

# Brain and Spinal Cord Injury Registry

1.New Record  
2.Update

Section 135.22 of the Iowa Code Requires hospitals to report brain and spinal cord injuries to the Iowa Department of Public Health

## DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Hospital Number: \_\_\_\_\_  
(Last) (First) (M)

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Gender:

|                                    |
|------------------------------------|
| 1. Male<br>2. Female<br>9. Unknown |
|------------------------------------|

Race:

|   |
|---|
| 1. White<br>2. Black<br>3. Asian/Pacific Islander<br>4. Am. Indian/Alaskan Native<br>5. Other<br>9. Unknown |
|---|

Hispanic:

|                            |
|----------------------------|
| 1.No<br>2.Yes<br>9.Unknown |
|----------------------------|

Date of Birth: \_\_ / \_\_ / \_\_\_\_\_

## INJURY INFORMATION

Date of Injury: \_\_ / \_\_ / \_\_\_\_\_ County of Injury: \_\_\_\_\_

Alcohol Involved:

|   |
|---|
| 1.Yes<br>2.Suspected<br>3.No<br>9.Unknown |
|---|

Drugs Involved:

|   |
|---|
| 1.Yes<br>2.Suspected<br>3.No<br>9.Unknown |
|---|

Work Related:

|                              |
|------------------------------|
| 1.Yes<br>2. No<br>9. Unknown |
|------------------------------|

Protective equipment used:

|  |
|--|
| 1. Child Restraint<br>2. Seat belt only<br>3. Airbag Only<br>4. Seat belt & airbag<br>5. Helmet<br>6. Other<br>7. None<br>8. Inappropriate Use<br>9. Unknown |
|--|

Place of Injury Occurrence:

|  |
|--|
| 0.Home<br>1.Farm<br>2.Quarry or mine<br>3.Industrial place or premises<br>4.Place for recreation or sports<br>5.Street or Highway<br>6.Public Building<br>7.Residential Institution<br>8.Other, specify _____<br>9.Unknown |
|--|

**ADDITIONAL INFORMATION FOR BRAIN INJURIES**

Glascow Coma Scale (GCS):

|                       |                  |                       |                        |
|-----------------------|------------------|-----------------------|------------------------|
| Eye Opening:          | Verbal Response: | Best Motor Response:  | *IF GCS UNKNOWN        |
| 4.Spontaneous         | 5.Oriented       | 6.Obeys Commands      | LVL of consciousness   |
| 3.To Voice            | 4.Confused       | 5.Localizes pain      | 1. Coma                |
| 2.To Pain             | 3.Inapp. words   | 4.Withdraw (on pain)  | 2. Moderate impairment |
| 1.None                | 2.Incomp. words  | 3.Flexion (on pain)   | 3. Min./ no impairment |
| 0.Preorbital swelling | 1.None           | 2.Extension (on pain) | 9.Unknown              |
|                       | T.Intubated      | 1.None                |                        |

Total GCS Score: \_\_\_\_\_

Neurological abnormalities: \_\_\_\_\_

Amnesia: \_\_\_\_\_

|  |
|--|
| 1.Yes<br>2.No<br>3.NA/Died before examination<br>9.Unknown |
|--|

|  |
|--|
| 1.Yes<br>2.No<br>3.N/A (coma/death)<br>9.Unknown |
|--|

**DIAGNOSTIC & DISCHARGE INFORMATION**

TYPE OF CARE PROVIDED:

|   |
|---|
| 1.Transfer to other acute care hospital from ED*<br>2.None, pre-hospital death<br>3.Died in ED<br>4.Hospitalized**<br>9.Unknown |
|---|

\*Name of Facility \_\_\_\_\_

\*\*Date of Admission \_\_ / \_\_ / \_\_\_\_

\*\*Date of Discharge \_\_ / \_\_ / \_\_\_\_

ICD-9 Diagnoses (N-Codes): 1. \_\_\_\_ . \_\_\_\_ 2. \_\_\_\_ . \_\_\_\_ 3. \_\_\_\_ . \_\_\_\_ 4. \_\_\_\_ . \_\_\_\_

5. \_\_\_\_ . \_\_\_\_ 6. \_\_\_\_ . \_\_\_\_ 7. \_\_\_\_ . \_\_\_\_ 8. \_\_\_\_ . \_\_\_\_ 9. \_\_\_\_ . \_\_\_\_ 10. \_\_\_\_ . \_\_\_\_

ICD-9 External Cause (E-Code):

1. \_\_\_\_ - \_\_\_\_ 2. \_\_\_\_ - \_\_\_\_ 3. \_\_\_\_ - \_\_\_\_ 4. \_\_\_\_ - \_\_\_\_

Discharge Disposition from Inpatient Care:

|   |             |
|---|-------------|
| 1.Transfer to other acute care hospital*<br>2.Home<br>3.Residential facility with or without skilled nursing services*<br>4.Inpatient Rehabilitation facility*<br>5.Died as inpatient<br>6.Other<br>9.Unknown | *Name _____ |
|---|-------------|

Primary Payment Source:

- |                          |             |         |
|--------------------------|-------------|---------|
| 0.Blue Cross/Blue Shield | 5.Champus   |         |
| 1.Medicaid               | 6.Self Pay  |         |
| 2.Medicare               | 7.No charge |         |
| 3.Workers Compensation   | 8.Other     |         |
| 4.H.M.O                  | 9.Unknown   | 10.None |

\*\*Please submit form to:

Bureau of EMS, Iowa Department of Public Health, 321 E. 12<sup>th</sup> Street, Des Moines, IA 50319-0075 or fax (515) 281- 0488