

## FOLLOW UP CONCUSSION FORM

Organization: \_\_\_\_\_ Athlete's Name: \_\_\_\_\_

Athlete's D.O.B. : \_\_\_\_\_ Athlete's Parent/Guardian: \_\_\_\_\_

Injury Date/Time: \_\_\_\_\_ Sport/Activity: \_\_\_\_\_

Concussion Team Leader: \_\_\_\_\_ Athlete's PCP: \_\_\_\_\_

Concussion symptom score: \_\_\_\_\_ Date concussion score was obtained: \_\_\_\_\_

**To the athlete's Medical Care Provider:** The athlete named above has suffered a presumed concussion and is now enrolled in the concussion management protocol (a copy of which can be found under the "resources" tab of [www.concussionconsultants.org](http://www.concussionconsultants.org)) but may not return to ANY athletic activity (practice, games, contact drills) until cleared by a qualified medical provider. Qualified medical providers may include an M.D., D. O., Nurse Practitioner or Physician Assistant. After your evaluation, please check which option or options you would now recommend:

\_\_\_\_\_ Start this student athlete on the graduated exercise program as detailed in the concussion management protocol. At any stage, if the student has any increased post concussive symptoms with exertion, he or she must be taken back to the previous stage of graduated exercise for at least 24 hours. If the athlete has any persistent post concussive symptoms that are worsening, that athlete will be returned to medical personnel for re-evaluation and will not be allowed to return to the graduated exercise program until cleared by qualified medical personnel to do so.

\_\_\_\_\_ No physical exertion until the next clinic visit scheduled for \_\_\_\_\_

\_\_\_\_\_ Academic accommodations including decreased amount of homework, testing, etc. until \_\_\_\_\_

\_\_\_\_\_ Additional recommendations:

This athlete may start on the graduated exercise program as of (date): \_\_\_\_\_

Name of Qualified Medical Provider (please print): \_\_\_\_\_

Signature of Qualified Medical Provider: \_\_\_\_\_

Title of Qualified Medical Provider (please circle one): M.D. D.O. P.A. N.P.

Phone number of Qualified Medical Provider: \_\_\_\_\_ Date of evaluation: \_\_\_\_\_

## SEVERITY RATING

Please use this scale to rate each symptom.

None Mild Moderate Severe  
0 1 2 3 4 5 6

PATIENT'S NAME: \_\_\_\_\_

# POST-CONCUSSION SYMPTOM SCALE

Symptoms	Date:	Date:	Date:	Date:	Date:	Date:
Headache						
Nausea						
Vomiting						
Balance Problems						
Dizziness (spinning or movement sensation)						
Lightheadedness						
Fatigue						
Trouble falling asleep						
Sleeping more than usual						
Sleeping less than usual						
Drowsiness						
Sensitivity to light						
Sensitivity to noise						
Irritability						
Sadness						
Nervous/Anxious						
Feeling more emotional						
Numbness or tingling						
Feeling slowed down						
Feeling like "in a fog"						
Difficulty concentrating						
Difficulty remembering						
Visual problems						
Other						
<b>Total</b>						