

Appendix 1.1

Acute Concussion Evaluation (ACE): Physician/Clinician Office Version

ACUTE CONCUSSION EVALUATION (ACE)

PHYSICIAN/CLINICIAN OFFICE VERSION

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Patient Name: _____
 DOB: _____ Age: _____
 Date: _____ ID/MR# _____

A. Injury Characteristics Date/Time of Injury _____ Reporter: Patient Parent Spouse Other _____

1. Injury Description _____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? Yes No Unknown
 1b. Is there evidence of intracranial injury or skull fracture? Yes No Unknown
 1c. Location of Impact: Frontal Lft Temporal Rt Temporal Lft Parietal Rt Parietal Occipital Neck Indirect Force
 2. Cause: MVC Pedestrian-MVC Fall Assault Sports (specify) _____ Other _____
 3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? Yes No Duration _____
 4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? Yes No Duration _____
 5. Loss of Consciousness: Did you/ person lose consciousness? Yes No Duration _____
 6. EARLY SIGNS: Appears dazed or stunned Is confused about events Answers questions slowly Repeats Questions Forgetful (recent info)
 7. Seizures: Were seizures observed? No Yes Detail _____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day? Indicate presence of each symptom (0=No, 1=Yes). *Lovell & Collins, 1998 JHTR

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1 N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1 N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1 N/A
Dizziness	0 1	COGNITIVE Total (0-4) _____		SLEEP Total (0-4) _____	
Visual problems	0 1	EMOTIONAL (4)		Exertion: Do these symptoms <u>worsen</u> with: Physical Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Cognitive Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Overall Rating: How <u>different</u> is the person acting compared to his/her usual self? (circle) Normal 0 1 2 3 4 5 6 Very Different	
Fatigue	0 1	Irritability	0 1		
Sensitivity to light	0 1	Sadness	0 1		
Sensitivity to noise	0 1	More emotional	0 1		
Numbness/Tingling	0 1	Nervousness	0 1		
PHYSICAL Total (0-10) _____		EMOTIONAL Total (0-4) _____			
(Add Physical, Cognitive, Emotion, Sleep totals)					
Total Symptom Score (0-22)					

C. Risk Factors for Protracted Recovery (check all that apply)

Concussion History? Y ___ N ___	✓	Headache History? Y ___ N ___	✓	Developmental History	✓	Psychiatric History
Previous # 1 2 3 4 5 6+		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days ___ Weeks ___ Months ___ Years ___		History of migraine headache ___ Personal ___ Family		Attention-Deficit/ Hyperactivity Disorder		Depression
If multiple concussions, less force caused reinjury? Yes ___ No ___				Other developmental disorder _____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures) _____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

- * Headaches that worsen
- * Looks very drowsy/ can't be awakened
- * Can't recognize people or places
- * Neck pain
- * Seizures
- * Repeated vomiting
- * Increasing confusion or irritability
- * Unusual behavioral change
- * Focal neurologic signs
- * Slurred speech
- * Weakness or numbness in arms/legs
- * Change in state of consciousness

E. Diagnosis (ICD): Concussion w/o LOC 850.0 Concussion w/ LOC 850.1 Concussion (Unspecified) 850.9 Other (854) _____ No diagnosis

F. Follow-Up Action Plan Complete ACE Care Plan and provide copy to patient/family.

No Follow-Up Needed
 Physician/Clinician Office Monitoring: Date of next follow-up _____
 Referral:
 Neuropsychological Testing
 Physician: Neurosurgery ___ Neurology ___ Sports Medicine ___ Physiatrist ___ Psychiatrist ___ Other _____
 Emergency Department

ACE Completed by: _____

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This form is part of the "Heads Up: Brain Injury in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).

ACE Instructions

The ACE is intended to provide an evidence-based clinical protocol to conduct an initial evaluation and diagnosis of patients (both children and adults) with known or suspected MTBI. The research evidence documenting the importance of these components in the evaluation of an MTBI is provided in the reference list.

A. Injury Characteristics:

1. Obtain **description of the injury** – how injury occurred, type of force, location on the head or body (if force transmitted to head). Different biomechanics of injury may result in differential symptom patterns (e.g., occipital blow may result in visual changes, balance difficulties).
2. Indicate the **cause of injury**. Greater forces associated with the trauma are likely to result in more severe presentation of symptoms.
- 3/4. **Amnesia:** Amnesia is defined as the failure to form new memories. Determine whether amnesia has occurred and attempt to determine length of time of memory dysfunction – before (retrograde) and after (anterograde) injury. Even seconds to minutes of memory loss can be predictive of outcome. Recent research has indicated that amnesia may be up to 4-10 times more predictive of symptoms and cognitive deficits following concussion than is LOC (less than 1 minute).¹
5. **Loss of consciousness (LOC)** – If occurs, determine length of LOC.
6. **Early signs.** If present, ask the individuals who know the patient (parent, spouse, friend, etc) about specific signs of the concussion that may have been observed. These signs are typically observed early after the injury.
7. Inquire whether **seizures** were observed or not.

B. Symptom Checklist:²

1. Ask patient (and/or parent, if child) to report presence of the four categories of symptoms since injury. It is important to assess all listed symptoms as different parts of the brain control different functions. One or all symptoms may be present depending upon mechanisms of injury.³ Record “1” for Yes or “0” for No for their presence or absence, respectively.
2. For all symptoms, indicate presence of symptoms as experienced within the past 24 hours. Since symptoms can be present pre-morbidly/at baseline (e.g., inattention, headaches, sleep, sadness), it is important to assess change from their usual presentation.
3. **Scoring:** Sum total number of symptoms present per area, and sum all four areas into Total Symptom Score (score range 0-22). (Note: most sleep symptoms are only applicable after a night has passed since the injury. Drowsiness may be present on the day of injury.) If symptoms are new and present, there is no lower limit symptom score. Any score > 0 indicates positive symptom history.
4. **Exertion:** Inquire whether any symptoms worsen with physical (e.g., running, climbing stairs, bike riding) and/or cognitive (e.g., academic studies, multi-tasking at work, reading or other tasks requiring focused concentration) exertion. Clinicians should be aware that symptoms will typically worsen or re-emerge with exertion, indicating incomplete recovery. Over-exertion may protract recovery.
5. **Overall Rating:** Determine how different the person is acting from their usual self. Circle “0” (Normal) to “6” (Very Different).

C. Risk Factors for Protracted Recovery:

Assess the following risk factors as possible complicating factors in the recovery process.

1. **Concussion history:** Assess the number and date(s) of prior concussions, the duration of symptoms for each injury, and whether less biomechanical force resulted in re-injury. Research indicates that cognitive and symptom effects of concussion may be cumulative, especially if there is minimal duration of time between injuries and less biomechanical force results in subsequent concussion (which may indicate incomplete recovery from initial trauma).⁴⁻⁸
2. **Headache history:** Assess personal and/or family history of diagnosis/treatment for headaches. Research indicates headache (migraine in particular) can result in protracted recovery from concussion.⁹⁻¹¹
3. **Developmental history:** Assess history of learning disabilities, Attention-Deficit/Hyperactivity Disorder or other developmental disorders. Research indicates that there is the possibility of a longer period of recovery with these conditions.¹²
4. **Psychiatric history:** Assess for history of depression/mood disorder, anxiety, and/or sleep disorder.¹³⁻¹⁶

D. Red Flags:

The patient should be carefully observed over the first 24-48 hours for these serious signs. Red flags are to be assessed as possible signs of deteriorating neurological functioning. Any positive report should prompt strong consideration of referral for emergency medical evaluation (e.g. CT Scan to rule out intracranial bleed or other structural pathology).¹⁷

E. Diagnosis:

The following ICD diagnostic codes may be applicable.

850.0 (Concussion, with no loss of consciousness) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); no evidence of LOC (A5), skull fracture or intracranial injury (A1b).

850.1 (Concussion, with brief loss of consciousness < 1 hour) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); positive evidence of LOC (A5), skull fracture or intracranial injury (A1b).

850.9 (Concussion, unspecified) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); unclear/unknown injury details; unclear evidence of LOC (A5), no skull fracture or intracranial injury.

Other Diagnoses – If the patient presents with a positive injury description and associated symptoms, but additional evidence of intracranial injury (A 1b) such as from neuroimaging, a moderate TBI and the diagnostic category of 854 (Intracranial injury) should be considered.

F. Follow-Up Action Plan:

Develop a follow-up plan of action for symptomatic patients. The physician/clinician may decide to (1) monitor the patient in the office or (2) refer them to a specialist. Serial evaluation of the concussion is critical as symptoms may resolve, worsen, or ebb and flow depending upon many factors (e.g., cognitive/physical exertion, comorbidities). Referral to a specialist can be particularly valuable to help manage certain aspects of the patient's condition. (Physician/Clinician should also complete the ACE Care Plan included in this tool kit.)

1. **Physician/Clinician serial monitoring** – Particularly appropriate if number and severity of symptoms are steadily decreasing over time and/or fully resolve within 3-5 days. If steady reduction is not evident, referral to a specialist is warranted.
2. **Referral to a specialist** – Appropriate if symptom reduction is not evident in 3-5 days, or sooner if symptom profile is concerning in type/severity.
 - **Neuropsychological Testing** can provide valuable information to help assess a patient's brain function and impairment and assist with treatment planning, such as return to play decisions.
 - **Physician Evaluation** is particularly relevant for medical evaluation and management of concussion. It is also critical for evaluating and managing focal neurologic, sensory, vestibular, and motor concerns. It may be useful for medication management (e.g., headaches, sleep disturbance, depression) if post-concussive problems persist.

* Taken with permission from the authors. Gioia GA, Collins M, Isquith PK. Improving identification and diagnosis of mild traumatic brain injury with evidence: psychometric support for the acute concussion evaluation. *Journal of Head Trauma Rehabilitation*. 2008;23(4):230-42.