hear about the BIC Case Review process?

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