Downloaded from http://bjsm.bmj.com/ on April 27, 2017 - Published by group.bmj.com

OFFICE OR OFF-FIELD ASSESSMENT

Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.

STEP 1: ATHLETE BACKGROUND

Sport / team / school: ______

Date / time of injury: ______

Years of education completed: ______

Age: ______

Gender: M / F / Other

Dominant hand: left / neither / right

How many diagnosed concussions has the athlete had in the past?: ______

When was the most recent concussion?: ______

How long was the recovery (time to being cleared to play) from the most recent concussion?: ______ (days)

Has the athlete ever been:

Hospitalized for a head injury?	Yes	No
Diagnosed / treated for headache disorder or migraines?	Yes	No
Diagnosed with a learning disability / dyslexia?	Yes	No
Diagnosed with ADD / ADHD?	Yes	No
Diagnosed with depression, anxiety or other psychiatric disorder?	Yes	No

Current medications? If yes, please list:

______

______

______

______

______

______

Name: JACKSON PILLIFANT

DOB: ______

Address: ______

ID number: ______

Examiner: ______

Date: 7/30/19

2

STEP 2: SYMPTOM EVALUATION

The athlete should be given the symptom form and asked to read this instruction paragraph out loud then complete the symptom scale. For the baseline assessment, the athlete should rate his/her symptoms based on how he/she typically feels and for the post injury assessment the athlete should rate their symptoms at this point in time.

Please Check: ☒ Baseline ☐ **Post-Injury**

Please hand the form to the athlete

	none	mild		moderate		severe	
Headache	(0)	1	2	3	4	5	6
"Pressure in head"	(0)	1	2	3	4	5	6
Neck Pain	(0)	1	2	3	4	5	6
Nausea or vomiting	(0)	1	2	3	4	5	6
Dizziness	(0)	1	2	3	4	5	6
Blurred vision	(0)	1	2	3	4	5	6
Balance problems	0	(1)	2	3	4	5	6
Sensitivity to light	(0)	1	2	3	4	5	6
Sensitivity to noise	(0)	1	2	3	4	5	6
Feeling slowed down	(0)	1	2	3	4	5	6
Feeling like "in a fog"	(0)	1	2	3	4	5	6
"Don't feel right"	(0)	1	2	3	4	5	6
Difficulty concentrating	(0)	1	2	3	4	5	6
Difficulty remembering	(0)	1	2	3	4	5	6
Fatigue or low energy	(0)	1	2	3	4	5	6
Confusion	(0)	1	2	3	4	5	6
Drowsiness	(0)	1	2	3	4	5	6
More emotional	(0)	1	2	3	4	5	6
Irritability	(0)	1	2	3	4	5	6
Sadness	(0)	1	2	3	4	5	6
Nervous or Anxious	(0)	1	2	3	4	5	6
Trouble falling asleep (if applicable)	(0)	1	2	3	4	5	6

Total number of symptoms:	of 22
Symptom severity score:	of 132
Do your symptoms get worse with physical activity?	Y (N)
Do your symptoms get worse with mental activity?	Y (N)
If 100% is feeling perfectly normal, what percent of normal do you feel?	100%

If not 100%, why? 100%

______

______

Please hand form back to examiner

© Concussion in Sport Group 2017

Downloaded from http://bjsm.bmj.com/ on April 27, 2017 - Published by group.bmj.com

3

Name:
DOB:
Address:
ID number:
Examiner:
Date:

STEP 3: COGNITIVE SCREENING

Standardised Assessment of Concussion (SAC)[4]

ORIENTATION

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within 1 hour)	0	1
Orientation score		5 of 5

IMMEDIATE MEMORY

The Immediate Memory component can be completed using the traditional 5-word per trial list or optionally using 10-words per trial to minimise any ceiling effect. All 3 trials must be administered irrespective of the number correct on the first trial. Administer at the rate of one word per second.

Please choose EITHER the 5 or 10 word list groups and circle the specific word list chosen for this test.

I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order. For Trials 2 & 3: I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before.

List	Alternate 5 word lists					Score (of 5) Trial 1	Trial 2	Trial 3
A	Finger	Penny	Blanket	Lemon	Insect			
B	Candle	Paper	Sugar	Sandwich	Wagon			
C	Baby	Monkey	Perfume	Sunset	Iron			
D	Elbow	Apple	Carpet	Saddle	Bubble			
E	Jacket	Arrow	Pepper	Cotton	Movie			
F	Dollar	Honey	Mirror	Saddle	Anchor			
					Immediate Memory Score	of [illegible]		
					Time that last trial was completed			

List	Alternate 10 word lists					Score (of 10) Trial 1	Trial 2	Trial 3
G	Finger Candle	Penny Paper	Blanket Sugar	Lemon Sandwich	Insect Wagon	7	8	10
H	Baby Elbow	Monkey Apple	Perfume Carpet	Sunset Saddle	Iron Bubble			
I	Jacket Dollar	Arrow Honey	Pepper Mirror	Cotton Saddle	Movie Anchor			
					Immediate Memory Score	25 of 30		
					Time that last trial was completed			

CONCENTRATION

DIGITS BACKWARDS

Please circle the Digit list chosen (A, B, C, D, E, F). Administer at the rate of one digit per second reading DOWN the selected column.

I am going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7.

Concentration Number Lists (circle one) List A	List B	List C			
4-9-3	5-2-6	1-4-2	Y	N	0
6-2-9	4-1-5	6-5-8	Y	N	1
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	0
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	1
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	0
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	1
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	0
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	1
List D	**List E**	**List F**			
7-8-2	3-8-2	2-7-1	Y	N	0
9-2-6	5-1-8	4-7-9	Y	N	1
4-1-8-3	2-7-9-3	1-6-8-3	Y	N	0
9-7-2-3	2-1-6-9	3-9-2-4	Y	N	1
1-7-9-2-6	4-1-8-6-9	2-4-7-5-8	Y	N	0
4-1-7-5-2	9-4-1-7-5	8-3-9-6-4	Y	N	1
2-6-4-8-1-7	6-9-7-3-8-2	5-8-6-2-4-9	Y	N	0
8-4-1-9-3-5	4-2-7-9-3-8	3-1-7-8-2-6	Y	N	1
		Digits Score:			of 4

MONTHS IN REVERSE ORDER

Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November. Go ahead.

Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan	0	1
Months Score	1	of 1
Concentration Total Score (Digits + Months)	4	of 5

© Concussion in Sport Group 2017

Downloaded from http://bjsm.bmj.com/ on April 27, 2017 - Published by group.bmj.com

4

STEP 4: NEUROLOGICAL SCREEN

See the instruction sheet (page 7) for details of test administration and scoring of the tests.

Can the patient read aloud (e.g. symptom check-list) and follow instructions without difficulty?	Y (circled)	N
Does the patient have a full range of pain-free PASSIVE cervical spine movement?	Y (circled)	N
Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y (circled)	N
Can the patient perform the finger nose coordination test normally?	Y (circled)	N
Can the patient perform tandem gait normally?	Y (circled)	N

BALANCE EXAMINATION

Modified Balance Error Scoring System (mBESS) testing[5]

Which foot was tested (i.e. which is the non-dominant foot) ☐ Left ☒ Right

Testing surface (hard floor, field, etc.) ___________

Footwear (shoes, barefoot, braces, tape, etc.) ___________

Condition	Errors
Double leg stance	1 of 10
Single leg stance (non-dominant foot)	8 of 10
Tandem stance (non-dominant foot at the back)	7 of 10
Total Errors	16 of 30

Name: ___________

DOB: ___________

Address: ___________

ID number: ___________

Examiner: ___________

Date: ___________

5

STEP 5: DELAYED RECALL:

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section. Score 1 pt. for each correct response.

Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order.

Time Started 5 MIN

Please record each word correctly recalled. Total score equals number of words recalled.

____

____

____

Total number of words recalled accurately: [illegible, crossed out] of 5 or 9 of 10

6

STEP 6: DECISION

Domain	Date & time of assessment:		
Symptom number (of 22)			
Symptom severity score (of 132)			
Orientation (of 5)			
Immediate memory	of 15 of 30	of 15 of 30	of 15 of 30
Concentration (of 5)			
Neuro exam	Normal Abnormal	Normal Abnormal	Normal Abnormal
Balance errors (of 30)			
Delayed Recall	of 5 of 10	of 5 of 10	of 5 of 10

Date and time of injury: ___________

If the athlete is known to you prior to their injury, are they different from their usual self?

☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**

(If different, describe why in the clinical notes section)

Concussion Diagnosed?

☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**

If re-testing, has the athlete improved?

☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**

I am a physician or licensed healthcare professional and I have personally administered or supervised the administration of this SCAT5.

Signature: ___________

Name: ___________

Title: ___________

Registration number (if applicable): ___________

Date: ___________

SCORING ON THE SCAT5 SHOULD NOT BE USED AS A STAND-ALONE METHOD TO DIAGNOSE CONCUSSION, MEASURE RECOVERY OR MAKE DECISIONS ABOUT AN ATHLETE'S READINESS TO RETURN TO COMPETITION AFTER CONCUSSION.

© Concussion in Sport Group 2017