

TNO:

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Concomitant Treatments

CONCOMITANT TREATMENTS

Craniotomy for evacuation of haematoma	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Ventriculostomy	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Neuromuscular paralysis infusion for ICP control	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Pharmacologic blood-pressure augmentation	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Therapeutic hypothermia for ICP control	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Decompressive craniectomy	Yes – bifrontal <input type="checkbox"/> Yes – unilateral <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Barbiturate coma	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
CSF drainage	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of treatment: <table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												

FORM COMPLETED BY:

Name (please print):		Date completed:	<table border="1"><tr><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> / <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												
Signature:			DD/MMM/YYYY												