

TNO: 

Baseline

## BASELINE CHARACTERISTICS

Date and time of primary head injury	<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"/> <input type="text"/> <input type="text"/> DD/MMM/YYYY	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> HH/MM		
Date and time of <u>first</u> hospital ED admission:	<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"/> <input type="text"/> <input type="text"/> DD/MMM/YYYY	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> HH/MM		
Date and time of arrival at neurocentre ICU	<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"/> <input type="text"/> <input type="text"/> DD/MMM/YYYY	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> HH/MM		
Sex at birth	Male <input type="checkbox"/> Female <input type="checkbox"/>			
Weight	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kg Estimated <input type="checkbox"/> Actual <input type="checkbox"/>			
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"/>

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		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"/>				
		Developmental history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Polytrauma?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Details of injury on head and other body systems</b>	<b>Body region</b>		<b>AIS score</b>						
		<b>N/A</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	
	Externa (skin)	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
	Brain injury	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
	Face	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
	Thoracic spine	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
	Lumbar spine	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
<b>Craniotomy / craniectomy before randomisation?</b>		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"/>							
<b>Patient taking anti-coagulant medication at time of injury?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Patient taking anti-platelet therapy at time of injury?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Number of concomitant medications patient taking at time of injury</b>		<table border="1"> <tr> <td></td> <td></td> </tr> </table>							

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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"/> <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"/>

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	3	<b>Diffuse injury with swelling:</b> Cisterns compressed or absent, shift 0-5mm, no high or mixed density lesion >25cc	<input type="checkbox"/>
	4	<b>Diffuse injury with shift:</b> Shift >5mm, no high or mixed density lesion >25cc	<input type="checkbox"/>
	5	<b>Evacuated mass lesions:</b> Any lesion evacuated surgically	<input type="checkbox"/>
	6	<b>Non-evacuated mass lesions:</b> High or mixed density lesions >25cc, not surgically evacuated	<input type="checkbox"/>
<b>Best GCS score prior to intubation/sedation</b>	<b><u>Best eye response</u></b>		
	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"/>
	<b><u>Best verbal response</u></b>		
	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"/>
<b>GCS confounders (tick all that apply)</b>	GCS accurate		
	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If no:		
	Muscle relaxant		<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"/>

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**Baseline**

**Is the patient co-enrolled on another study?**

Yes ☐No ☐

If yes, please enter name of the study: \_\_\_\_\_

**Optional at discretion of clinical team**

**Was a pregnancy test done?** Yes ☐ No ☐ N/A ☐

**PREGNANCY TEST****Date of assessment:**

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DD/MMM/YYYY

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

Name (please print):

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Date completed:

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Signature:

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DD/MMM/YYYY