

--	--	--	--



Baseline

BASELINE CHARACTERISTICS				
Date and time of primary head injury	<div><div><div></div><div></div></div><div><div></div><div></div><div></div><div></div></div><div><div></div><div></div><div></div><div></div><div></div><div></div></div></div> <div>DD/MMM/YYYY</div>		<div><div><div></div><div></div></div><div><div></div><div></div></div></div> <div>HH/MM</div>	
Date and time of <u>first</u> hospital ED admission:	<div><div><div></div><div></div></div><div><div></div><div></div><div></div><div></div></div><div><div></div><div></div><div></div><div></div><div></div><div></div></div></div> <div>DD/MMM/YYYY</div>		<div><div><div></div><div></div></div><div><div></div><div></div></div></div> <div>HH/MM</div>	
Date and time of arrival at neurocentre ICU	<div><div><div></div><div></div></div><div><div></div><div></div><div></div><div></div></div><div><div></div><div></div><div></div><div></div><div></div><div></div></div></div> <div>DD/MMM/YYYY</div>		<div><div><div></div><div></div></div><div><div></div><div></div></div></div> <div>HH/MM</div>	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>			
Weight	<div><div><div></div><div></div><div></div></div><div><div></div><div></div></div></div> <div>kg</div> <div>Estimated <input type="checkbox"/> Actual <input type="checkbox"/></div>			
Mechanism of traumatic brain injury (tick all that apply)		Yes	No	Unknown
	Acceleration/deceleration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Direct impact: blow to head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Direct impact: head against object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ground level fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fall from height > 1 metre (3ft)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gunshot wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fragment (including shell/shrapnel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other penetrating brain injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant past medical history		Yes	No	Unknown
	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eye, ear, nose & throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Haematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TNO:

--	--	--	--

**Baseline**

	Hepatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Previous TBI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Oncologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Renal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Social history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Developmental history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	Polytrauma?	Yes <input type="checkbox"/> No <input type="checkbox"/>						
Details of injury on head and other body systems	Body region	AIS score						
		1	2	3	4	5	6	
	Externa (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Head and neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Brain injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Cervical spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Thorax/chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Thoracic spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Abdomen/pelvic contents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lumbar spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Extremities and pelvic girdle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Craniotomy / craniectomy before randomisation?	Yes - craniotomy <input type="checkbox"/> Yes - craniectomy <input type="checkbox"/> No <input type="checkbox"/>							
	If yes: bone flap in <input type="checkbox"/> bone flap out <input type="checkbox"/>							
Patient taking anti-coagulant medication at time of injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>							
Patient taking anti-platelet therapy at time of injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>							
Number of concomitant medications patient taking at time of injury	<table border="1"> <tr> <td></td> <td></td> </tr> </table>							

TNO: 

Baseline

Pre-admission function (Clinical Frailty Scale)	Very Fit	<input type="checkbox"/>
	Well	<input type="checkbox"/>
	Managing Well	<input type="checkbox"/>
	Vulnerable	<input type="checkbox"/>
	Mildly Frail	<input type="checkbox"/>
	Moderately Frail	<input type="checkbox"/>
	Severely Frail	<input type="checkbox"/>
	Very Severely Frail	<input type="checkbox"/>
	Terminally Ill	<input type="checkbox"/>
ICP prior to randomisation	<input type="text"/> <input type="text"/> mmHg	
Serum sodium level at randomisation	<input type="text"/> <input type="text"/> <input type="text"/> mmol/L	
Hyperosmolar therapy administered prior to randomisation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes:	
	Mannitol 20%	<input type="checkbox"/>
	Mannitol 15%	<input type="checkbox"/>
	Mannitol 10%	<input type="checkbox"/>
	Sodium chloride 30%	<input type="checkbox"/>
	Sodium chloride 5%	<input type="checkbox"/>
	Sodium chloride 2.7%	<input type="checkbox"/>
	Other, please specify _____	<input type="checkbox"/>
	Dose given _____ ml	
Number of doses given <input type="text"/>		
Date and time of CT scan:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD/MMM/YYYY HH/MM	
CT scan appearance (Marshall CT classification code) <i>This relates to the initial CT scan at the first hospital the patient was admitted to</i>	1	Diffuse injury: No visible intracranial pathology <input type="checkbox"/>
	2	Diffuse injury: Cisterns present with shift 0-5mm, lesions present, but no high or mixed density lesion >25cc. May include bone fragments and foreign bodies <input type="checkbox"/>

TNO:

--	--	--	--



Baseline

	3	Diffuse injury with swelling: Cisterns compressed or absent, shift 0-5mm, no high or mixed density lesion >25cc	<input type="checkbox"/>
	4	Diffuse injury with shift: Shift >5mm, no high or mixed density lesion >25cc	<input type="checkbox"/>
	5	Evacuated mass lesions: Any lesion evacuated surgically	<input type="checkbox"/>
	6	Non-evacuated mass lesions: High or mixed density lesions >25cc, not surgically evacuated	<input type="checkbox"/>
Best GCS score prior to intubation/sedation	Best eye response		
	1	No eye opening	<input type="checkbox"/>
	2	Eye opening to pain	<input type="checkbox"/>
	3	Eye opening to verbal command	<input type="checkbox"/>
	4	Eyes open spontaneously	<input type="checkbox"/>
		Untestable/unknown	<input type="checkbox"/>
	Best verbal response		
	1	No verbal response	<input type="checkbox"/>
	2	Incomprehensible sound	<input type="checkbox"/>
	3	Inappropriate words	<input type="checkbox"/>
	4	Confused	<input type="checkbox"/>
	5	Oriented	<input type="checkbox"/>
		Untestable/unknown	<input type="checkbox"/>
GCS confounders (tick all that apply)	GCS accurate		<input type="checkbox"/>
	Paralytic		<input type="checkbox"/>
	ETOH/drug administration at time of injury		<input type="checkbox"/>
	C-spine injury		<input type="checkbox"/>
	Hypoxia/hypotension		<input type="checkbox"/>
	Hypothermia		<input type="checkbox"/>
	Sedation		<input type="checkbox"/>
	Unknown		<input type="checkbox"/>
Is the patient co-enrolled on another study?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

TNO:

--	--	--	--

**Baseline**

If yes, please enter name of the study: _____

Optional at discretion of clinical teamWas a pregnancy test done? Yes ☐ No ☐**PREGNANCY TEST****Date of assessment:**

		/				/				
--	--	---	--	--	--	---	--	--	--	--

DD/MMM/YYYY

Pregnancy test result:Negative ☐Positive ☐**FORM COMPLETED BY:**

Name (please print):

Date completed:

		/				/				
--	--	---	--	--	--	---	--	--	--	--

DD/MMM/YYYY

Signature: