

Patient name			
MHN	DOB	Age	Gender

**Acute Concussion Evaluation (ACE)**

**Care Plan**

Service date (month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Injury date (month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

You have been diagnosed with a concussion (also known as a mild traumatic brain injury). This personal plan is based on your symptoms and is designed to help enhance your recovery. Your careful attention to it can also prevent further injury.

You should not participate in any high risk activities (e.g. sports, physical education (PE), riding a bike, etc.) if you still have any of the symptoms below. It is important to limit activities that require a lot of thinking or concentration (homework, job-related activities), as this can also make your symptoms worse. If you no longer have any symptoms and believe that your concentration and thinking are back to normal, you can slowly and carefully return to your daily activities. Children and teenagers will need help from their parents, teachers, coaches, or athletic trainers to help monitor their recovery and return to activities.

The student may return to \_\_\_\_\_ high school utilizing the school's concussion plan, per school health care/LAT procedure.

<b>Today the following symptoms are present (check all that apply):</b>				<input type="checkbox"/> <b>No reported symptoms</b>
Physical		Thinking	Emotional	Sleep
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Feeling mentally foggy	<input type="checkbox"/> Irritability	<input type="checkbox"/> Drowsiness
<input type="checkbox"/> Nausea	<input type="checkbox"/> Sensitivity to noise	<input type="checkbox"/> Problems concentrating	<input type="checkbox"/> Sadness	<input type="checkbox"/> Sleeping more than usual
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Problems remembering	<input type="checkbox"/> Feeling more emotional	<input type="checkbox"/> Sleeping less than usual
<input type="checkbox"/> Visual problems	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Feeling more slowed down	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Trouble falling asleep
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Dizziness			

**Returning to Daily Activities**

1. Get lots of rest. Be sure to get enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Take daytime naps or rest breaks when you feel tired or fatigued.
3. **Limit physical activity as well as activities that require a lot of thinking or concentration. These activities can make symptoms worse.**
  - Physical activity includes PE, sports practices, weight-training, running, exercising, heavy lifting, etc.
  - Thinking and concentration activities (e.g. homework, classwork load, job-related activity).
4. Drink lots of fluids and eat carbohydrates or protein to maintain appropriate blood sugar levels.
5. **As symptoms decrease, you may begin to gradually return to your daily activities. If symptoms worsen or return, lessen your activities, then try again to increase your activities gradually.**
6. During recovery, it is normal to feel frustrated and sad when you do not feel right and you can't be as active as usual.
7. Repeated evaluation of your symptoms is recommended to help guide recovery.

**Returning to School**

1. If you (or your child) are still having symptoms of concussion, you may need extra help to perform school-related activities. As your (or your child's) symptoms decrease during recovery, the extra help or supports can be removed gradually.
2. Inform the teacher(s), school nurse, school psychologist or counselor, and administrator(s) about your (or your child's) injury and symptoms. School personnel should be instructed to watch for:
  - Increased problems paying attention or concentrating
  - Increased problems remembering or learning new information
  - Longer time needed to complete tasks or assignments
  - Greater irritability, less able to cope with stress
  - Symptoms worsen (e.g. headache, tiredness) when doing school work

~ Continued on next page ~

**Care Plan (Continued)**

Patient name	MHN	DOB	Age	Gender
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**Returning to School (Continued)**

**Until you (or your child) have fully recovered, the following supports are recommended:** (check all that apply)

- No return to school. Return on (date – m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Return to school with following supports. Review on (date – m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Shortened day. Recommend \_\_\_\_\_ hours per day until (date – m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Shortened classes (i.e. rest breaks during classes). Maximum class length \_\_\_\_\_ minutes.
- Allow extra time to complete coursework/assignments and tests.
- Lessen homework load by \_\_\_\_\_ %. Maximum length of nightly homework \_\_\_\_\_ minutes.
- No significant classroom or standardized testing at this time.
- Check for the return of symptoms (use symptom table on front page of this form) when doing activities that require a lot of attention or concentration.
- Take rest breaks during the day as needed.
- Request meeting of 504 or School Management Team to discuss this plan and needed supports.

**Returning to Sport**

1. **You should NEVER return to play if you still have ANY symptoms** – (Be sure that you do not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration.)
2. With the absence of physical symptoms, neuropsychological testing in concussion has been shown to be of clinical value and can provide valuable information to assist the health care provider with treatment planning, such as return-to-activity decisions.
3. Be sure that the PE teacher, coach, and/or athletic trainer are aware of your injury and symptoms.
4. It is normal to feel frustrated, sad and even angry because you cannot return to sports right away. With any injury, a full recovery will reduce the chances of getting hurt again. It is better to miss one or two games than the whole season.

**The following are recommended at the present time:**

- Do not return to PE class at this time.
- Return to PE class.
- Do not return to sports practices/games at this time.
- Gradual** return to sports practices under the supervision of an appropriate health care provider.
  - Return to play should occur in **gradual steps** beginning with aerobic exercise only to increase your heart rate (e.g. stationary cycling); moving to increasing your heart rate with movement (e.g. running); then adding controlled contact if appropriate; and finally return to sports competition.

**Gradual Return to Play Plan**

1. No physical activity.
2. Low levels of physical activity. This includes walking, light jogging, light stationary biking, light weightlifting (lower weight, higher reps, no bench, no squat).
3. Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (reduced time and/or reduced weight from your typical routine).
4. Heavy non-contact physical activity. This includes sprinting/running, high-intensity stationary biking, regular weightlifting routine, non-contact sport-specific drills (in 3 planes of movement).
5. Full contact in controlled practice.
6. Full contact in game play.

\*Generally, each step should take 24 hours so that a patient would take approximately 1 week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any concussion symptoms occur while in the stepwise program, then the patient should drop back to the previous asymptomatic level and try to progress again after a 24-hour period of rest has passed.

**This referral plan is based on today's evaluation:**

- Return to this office. Date (m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time \_\_\_\_\_
- Refer to:  Neurosurgery  Neurology  Sports Medicine  Physiatrist  Psychiatrist  Other \_\_\_\_\_
- Refer for neuropsychological testing \_\_\_\_\_
- Other \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date (m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time \_\_\_\_\_