RUTGERS
Office of Disability Services

Lucy Stone Hall-- Livingston Campus
54 Joyce Kilmer Avenue, Suite A14
Piscataway, NJ 08854
Phone: 848-445-6800, Email: dsoffice@echo.rutgers.edu, Fax: 732-445-3388
Website: https://ods.rutgers.edu

Traumatic Brain Injury (TBI) Documentation

Student's First Name:

Student's Last Name:

Date of Birth

Student's Street Address

City

State

Zip Code

In order to help this student adapt to college life after his/her injury, please supply (in as much detail as possible) answers to the questions that follow. Please complete all items which you have a history or have assessed in the course of clinical evaluation. If you wish to, please attach any relevant reports. At the end of this form, please hit submit and attach any items.

Date of Injury

Number of Concussions with loss of consciousness

Number of Concussions without loss of consciousness

Date(s) without loss of consciousness

Hospitalization with any of these injuries?
- ◯ Yes
- ◯ No

Surgery needed for any of these injuries?
- ◯ Yes
- ◯ No

If you answered yes to any of the above, please provide details here:

II. Post-Concussive Status

Check all if present now:

- [ ] Fatigue
- [ ] Attention Problems
- [ ] Balance Problems
- [ ] Dizziness
- [ ] Noise Sensitivity
- [ ] Light Sensitivity
- [ ] Headaches
- [ ] Sleep Problems
- [ ] Memory Problems
- [ ] Amnesia
- [ ] Confused Periods
- [ ] Seizures
- [ ] Personality Change
- [ ] Irritability
- [ ] Behavioral Problems
- [ ] Anxiety
- [ ] Depression
- [ ] Suicidal Tendencies

Please check if the following were done and provide the reports

- [ ] Skull X-ray
- [ ] EEG
- [ ] CT/MRI
- [ ] SPECT

Check if there is any prior history of:

- ☐ Special Education
- ☐ Learning Disability
- ☐ ADD/ADHD
- ☐ Meningitis/Encephalitis
- ☐ Substance/Alcohol abuse
- ☐ Psychiatric/Psychological counseling

Please provide reports from any neuropsychological/educational testing relating to TBI or any items listed in the section above

List any current medications and the name of the prescribing M.D

Please comment on the particular problems that may impair this student's functioning in the post-secondary school environment (e.g the students/patient has difficulty functioning in the morning) and elaborate on present symptoms checked in the post-concussive status.

Name of doctor completing this form:

License number:

Date: