Basic orientation questions:

1. “How old are you?” .................................................................................................................... (2 POINTS)
   (People usually recite correct birthdates even while getting their age wrong)

2. “What year are we having right now?” ....................................................................................... (2 POINTS)

3. “What month is it right now?” .................................................................................................. (1 POINT)

4. “What day of the month is it?” ................................................................................................ (1 POINT)

5. “What day of the week is today?” ........................................................................................... (1 POINT)

6. “What hour of the day does it feel like right now?” ................................................................. (1 POINT)

7. “What is this place that we’re in?”
   Motion to surrounding setting.
   If patient says ‘hospital,’ then credit and ask: ........................................................................ (1 POINT)
   “What’s the name of this hospital?”......................................................................................... (1 POINT)

8. “What city are we in right now?” ............................................................................................ (2 POINTS)

TOTAL SCORE RANGE:
Normal = 10-12     Mildly Impaired = 7-9     Moderately Impaired = 6     Mod / Severe = 5     Severely Impaired = 4 or less

IF score = 9 or less, omit the following questions and document that the patient remains in post-traumatic amnesia (PTA)

If score > 9, then ask the following questions:

• “What brought you in here?” If patient has no accurate explanation, then clearly there has been – and may continue to be PTA, even if normally oriented at the present moment. DO NOT ASK THE PATIENT FOR HIS/HER OPINION ABOUT HIS/HER OWN LOSS OF CONSCIOUSNESS.

• “I want you to set aside everything you learned about the accident/fall/injury after it was over and just think about what your brain was able to record on its own power.”

• “What was the very last thing you can remember – on you own power – right before the impact?” Record verbatim.

• “What was the very next thing you can remember?” Record verbatim.

• Ask for any recall of each subsequent step, i.e. first responder, being extricated, being placed in an ambulance/helicopter, the ride to the hospital, being brought to the ED.

• Calculate/estimate the amount of time that passed while the patient’s brain was unable to record events, i.e. between the moment of impact and the resumption of recall for a continuous flow of events. This amount of time is the duration of post-traumatic amnesia.

*Taken from COGNISTAT —The Neurobehavioral Cognitive Status Examination. (A widely used standardized screening test.)
Patients Admitted with Head Injury

MILD
GCS 13 - 15

ALPHA: GCS<10, worsening LOC
BRAVO: GCS 15, prolonged LOC, waxing/waning LOC, seizure

Obtain CT SCAN if (+) LOC or (+) POST TRAUMATIC AMNESIA (>30 min. pre-impact) or if any RISK FACTOR present:
- GCS < 13 at any time since injury
- Focal neurological deficit
- GCS 13 or 14 two hours post injury
- Evidence skull fracture (raccoon eyes, battles' sign, oto/rhinorrhea)
- Worsening headache
- Vomiting > 1 episode
- Post-traumatic seizure
- - Coumadin Rx/Coagulopathy – STAT PT/INR and T&S
  (bleeding d.o., antiplatelet tx, cirrhosis, renal dialysis)
- Dangerous mechanism (pedestrian vs. car, ejection MVA, falls > 1 meter or 5 stairs) with presence of some degree LOC or amnesia
- Age >65 with presence of some degree LOC or amnesia

If any focal neuro deficit, skull fracture, CSF leak, GCS has not returned to 15, continued worrisome signs (persistent vomiting, worsening headaches, etc)?

CT SCAN:
(-) ICH

If any focal neuro deficit, skull fracture, CSF leak, GCS has not returned to 15, continued worrisome signs (persistent vomiting, worsening headaches, etc)?

CT SCAN:
(+/-) ICH
(excludes scalp injury)

CT SCAN:
(+/-) ICH

YES

NEUROSURGERY CONSULT
Immediate call: GCS<9 or (+)ICH
Non-urgent: GCS 9-15 with (-)ICH

NO

Admission Criteria:
- Other injuries present
- Other concerns: ETOH intoxication
- Presence of risk factor listed above
- Lack of home supervision

ADMISSION ORDERS #1:
- Q2 hour neuro checks
- Cautious use narcotics
- NO HALDOL
- PMR consult for TBI evaluation
- Head injury education sheet

ADMISSION ORDERS #2:
- GCS <9 or (+)ICH: Level of monitoring and freq. of neuro checks based on CT results and NS recommendations
- GCS >9 and (-)ICH: follow admission orders #1. Enter order for NS consult, no phone call necessary.
  - Rapid anticoagulation reversal if (+) ICH – begin in ED with Non-crossmatched FFP while awaiting Type & Screen
    - Consider administering platelets if pt on platelet-inhibiting agents
    - Follow up CT scanning per NS recs
    - PMR physician consult
- NO ASA, NSAIDS, HEPARIN, etc
- NO HALDOL
- PT/OT/Speech consults when appropriate
- See also SJMH Trauma Policy #165.0: Protocol for the Management of Head Injury in Multiple Trauma