

Traumatic Brain Injury Model Systems
Live Syllabus

**Revised Syllabus Pages
for Third Quarter 2004**

Compiled and Distributed by the

**Traumatic Brain Injury
Model Systems National Data Center**

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LIVE SYLLABUS

VERSION OF FORM II BEING ENTERED

Variable 02

Date of last revision: 07/01/04

DEFINITION:

Version number of the data entry form on which data for the present case was recorded. For the version number, refer to the upper right corner of the header of the data entry form (Form II) on which the data are recorded.

CODE:

Version numbers of Form IIs that can be entered into the database are listed in the drop-down menu (e.g., 7.0, 7.5...)

CHARACTERS:

2 numeric

NOTE:

As of 4/1/02, the TBIMS data entry system has the capacity to present data entry screens that match more than one version of the Form II. Obtain the data entry screens that match the Form II you wish to enter by selecting the version number of your Form II from the drop down menu.

*As of 4/1/04, all versions of Form II from V7.5 on are available as data entry screens. If the version of the Form II that you wish to edit or enter into the database is not listed on the drop-down menu, refer to 22j.Editing+entering old data (http://syllabus/pdf/22j_Editing_entering_old_data.pdf) in Appendix I.

EXAMPLE:

Data for patient was recorded on Form II version 7.5

7.5

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Variable ID number changed from 001 to 02.
2004-04-01	Added note about editing/entering old data
2004-04-01	Changed description of number of CHARACTERS to "2 (not including decimal)"
2004-04-01	Removed instructions about editing/entering old data.
2002-07-01	Variable added to syllabus.
2002-04-01	Variable added to database.

LIVING STATUS OF PERSON WITH BRAIN INJURY

Variable 20Aa

Date of last revision: 07/01/04

DEFINITION:

Code the living status of the person with brain injury. If patient has died, code the cause of death.

Instructions for coding ICD-9-CM primary and secondary causes of death are in [16a.Guidelines coding cause of death \(http://syllabus/pdf/16a_Guidelines_coding_cause_of_death.pdf\)](http://syllabus/pdf/16a_Guidelines_coding_cause_of_death.pdf) in Appendix C. Instructions for coding the E-code cause of death are in [24b.Guidelines for Coding Cause of Injury and Etiology of Injury \(E-codes\) \(http://syllabus/pdf/v133b_guide_2.pdf\)](http://syllabus/pdf/v133b_guide_2.pdf) in Appendix K.

CODE:

Code the two boxes for the ICD-9-CM codes and the box for the External Cause of Injury Codes (E-codes) as follows.

ICD-9-CM code boxes:

For a list of ICD-9 codes, refer to an ICD-9 code manual at your facility.

777.77 Person expired but cause of death unknown

888.88 Not Applicable--person alive, or no other *internal cause of death indicated, *or death due to external causes

999.99 Unknown if person expired

E-code box:

For an abbreviated list of E-codes, see: [24a.ICD-9-CM E-code categories](http://syllabus/pdf/v133b_categories_3.pdf)

(http://syllabus/pdf/v133b_categories_3.pdf) in Appendix K. A complete list of E-codes is available at [E-Code list-complete](http://syllabus/pdf/ECodes_52.pdf) (http://syllabus/pdf/ECodes_52.pdf).

777.7 Person expired but cause of death unknown

888.8 Not Applicable--person alive *or death not due to external causes

999.9 Unknown if person expired

CHARACTERS:

3 numeric

4 numeric

5 numeric

NOTE:

If autopsy was performed obtain report, document cause(s) of death by use of ICD-9-CM diagnosis codes or E-code if applicable. Record date of death in *Variable 201*.

If patient expired, complete only variables 20Aa through 201 then stop.

The look-up boxes on the database screen provide the E-Codes and their definitions. When taking E-Codes from the Medical Record, they should be checked to ensure that they reflect the best / most current information available about the cause of the injury. Data collectors may submit E-Codes that differ from those recorded in the Medical Record in cases where they feel the Medical Record E-Codes may not reflect the best / most current information available. There should be clear documentation on the data collection form when an E-Code entered into the database does not reflect the E-Code recorded in the Medical Record. In unusual cases where no E-Code relative to the injury that resulted in traumatic brain injury is recorded in the Medical Record, the data collector should use best judgement and the consultation of other personnel, as necessary, to determine the appropriate E-Code from the TBIMS database list.

SOURCE:

UAB

ICD-9-CM 2001: International Classification of Diseases 9th Revision Clinical Modification, AMA Press. Volume 1, 2000, 251-279. ISBN: 1579471501.

EXAMPLE:

Patient died of Septicemia (primary cause) and Pneumonia (secondary)

ICD-9-CM CODES: 038.90 primary; 486.00 (secondary)

E CODE: 888.8

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, corrected the labels for 888.88 (ICD-9) and 888.8 (E-code). For 888.88, "NA-Person alive, or no other cause of death indicated" has been changed to "NA-Person alive, or no other internal cause of death indicated, or death due to external causes". For 888.8, "NA-Person alive, or no other cause of death indicated" has been changed to "NA-Person alive, or death not due to external causes".
2004-04-01	Added link to comprehensive list of E-Codes.
2004-04-01	Revised the format of the CODES box.
2002-10-14	Changed data entry mask so parts A and B can accept 3-digit codes without decimals.
2002-04-01	Added note about instructions for E-codes.
2002-04-01	Added reference to Appendix K.
1995-01-01	Dropped 3rd ICD-9 code and 2nd and 3rd E-codes.
1995-01-01	Revised code description for 999.99 and 999.9.
1995-01-01	Added codes 777.77 and 777.7.
1994-08-19	Corrected references to E-codes, corrected description of Not applicable code to be consistent with V146.

ANNUAL EARNINGS

Variable 111i

Date of last revision: 07/01/04

DEFINITION:

Dollar earnings from all jobs held by patient during the year prior to injury.

CODE:

- 01 \$9,999 or less
- 02 \$10,000-\$19,999
- 03 \$20,000-\$29,999
- 04 \$30,000-\$39,999
- 05 \$40,000-\$49,999
- 06 \$50,000-\$59,999
- 07 \$60,000-\$69,999
- 08 \$70,000-\$79,999
- 09 \$80,000-\$89,999
- 10 \$90,000-\$99,999
- 11 \$100,000 or more
- 66 Variable did not exist
- 77 Refused
- 88 N/A, no competitive employment in the last year
- 99 Unknown

CHARACTERS:

2 numeric

NOTE:

Include only competitive, legal employment. Exclude income support, investment income, and settlements. *Include tips.

This is pre-tax income.

EXAMPLE:

Patient earned \$75,956 in the year prior to injury.

08

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Corrected VARIABLE HISTORY for 7/1/02: changed "year prior to evaluation" to "year prior to injury".
2004-01-01	Added NOTE to include tips.
2002-07-01	Changed code 88 from "not competitively employed" to "no competitive employment", to indicate that 88 should be used only if person has not been competitively employed for the entire year prior to injury.
2002-04-01	Added "not competitively employed" to code 88.
2002-01-01	Added NOTE that this is pretax earnings.
2001-08-20	Added CODE "66=Variable did not exist".
2001-07-01	Variable added to database.

DATE EMERGED FROM PTA

Variable 144a

Date of last revision: 07/01/04

DEFINITION:

Date of emergence from Post-Traumatic Amnesia (PTA). PTA emergence can be defined as 1) two consecutive GOAT scores of 76 or greater within a period of 24-72 hours, 2) two consecutive scores of 11 or greater on the Revised GOAT within a period of 24-72 hours, 3) two consecutive scores of 25 or greater on the Orientation-Log within a period of 24-72 hours, or 4) in the judgement of a qualified clinician (i.e., speech-language pathologist, physician, neuropsychologist), the person has cleared PTA but administration of the GOAT is not possible due to language functioning.

A modified GOAT can be used to assist with this decision. The examiner presents three alternatives, in written form and orally, including the correct choice for each question. The patient is to indicate a choice in some manner, such as nodding or pointing. This procedure can be used for all questions except numbers 4 and 5. The three response alternatives for each question should be arranged vertically in large print on an index card. Error points are assigned and subtracted from 80 (the maximum score with items 4 and 5 removed). A score of 61 or higher is reflective of orientation. PTA is considered resolved when a score of 61 or greater is achieved on two consecutive occasions within a period of 24-72 hours. Scores from the modified GOAT are for determination of PTA duration only.

In the case of a responsive patient, it is the choice of the neuropsychologist whether to use the GOAT, Revised GOAT (Bode, Heinemann, & Semik, 2000--see SOURCES) or the Orientation-Log (Jackson, Novack, & Dowler, 1998; Novack, Dowler, Bush, Glen, & Schneider, 2000--see SOURCES) to establish the duration of PTA. Alternating use of the scales in an individual patient is not acceptable, however.

Date of emergence from PTA can also be determined via chart review. For those patients who are oriented at rehabilitation admission (as defined by first two GOAT scores after rehab. Admission >75), the following procedure can be used to determine the length of PTA based on hospital records.

1. Obtain all available physician, nursing and therapy notes from the acute hospitalization. In most hospital medical records, physician, nursing and therapy notes are filed in different sections. You may have to specifically request therapy and nursing notes, if you routinely only receive the physician progress notes.
2. Review all notes to determine the first date on which all notes referencing orientation indicate that the patient is fully oriented, oriented X3 (or 4, or OX#, etc.). This is orientation day 1.
3. Review notes from the next calendar day to determine that all relevant notes indicate that the patient is fully oriented.
4. If Orientation Day 2 falls within three calendar days of Orientation Day 1, and if no notes from intervening days indicate less than full orientation, record Orientation Day 1 as the resolution date of PTA.
5. If any note from calendar days intervening between Orientation Days 1 and 2 indicate less than full orientation, use Day 2 as the new starting point (i.e. new Day 1) and repeat procedure from Step 3 above.
6. If there is no Orientation Day 2 (i.e., if the patient is never fully oriented on more than one day; or if more than 3 days elapse after Orientation Day 1 with no further notation about orientation), code date of PTA resolution as unknown. An exception would be if on the day before or the day of transfer to rehabilitation, the patient is specifically noted not to be oriented. If the patient then produces GOATs > 75 on the first two examinations after rehabilitation admission, code the date of PTA resolution in the usual manner

CODE:

MM/DD/YYYY

07/07/7777 Never had amnesia. [Code replaced with date of admission to ER.]

08/08/8888 Not Applicable - ptn still has amnesia or is unconscious as of discharge from TBI system.

09/09/9999 Unknown

Code date of admission to ER if person was never in PTA.

CHARACTERS:

8 date

NOTE:

Computer calculates duration of post traumatic amnesia by subtracting the date of injury from this date. Duration of PTA is calculated only for those cases which emerge from PTA prior to discharge from inpatient rehabilitation.

Neuropsych Committee databusters confirmed that duration of PTA is not to be calculated from date of emergence from coma (V130a).

The date emerged from PTA is the date of the first of the two consecutive GOAT scores >75.

Administer the test every 1 to 3 days until patient emerges from PTA.

SOURCE:**GOAT:**

Levin, HS, O'Donnell, VM, & Grossman, RG. (1979). The Galveston Orientation and Amnesia Test: A practical scale to assess cognition after head injury. *Journal of Nervous and Mental Diseases*, 167, 675-684. *[Link to PubMed: Levin, HS, O'Donnell, VM, & Grossman, RG for v144a](#)

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=501342)

Revised GOAT:

Bode RK, Heinemann AW, Semik P. Measurement properties of the Galveston Orientation and Amnesia Test (GOAT) and improvement patterns during inpatient rehabilitation. *J Head Trauma Rehabil*. 2000 Feb;15(1):637-55. *[Link to PubMed: Bode RK, Heinemann AW, Semik P. for v144a](#)

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=10745181)

Orientation-Log:

Jackson WT, Novack TA, Dowler RN. Effective serial measurement of cognitive orientation in rehabilitation: the Orientation Log.

Arch Phys Med Rehabil. 1998 Jun;79(6):718-20. *[Link to PubMed: Jackson WT, Novack TA, Dowler RN for v144a](#)
(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9630156)

Novack, TA, Dowler, RN, Bush, BA, Glen, T, Schneider, JJ. Validity of the Orientation Log, Relative to the Galveston Orientation and Amnesia Test. *J Head Trauma Rehabil*, 2000, 15(3), 957-961. *[Link to PubMed: Novack TA, Dowler RN, Bush BA, Glen T, Schneider JJ. for v144a](#)

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=10785625)

*[Introduction to O-Log \(COMBI\) \(http://www.tbims.org/combi/olog/index.html\)](http://www.tbims.org/combi/olog/index.html).

*[O-Log frequently asked questions \(COMBI\) \(http://www.tbims.org/combi/olog/ologfaq.html\)](http://www.tbims.org/combi/olog/ologfaq.html).

*[O-Log Syllabus \(COMBI\) \(http://www.tbims.org/combi/olog/ologsyl.html\)](http://www.tbims.org/combi/olog/ologsyl.html).

*[O-Log Rating Form \(COMBI\) \(http://www.tbims.org/combi/olog/olograt.html\)](http://www.tbims.org/combi/olog/olograt.html).

*[O-Log Properties \(COMBI\) \(http://www.tbims.org/combi/olog/ologprop.html\)](http://www.tbims.org/combi/olog/ologprop.html).

*[O-Log References \(COMBI\) \(http://www.tbims.org/combi/olog/ologref.html\)](http://www.tbims.org/combi/olog/ologref.html).

EXAMPLE:

Patient emerged from PTA on August 22, 1988.

MM/DD/YYYY

08/22/1988

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added links to COMBI.
2004-04-01	Added full references to SOURCES.
2004-04-01	In DEFINITION removed reference to the neuropsychological battery.
2004-04-01	Added links to COMBI.
2004-04-01	Added links to PubMed.
2004-01-01	Added NOTE that NP databusters confirmed current procedure for calculation (approx 9/02).
2003-01-01	Deleted code "07/07/7777=Never had amnesia".
2003-01-01	Added to NOTES that if person never had PTA, code date of admission to ER.
2002-01-01	Added to DEFINITION the Revised GOAT, Orientation-Log, and modified GOAT.
2002-01-01	SOURCES section added, with references for Revised GOAT and Orientation-Log.
2001-10-01	Clarified DEFINITION and instruction in NOTES that date of emergence from PTA is the date of the first of 2 [u]consecutive[/u] scores greater than 75.
2000-07-01	Added PTA determination based on Chart Review (see 144b on following page).
1999-10-01	Added NOTE to clarify which date to use.
1999-04-02	Revised unknown codes to be compatible with new software.
1998-09-01	Revised definition of PTA.
1998-08-15	Year expanded to four digits.
1995-07-01	Added NOTE regarding calculation of duration of PTA.
1994-09-13	Added reference regarding use of modified GOAT.

CAUSE(S) OF DEATH

Variable 146

Date of last revision: 07/01/04

DEFINITION:

The first coded cause of death is the primary cause. Thereafter list secondary cause and/or external cause of death, if applicable. For more information, see: [16a.Guidelines coding cause of death](http://syllabus/pdf/16a_Guidelines_coding_cause_of_death.pdf) (http://syllabus/pdf/16a_Guidelines_coding_cause_of_death.pdf), in Appendix C.

CODE:

Code the two boxes for the ICD-9-CM codes and the box for the External Cause of Injury Codes (E-codes) as follows.

ICD-9-CM code boxes:

For a list of ICD-9 codes, refer to an ICD-9 code manual at your facility.

*777.77 Person expired but cause of death unknown

888.88 Not Applicable--person alive, or no other *internal cause of death indicated, *or death due to external causes

999.99 Unknown if person expired

E-code box:

For an abbreviated list of E-codes, see: [24a.ICD-9-CM E-code categories](http://syllabus/pdf/v133b_categories_3.pdf)

(http://syllabus/pdf/v133b_categories_3.pdf) in Appendix K. A complete list of E-codes is available at [E-Code list-complete](http://syllabus/pdf/ECodes_52.pdf) (http://syllabus/pdf/ECodes_52.pdf).

*777.7 Person expired but cause of death unknown

888.8 Not Applicable--person alive, *or death not due to external causes

999.9 Unknown if person expired

CHARACTERS:

3 numeric

4 numeric

5 numeric

NOTE:

Submit Form I data to the data base on patients which expire anytime after inpatient rehabilitation has begun and prior to definitive discharge from inpatient rehabilitation; even if the patient was transferred back to acute care from rehabilitation prior to expiring.

If autopsy was performed obtain report, document cause(s) of death by use of ICD-9-CM diagnosis codes or E-codes if applicable.

If using death certificate information, usually code the 3rd number. First number is immediate cause, second number is the cause of the immediate cause, and the third number is the more underlying cause.

Numbers should be coded just as they appear on the record and not padded with zeros.

The look-up boxes on the database screen provide the E-Codes and their definitions. When taking E-Codes from the Medical Record, they should be checked to ensure that they reflect the best / most current information available about the cause of the injury. Data collectors may submit E-Codes that differ from those recorded in the Medical Record in cases where they feel the Medical Record E-Codes may not reflect the best / most current information available. There should be clear documentation on the data collection form when an E-Code entered into the database does not reflect the E-Code recorded in the Medical Record. In unusual cases where no E-Code relative to the injury that resulted in traumatic brain injury is recorded in the Medical Record, the data collector should use best judgement and the consultation of other personnel, as necessary, to determine the appropriate E-Code from the TBIMS database list.

SOURCE:

UAB

EXAMPLE:

Patient died of unspecified septicemia (primary cause) and unspecified pneumonia (secondary).

ICD-9-CM codes:038.9 (primary); 486. (secondary)

E CODE: 888.8

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added "777.7(7)=Person expired but cause of death unknown". Corrected the labels for 888.88 (ICD-9) and 888.8 (E-code). For 888.88, "NA-Person alive, or no other cause of death indicated" has been changed to "NA-Person alive, or no other internal cause of death indicated, or death due to external causes". For 888.8, "NA-Person alive, or no other cause of death indicated" has been changed to "NA-Person alive, or death not due to external causes".
2004-04-01	Added reference to Coding Guidelines in Appendix C.
2002-04-01	Added reference to instructions for E-codes in Appendix K.
1995-01-01	Dropped 3rd ICD-9 code and 2nd and 3rd E-codes.
1994-02-01	Added NOTE clarifying the submission of patients which expire during inpatient rehabilitation.
1994-02-01	Removed reference to Appendix D (coding cause of death) which was never written.

DISABILITY RATING SCALE

Variable 151

Date of last revision: 07/01/04

DEFINITION:

Disability Rating Scale ratings are to be completed within 72 hours after rehab admission and within 72 hours before rehab discharge. Indicate ratings for all items. Information about the DRS is available from COMBI at these two links: [Introduction to the DRS \(http://www.tbims.org/combi/drs/index.html\)](http://www.tbims.org/combi/drs/index.html); [Definition of DRS items \(http://www.tbims.org/combi/drs/drssyl.html\)](http://www.tbims.org/combi/drs/drssyl.html)

There are four acceptable versions of the DRS data collection form: 23b.DRS Rating Form (COMBI) (<http://tbims.org/combi/drs/drsrat.html>), PDF DRS form (COMBI) (<http://www.tbims.org/combi/drs/drs.pdf>), 23a.Disability Rating Scale Form (SCVMC 9/16/97) (http://syllabus/pdf/23a_DRS_form_SCVMC_1997.pdf), and 23h.DRS Form (SCVMC 9/2003) (http://syllabus/pdf/23h_DRS_SCVMC_2003.pdf). The version(s) your Center should be in Appendix J.

CODE:

1. Eye Opening:

- 0 Spontaneous
 - 1 To Speech
 - 2 To Pain
- 3 None
- 9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

2. Communication Ability (Verbal, writing, or letter board or sign - e.g. eye blink, head nod):

- 0 Oriented
- 1 Confused
- 2 Inappropriate
 - 3 Incomprehensible
 - 4 None
- 9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

3. Motor Response:

- 0 Obeying
- 1 Localizing
- 2 Withdrawing
 - 3 Flexing
 - 4 Extending
- 5 None
- 9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

Items 4,5,6,7 and 8 can be rated on a .5 scale. For example, if patient's feeding ability falls between 1.0 (Partial) and 2.0 (Minimal), use a rating of 1.5.

4. Feeding (cognitive ability only):

- 0.0 Complete**
- 0.5 Between complete and partial
- 1.0 Partial**
- 1.5 Between partial and minimal
 - 2.0 Minimal**
 - 2.5 Between minimal and none
- 3.0 None**
- 9.9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

5. Toileting (cognitive ability only):

- 0.0 Complete**
- 0.5 Between complete and partial
- 1.0 Partial**
- 1.5 Between partial and minimal
 - 2.0 Minimal**
 - 2.5 Between minimal and none
- 3.0 None**
- 9.9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

6. Grooming (cognitive ability only):

- 0.0 Complete**
- 0.5 Between complete and partial
- 1.0 Partial**
- 1.5 Between partial and minimal
 - 2.0 Minimal**
 - 2.5 Between minimal and none
- 3.0 None**
- 9.9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

7. Level of Functioning (physical and cognitive disability):

- 0.0 Completely Independent**
- 0.5 Between completely indep and indep in special environ.
- 1.0 Independent in Special Environment**
- 1.5 Between indep in special environ and mildly depend.
- 2.0 Mildly Dependent-limited assistance (non-resid helper)**
- 2.5 Between mildly depend. and moderately dependent
- 3.0 Moderately Dependent-moderate assist (person in home)**
- 3.5 Between moderately dependent and markedly dependent

4.0 Markedly Dependent-assist all major activities, all times

4.5 Between markedly dependent and totally dependent

5.0 Totally Dependent - 24 hour nursing care

9.9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

8. "Employability" (As a full time worker, homemaker, or student):

0.0 Not Restricted

0.5 Between not restricted and selective jobs, competitive

1.0 Selected Jobs, Competitive

1.5 Between selected jobs and sheltered workshop

2.0 Sheltered Workshop, Non-competitive

2.5 Between sheltered workshop and not employable

3.0 Not Employable

9.9 Unknown, or assessment not done, or does not reflect patient's status during the 72 hour window.

CHARACTERS:

1 numeric

2 numeric

NOTE:

If DRS assessments cannot be completed within the 72 hour windows, they should still reflect the patients' status within that time period. If this is not possible and the assessments are done out of the 72 hour window, code with 9's. Every effort should be made to obtain the DRS assessments, however, if any items can not be assessed, use code 9. Do not leave blanks.

An example of an appropriate use of a .5 rating for the "Level of Functioning" item is: at the time of discharge, the patient requires set-up for all activities of daily living, including dressing, eating, grooming, etc. He can be left alone for 2-3 hours, but he needs more than a non-resident helper. Therefore he is more than mildly dependent (rating of 2). On the other hand, he does not need another person at all times, as he can be left alone for short periods, e.g. between lunch and dinner, and is therefore not moderately dependent (rating of 3). He falls between a rating of 2 and 3 and should be rated 2.5.

If a patient has an intermittent acute care stay during inpatient rehabilitation, use the DRS scores from the first rehabilitation admission and the last definitive discharge. In addition, if a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the DRS scores should correspond to that date.

There are times, especially in the "Employability" item, when a client does not fit in one category or another, but falls in between two descriptions. This is when to use the .5 rating, i.e., only when a case does not fit fairly well within an existing "whole number" category. The .5 ratings are available to increase the sensitivity of the scale.

Total DRS score is calculated using a computer program.

See:[Frequently Asked Questions about DRS \(COMBI\)](http://www.tbims.org/combi/drs/drsfaq.html) (<http://www.tbims.org/combi/drs/drsfaq.html>)

See:[DRS properties \(COMBI\)](http://www.tbims.org/combi/drs/drsprop.html) (<http://www.tbims.org/combi/drs/drsprop.html>)

TRAINING:

*It is the responsibility of each center to assure that all staff who perform DRS ratings (Form I and Form II) are trained and certified through the website at "www.tbims.org/combi/drs/". All staff should be re-certified every other year. The Northern California TBI Model System (at Santa Clara Valley Medical Center) will send a reminder to individuals nearing the end of their two-year DRS credentialing. See:DRS training & testing (COMBI)_____
(<http://www.tbims.org/combi/drs/drstat.html>) in Appendix J.

SOURCE:

Rappaport M, Hall KM, Hopkins K, Belleza T, Cope N. (1982). Disability Rating Scale for severe head trauma patients: Coma to community. Arch Phys Med & Rehabil, 63:118-123. rev 8/87. For an abstract of this article, see: PubMed:Rappaport M, et al (1987).

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=7073452).

See:Other References for DRS (COMBI) (<http://www.tbims.org/combi/drs/drsref.html>).

EXAMPLE:

Patient has the following Disability Rating Scale score

Rehab Admission

1. Eye Opening 2
2. Communication Ability 3
3. Motor Response 3
4. Feeding 2.0
5. Toileting 2.5
6. Grooming 1.0
7. Level of Functioning 3.0
8. Employability 2.0

Rehab Discharge

1. Eye Opening 1
2. Communication Ability 1
3. Motor Response 0
4. Feeding 0.0
5. Toileting 0.0
6. Grooming 0.0
7. Level of Functioning 2.5
8. Employability 1.5

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	To TRAINING, added information about certification from "22f.Data Quality Guidelines".
2004-04-01	Added links to COMBI.
2004-04-01	Added link from source document to PubMed.
1998-09-01	Added NOTE regarding .5 ratings.
1995-01-01	Dropped total score.
1995-01-01	Added note and reference to Appendix J.
1994-09-13	Revised items 4-8 to a .5 scale.
1994-09-13	Dropped all "not applicable" codes.
1994-09-13	Dropped dates of assessment.
1994-09-13	Added NOTE about intermittent stays.
1994-02-01	Removed references to Level I and Acute Discharge rating.
1994-02-01	Added CODES for unknown.
1994-02-01	Added NOTES for coding clarification.

FUNCTIONAL INDEPENDENCE MEASURE (FIM)

Variable 152

Date of last revision: 07/01/04

DEFINITION:

The FIM is a measure of disability. It is intended to measure what the person with the disability actually does, not what he or she ought to be able to do, or might be able to do if certain circumstances were different. It is to be completed within 72 hours after Rehab Admission and again within 72 hours before Rehab Discharge.

FIM data are to be collected according to the current (4/1/04) *IRF-PAI coding instructions IRF-PAI Coding Instructions: 4/1/2004 version (<http://www.cms.hhs.gov/providers/irfpps/irfpaimanual040104.pdf>), supplemented by any further instructions in your syllabus. Information about the FIM can be found in the IRF-PAI manual in section III, pages 40-57, Appendix H, and pages 29-34. A copy of the FIM-related sections of this manual should be in your syllabus, in Appendix A. If it is not possible for your Center to follow the correct manual, notify the TBINDC.

*Information about the FIM is available from COMBI at these two links: Introduction (COMBI) (<http://www.tbims.org/combi/FIM/index.html>); Background (COMBI) (<http://www.tbims.org/combi/FIM/fimbg.html>).

CODE:

- 7 Complete Independence (Timely, Safely)
- 6 Modified Independence (Extra time, device)
- 5 Supervision (pt does 100%)
- 4 Minimal Assist (subject > 75% of task)
- 3 Moderate Assist (50 - 74% of task)
- 2 Maximal Assist (25 - 49% of task)
- 1 Total Assist (subject 72 hours)
- 66 Variable did not exist

Items 8b and 9b

- 7 No accidents
- 6 No accidents, uses device (e.g., catheter, ostomy)
- 5 One accident in the past 7 days
- 4 Two accidents in the past 7 days
- 3 Three accidents in the past 7 days
- 2 Four accidents in the past 7 days
- 1 Five or more accidents in the past 7 days
- 9 Unknown / assessed at >72 hours
- 66 Variable did not exist

Item 14: Primary mode of locomotion on discharge

- w Walking
- c Wheelchair
- 9 Unknown

Item 17: Primary mode of comprehension

- a Auditory comprehension > 50% of the time
- v Visual comprehension > 50% of the time
- b Both used equally
- 9 Unknown

Item 18: Primary mode of expression

- v Verbal expression > 50% of the time
- n Nonverbal expression > 50% of the time
- b Both used equally
- 9 Unknown

CHARACTERS:

- 1 numeric
- 2 numeric
- 1 alpha-numeric

NOTE:

All FIM items must be scored. Record what patient actually does. If FIM assessment cannot be completed within the 72 hour window, it should still reflect the patients' status within that time period. If this is not possible and the assessments are done out of the 72 hour window, code with 9's. Every effort should be made to obtain the FIM assessments; however, if any items are not assessed, use code 9 -- do not leave blanks.

For admission item #14, if patient is walking and not using wheelchair, code item 14b (wheelchair) "8=not applicable". If patient is unable to walk on admission, code item 14a (walking) "1=total assist". If, at discharge, patient is walking AND using a wheelchair, code 14 (mode) as the more frequently used mode of locomotion. Do not use the code "b=Both" (as is indicated by UDS instructions). If FIM scores provided by your hospital include "b" codes, use all sources of information to determine the more frequent mode of locomotion at the time of evaluation and code either "w" or "c" as appropriate. If the more frequent mode of locomotion cannot be determined, code "9".

According to the UDS Procedures for Scoring the FIM, "if the subject would be put at risk for injury if tested or does not perform the activity, enter 1". Use this same rule for the TBI Model Systems FIM data collection.

According to the UDS procedures for scoring the FIM, "the mode of locomotion for FIM item #14 (Walk/Wheelchair) must be the same on admission and discharge; if the subject changes the mode of locomotion from admission to discharge (usually wheelchair to walking), record the admission mode and score based on the most frequent mode of locomotion at discharge". Therefore, for the TBI Model Systems FIM data collection for FIM item #14, score both modes of locomotion (Walking and Wheelchair) on admission. The total admission score will be calculated by the computer and based on the UDS procedure described above (i.e., if the discharge mode is walking, the admission score for walking is used; if the discharge mode is wheelchair, the admission score for wheelchair is used).

If patient has an intermittent acute care stay during inpatient rehabilitation, use the FIM scores from the first rehabilitation admission and the last definitive discharge. In addition, if a patient has an intermittent stay which is longer than 30 days, it is then considered a system discharge and the discharge date from rehabilitation is the system discharge date and the FIM scores should correspond to that date.

"Level of assistance" (part a) and "Frequency of accidents" (part b) are recorded for #8 (Bladder Management) and #9 (Bowel Management).

For items 1-6 and 10-15 *at the admission evaluation only*, if patient does not perform the activity and a helper does not perform the activity for the patient, assign code "0=Activity does not occur". If the patient is simply not *observed* performing an activity, do not code "0" until all available sources of information have been consulted (e.g., other clinicians, medical record, family members). If at discharge evaluation an activity is not performed, assign code "1=Total assistance" (do not use the "0" code at the discharge evaluation).

For #8 (Bladder Management), if patient does not void (e.g., renal failure and on hemodialysis), assign code "7=Complete independence".

According to new FIM instructions (effective 1/1/02), all FIM items now have an "assessment time period". The person's score on a given FIM item is determined by his/her functional level during this "assessment time period"--a specified number of days prior to the evaluation. (FIM instructions prior to 1/1/02 did not indicate an assessment time period.) The assessment time period for all FIM items (except 8b and 9b-see below) is 3 days. Scoring reflects the patient's *poorest (most dependent) functioning* during the assessment time period¹. The evaluation is therefore not a snap-shot of the patient's performance at the time of evaluation, but a summary of performance over the entire assessment time period.

For items 8b and 9b (number of bladder accidents, number of bowel accidents), the assessment time period is 7 days--that is, the number of accidents is counted across the 7 days prior to the patient's FIM evaluation. Because the admission FIM evaluation must be done at the end of the first 3 days after rehab admission, the assessment time period therefore includes the 4 days prior to rehab admission. If information is not available from this 4-day period, then treat only the 3 days after rehab admission as the assessment time period. No adjustment in scoring of items 8b and 9b is made when the assessment time period is shorter than 7 days.

Wearing of eyeglasses causes Comprehension to be scored "6" only if the person's primary form of comprehension is visual (rather than auditory, which is usually primary).

*See: Properties of the FIM instrument (COMBI) (<http://www.tbims.org/combi/FIM/fimprop.html>)

¹ However, the current training manual qualifies this, as follows: "The patient's score on measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, a patient who can routinely ambulate more than 150 feet throughout the day with supervision (score of 5 for FIM Locomotion: Walk/Wheelchair item), but who is observed to ambulate only 20 feet at night to use the toilet because that is the distance from his/her bed, should receive a Walk score of 5 rather than a lower score" (IRF-PAI Training Manual 1/16/02, page III-4).

TRAINING:

FIM training will follow guidelines from the Uniform Data System (UDS). It is the responsibility of each center to assure that all staff who perform FIM assessments (Form I and Form II) are certified by a recognized credentialing organization (e.g., UDS, e-Rehab) and remain certified for the duration of the time that they collect data/assess patients for the TBIMS National Database.

SOURCE:

Uniform Data System for Medical Rehabilitation
232 Parker Hall
SUNY South Campus
3435 Main Street
Buffalo, New York 14214 3007
(716) 829 2076; FAX (716) 829 2080

The IRF-PAI instructions for the FIM are disseminated through the website of The Centers for Medicare and Medicaid Services. For information about the CMMS, go to: <http://www.cms.hhs.gov/researchers/projects/APR/2003/facts.pdf>.

EXAMPLE:

[It is not possible to display information in columns in the live syllabus, which is important for displaying the example for V152. A more neatly formatted example is available at:[FIM example](http://syllabus/pdf/F1_FIM_Example.pdf) (http://syllabus/pdf/F1_FIM_Example.pdf.)]

Admission Discharge**SELF CARE ITEMS:**

- 2 4 1. Feeding
- 1 4 2. Grooming
- 2 3 3. Bathing
- 3 5 4. Dressing Upper Body
- 3 5 5. Dressing Lower Body
- 2 4 6. Toileting

SPHINCTER CONTROL:

- 3 5 8. Bladder Management
- 4 5 a. Level of assistance
- 3 6 b. Frequency of accidents
- 4 5 9. Bowel Management
- 4 6 a. Level of assistance
- 5 5 b. Frequency of accidents

MOBILITY ITEMS:

- Transfers technique
- 3 4 10. Bed, Chair, Wheelchair
- 4 6 11. Toilet
- 3 3 12. Tub or Shower
- Locomotion
- 3 14a. Walking on admission
- 3 14b. Wheelchair on admission
- w 3 14. Walking/Wheelchair on discharge (w/c/9)
- 3 3 15. Stairs

COMMUNICATIONS:

- b 7 b 7 17. Comprehension (a/v/b/9)
- v 6 v 6 18. Expression (v/n/b/9)

PSYCHOSOCIAL ADJUSTMENT ITEMS:

- 6 5 22. Social Interaction

COGNITIVE FUNCTION:

- 5 6 26. Problem Solving
- 4 5 27. Memory

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added information about training and certification to TRAINING (from 22f.Data Quality Guidelines).
2004-07-01	In DEFINITION fixed the link to the current (4/1/2004) IRF-PAI manual and added a description of where in the manual to look for FIM-related information.
2004-04-01	Updated link to IRF-PAI manual (4/1/04 version).
2004-04-01	Added links to COMBI.
2004-01-01	Added note about scoring Comprehension when person wears eyeglasses.
2003-01-01	In SOURCE, updated the URL at which the IRF-PAI Training Manual can be viewed & printed.
2002-07-01	Revised 1st sentence in code "66" to read "Data not available with new (1/1/02) scoring."
2002-07-01	Updated SOURCE.
2002-07-01	Improved DEFINITION: added first two sentences; added reference to SOURCE; made explicit the requirement to follow current instructions.
2002-07-01	Added NOTE that score is to reflect poorest functioning during the assessment time period.
2002-07-01	Added note about admission score for 8b and 9b regarding use of 3-day rather than 7-day assessment period.
2002-04-01	Modified DEFINITION to refer to Center's instruction manual rather than Appendix.
2002-04-01	Corrected code 4 "Minimal Assist" -- ">75%" rather than ">75%".
2002-04-01	Added code "0=Activity does not occur" and NOTE about code "0".
2002-04-01	Added "66=Variable not available [data did not exist].
2002-04-01	Added to CODE 5 that "(pt does 100%)".
2002-04-01	Replaced in CODE 9 "doesn't perform task" with "or, for all items at discharge and for items 8, 8a, 8b,9,9a, 9b, and 17-27 at admission, if the activity does not occur."
2002-04-01	Added function modifier items "a=Level of assistance" and "b=Frequency of accidents" for #8 and 9, CODES for #8b and #9b, NOTE explaining scoring of #8 and 9, and EXAMPLES.
2002-04-01	Added NOTE about "assessment time period".
2002-04-01	Added note about how to score #8b if patient does not urinate.
2002-04-01	Added note about coding 14 (mode of locomotion) if patient both walks and uses wheelchair.
2002-04-01	Updated SOURCE.
2002-04-01	Added NOTE for #8 and 9 to obtain patient's function during last few days prior to discharge from acute hospital (4, 5, 6, or 7 days, depending on number of days after discharge the evaluation is done).
1999-10-01	Revised note and unknown code used if patient does not perform activity.
1999-07-01	FAM items deleted.
1998-04-15	Added note how to code optional FAM items not collected.
1998-04-01	Added note that 12 FAM items are now optional for collection. FIM items must be collected.
1995-07-01	Added code 8=not applicable, walking and not using wheelchair for item #14b (wheelchair admission) only.
1995-07-01	Clarified how to code person not walking at admission.
1995-07-01	Dropped mode of locomotion code "b" at discharge.
1995-03-24	Added unknown code for mode items 14, 17, and 18.
1994-09-13	Added unknown code.
1994-09-13	Added notes for coding clarification.
1994-09-13	Added admission score for walking and wheelchair.
1994-09-13	Deleted dates of assessment.
1994-09-13	Updated source to include FIM Version 4.0 and descriptors for #16, 23, and 25.

Date of last Revision	Description
1994-02-01	Added codes for unknown.
1994-02-01	Deleted not applicable date code since Level I data collection has been discontinued.
1994-02-01	Added notes for coding data collected out of 72 hour window.
1994-02-01	Updated source to include FIM Version 4.0.

PREMORBID DRUG USE

Variable 192a1

Date of last revision: 07/01/04

DEFINITION:

Indices of drug use and abuse prior to injury: During the year before your injury, did you use any illicit or non-prescription drugs?

CODE:

- 1 No
- 2 Yes
- 0 Variable not in existence when data collected for this case
- 9 Unknown

(DELETED Items 1a-f about specific drugs)

CHARACTERS:

1 numeric

NOTE:

Use patient's response, even if response contradicts other information. This is a self-report variable.

If cannot get patient's response, get family, if not family then medical chart.

*A report on substance use that is based on TBIMS data can be found on COMBI: Problematic Substance Use Identified in the TBIMS National Dataset (<http://www.tbims.org/combi/subst/index.html>)

EXAMPLE:

EXAMPLE #1: Person with brain injury used crack and marijuana.

(1) 2

EXAMPLE #2: Person with brain injury did not use any illicit/non-prescription drugs.

(1) 1

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added to CHARACTERISTICS OF DATA, an explanation for data in cases existing prior to implementation date (1/1/97).
2004-04-01	Added link to report on COMBI using TBIMS data.
2003-01-01	Items 1a-f deleted (specific drugs used).
2001-10-01	Added note about getting data from medical chart, if not available from ptn or SO.
1998-09-01	Added note regarding contradictory information from patient.
1997-01-01	Variable added to database.

PREMORBID ALCOHOL USE

Variable 192a2

Date of last revision: 07/01/04

DEFINITION:

- 1) During the month before the injury, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor?
- 2) During the month before the injury, how many days per week or per month did you drink any alcoholic beverages, on the average?
- 3) A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average?
- 4) Considering all types of alcoholic beverages, how many times during the month before the injury did you have five or more drinks on an occasion?

A "drink" is defined in: 20a.Standard Drink Chart (http://syllabus/pdf/20a_Standard_drink_chart.pdf), in Appendix G.

CODE:

Item 1):

- 1 No (autofills items 2-4 with 66=NA)
- 2 Yes
- 7 Refused (autofills items 2-4 with 77=Refused)
- 8 Variable did not exist when data collected (autofills items 2-4 with "88=Variable did not exist")
- 9] Unknown/Don't know/Not sure (autofills items 2-4 with "99=Unknown/Don't know/Not sure")

Item 2):

- a) ## enter number of days per week
- b) ## enter number of days per month
- a)& b) 66 N/A - Not Applicable (Use for item not answered; use for both items if item 1 = No.)
- 77 Refused
- 88 Variable did not exist when data collected
- 99 Unknown/Don't know/Not sure

Item 3) ## enter number of drinks

- 66 N/A - Not Applicable (use only if item 1 = No)
- 77 Refused
- 88 Variable did not exist when data collected
- 99 Unknown/Don't know/Not sure

Item 4) ## enter number of times

- 00 None
- 66 N/A (use only if item 1 = No)
- 77 Refused
- 88 Variable did not exist when data collected
- 99 Unknown/Don't know/Not sure

CHARACTERS:

- 1 numeric
- 2 numeric

NOTE:

Base the data recorded for these questions on self-response. Do not be influenced by information about drinking habits that may be available from hospital records, etc.

Use the higher score if a range (in # of drinks) is given.

Probe for size of drink, and adjust scoring according to answer received.

*A report on substance use that is based on TBIMS data can be found on COMBI: Problematic Substance Use Identified in the TBIMS National Dataset (<http://www.tbims.org/combi/subst/index.html>)

SOURCE:

Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System User's Guide. Atlanta: U.S. Department of Health and Human Services, 1998. National Household Survey on Drug Abuse. Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

EXAMPLE:

Prior to his/her injury, person with brain injury had a single glass of wine with dinner every night, but never consumed more than that amount.

- 1) 2
- 2a) *66
- 2b) 30
- 3) 1
- 4) 00

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Moved NOTE explaining why there are some cases prior to 1/1/97 that have data, to CHARACTERISTICS OF DATA.
2004-07-01	Corrected EXAMPLE so 2a is "66".
2004-04-01	Added "Unknown" to code "Don't know/Not sure"
2004-04-01	Reversed the codes for "Refused" (was 9, now 7) and "Unknown/Don't know/Not sure" (was 7, now 9)
2004-04-01	Added NOTE explaining why there are some cases prior to 1/1/97 that have data.
2004-04-01	Added NOTE that a report on alcohol use based on TBIMS data is on COMBI.
2004-01-01	Added coding instruction for item 2 that 66 should be scored for the item not answered.
2004-01-01	Added NOTE box with 2 notes (use self-report; reference to appendix G for definition of "drink") from the syllabus page for V292a2.
2004-01-01	Added note to code the higher score if a range is given.
2004-01-01	Added note to probe for size of drink, and adjust scoring according to answer received.
2002-04-01	In CODES, corrected autofills so will occur when #1 = 1, 5, 7, 8, or 9. Revised format of autofill information.
2001-01-01	Added/revised coding instructions.
1999-10-01	Dropped QFVI, replaced with alcohol questions from NHSDA and BRFSS module 13.
1997-01-01	Variable added to Form I database.

PREMORBID HISTORY OF PENAL INCARCERATIONS WITH CONVICTION FOR FELONY

Variable 192h

Date of last revision: 07/01/04

DEFINITION:

Did the person with brain injury have any penal incarcerations with conviction for felony prior to his/her injury?

CODE:

1 No
2 Yes
0 Variable not in existence when data collected for this case
9 Unknown

CHARACTERS:

1 numeric

EXAMPLE:

Person with brain injury did not have any penal incarceration with conviction for felony prior to his/her injury.

1

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added to CHARACTERISTICS OF DATA, an explanation for data in cases existing prior to implementation date (1/1/97).
1997-01-01	Variable added to database.

PREMORBID HISTORY OF LEARNING AND/OR BEHAVIOR PROBLEMS IN SCHOOL

Variable 192i

Date of last revision: 07/01/04

DEFINITION:

*Was the person with brain injury officially classified as Special Education student prior to his/her injury?

CODE:

- 1 No
- 2 Yes
- 0 Variable not in existence when data collected for this case
- 9 Unknown

CHARACTERS:

1 numeric

EXAMPLE:

The person with brain injury had some difficulty with high school. He was held back one grade but did graduate. He was never expelled and was not a special education student.

Special education₁

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added to CHARACTERISTICS OF DATA, an explanation for data in cases existing prior to implementation date (1/1/97).
2004-07-01	Changed format of EXAMPLE.
2004-07-01	Deleted references to the dropped items (1,2,4).
2003-01-01	Deleted items 1,2 and 4 (expelled, dropped out, failed to advance to next grade).
1997-01-01	Variable added to database.

SYSTEM/SUBJECT/FOLLOW-UP ID

Variable 200

Date of last revision: 07/01/04

DEFINITION:

A *9-digit number assigned to each patient with brain injury by Project Staff at each center. First 2 digits are system I.D.; next 5 digits are subject I.D.; last 2 digits identify the follow-up evaluation year.

CODE:

Start coding at:

*010000001 Mt. Sinai School of Medicine. This number was assigned in first round of funding. No data with this ID are in the database.

020000001 Medical College of Virginia

*030000001 The Institute for Rehabilitation & Research

040000001 Rehabilitation Institute of Michigan

050000001 Santa Clara Valley Medical Center

060000001 Ohio State University

070000001 Moss Rehabilitation Hospital

080000001 University of Alabama

090000001 Craig Hospital

*100000001 Emory University

110000001 Spaulding Rehabilitation Hospital

120000001 Mayo Clinic

*130000001 University of Missouri

140000001 Mississippi Methodist Rehabilitation Center

*150000001 Kessler Medical Rehabilitation & Education Corp.

160000001 Charlotte Institute

*170000001 Oregon Health Sciences University

180000001 University of Washington

190000001 JFK Johnson Rehabilitation Institute

200000001 University of Pittsburgh

210000001 Univ. of Texas Southwestern Medical Center

220000001 Mount Sinai School of Medicine

*=Not funded as of 10/2002.

CHARACTERS:

9 numeric

EXAMPLE:

Patient was treated at Rehabilitation Institute of Michigan, and was patient number 12345 for the first follow-up evaluation.

041234501

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Removed "annual" from descriptions of follow-up evaluations.
2004-01-01	In DEFINITION corrected number of digits--changed from 11 to 9.
2003-01-01	Added codes for 4 new centers.
2003-01-01	Indicated the 5 defunded centers.
1999-01-01	Corrected name for center 17.
1998-08-15	Added codes for 12 new centers.
1997-10-01	Added new codes for OSU and MOSS.
1995-01-01	Added 2 digits to number to identify year of annual follow-up evaluation.

MARITAL STATUS

Variable 207

Date of last revision: 07/01/04

DEFINITION:

Marital status at evaluation, *according to the best source of information (person with brain injury unless unavailable or unreliable).

CODE:

- 1 Single (a person who has never married)
- 2 Married (a person who is married, whether legally or by commonlaw definition of seven years cohabitation)
- 3 Divorced (a person who is legally divorced)
- 4 Separated (includes both legal separation and living apart from a married partner)
- 5 Widowed
- 7 Other
- 9 Unknown

CHARACTERS:

- 1 numeric

SOURCE:

UAB

EXAMPLE:

Patient was separated from spouse at time of evaluation.

4

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In DEFINITION, added instruction to obtain from the "best source". (This instruction was not added on 8/20/2001 as was stated).
2004-07-01	Removed "annual" from references to follow-up evaluation.
2004-04-01	Removed statement that TBINDC has recoded 08/08/8888 as 07/07/7777.
2004-04-01	Label for code 05/05/5555 changed from "permission" to "authorization".
2001-08-20	Instruction added to obtain from the "Best Source of Information".
1994-09-13	Dropped code 6=cohabitation.
1994-08-19	Removed note regarding collecting data from subject and SO.
1994-08-19	Corrected descriptions to be consistent with V107.

PRIMARY PERSON LIVING WITH

Variable 208

Date of last revision: 07/01/04

DEFINITION:

The primary person with whom the person with TBI is living with at time of evaluation, *according to the best source of information (person with brain injury unless unavailable or unreliable).

CODE:

- 01 Alone
- 02 Spouse (includes commonlaw partners of 7 or more yrs)
- 03 Parent(s)
- 04 Sibling(s)
- 05 Child/children (less than 21 years of age)
- 06 Other relative(s) or adult child(ren) (greater than 21 years of age)
- 07 Roommate(s)/friend(s)
- 08 Significant other (partners, not married)
- 09 Other patients (in hospital or nursing home)
- 10 Other residents (group living situation)
- 11 Personal Care Attendant
- 77 Other (includes correctional facility inmates)
- 99 Unknown

CHARACTERS:

2 numeric

NOTE:

If the patient is living with more than one person, list the person most involved in the patient's life and care.

SOURCE:

SCVMC

EXAMPLE:

Patient was living with a roommate at time of evaluation.

07

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In DEFINITION, added instruction to obtain from the "best source". (This instruction was not added on 8/20/2001 as stated).
2004-07-01	Remove references to "annual" evaluation.
2001-08-20	Instruction added to obtain from the "Best Source of Information".
1995-07-01	Dropped 2nd and 3rd persons living with.
1995-07-01	Dropped code 88.
1994-08-19	Removed note regarding collecting data from subject and SO.
1994-08-19	Added code 88 and added 88's to example.
1994-08-19	Added note about selecting the person to record, if subject is living with more than one person.

RESIDENCE

Variable 209

Date of last revision: 07/01/04

DEFINITION:

Where the person with brain injury is living at time of follow-up evaluation, *according to the best source of information (person with brain injury unless unavailable or unreliable).

CODE:

01 **Private Residence** (includes house, apartment, mobile home, foster home, condominium, dormitory [school, church, college], military barracks, boarding school, boarding home, rooming house, bunk-house, boys' ranch, fraternity/sorority house, commune, shelter, migrant farmworkers' camp)
02 **Nursing Home** (includes medi-center, residential, institutions licensed as hospitals but providing essentially long-term, custodial, chronic disease care, etc.)
03 **Adult Home** (adult foster care, independent living center, transitional living facility, group home)
04 **Correctional Institution** (includes prison, jail, penitentiary, correctional center, labor camp, etc.) *For a list of on-line databases of incarcerated persons, see: 25a. List of online offender databases (http://syllabus/pdf/25a_Incarceration_databases.pdf) in Appendix L.
05 **Hotel/Motel** (includes YWCA, YMCA, guest ranch, inn)
06 **Homeless**
07 **Hospital - Acute Care**
08 **Hospital - Rehabilitation**
09 **Hospital - Other** (includes mental hospital)
10 **Subacute care** (includes subacute hospital bed, skilled nursing facility)
77 **Other**
99 **Unknown**

CHARACTERS:

2 numeric

EXAMPLE:

Patient lived at home at time of evaluation.

01

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added instruction in DEFINITION to obtain from the "best source". (This instruction was not added on 8/20/2001 as stated).
2004-04-01	In CODES, added note about availability of incarceration online databases in Appendix L.
2001-08-20	Instruction added to obtain information from "Best Source of Information".
2001-07-01	Zip Code removed and made into V209a.
2001-01-01	Added Zip Code.
1995-07-01	Revised codes, moved dorm thru farmworkers camp from 3 to 1, moved skilled nursing facility from 2 to 10, moved all 11 to 3, added new code 10=subacute.
1994-09-13	Added "adult foster care" to code 3.
1994-08-19	Removed note regarding collecting data from subject and SO.
1994-08-19	Dropped code 88.

ZIP CODE
Variable 209a
Date of last revision: 07/01/04

DEFINITION:

Zip Code at time of interview, *according to the best source of information (person with brain injury unless unavailable or unreliable).

PURPOSE: To allow an estimate of the extent and type of health care services available in the participant's vicinity.

CODE:

Zip Code collected for residence at time of follow-up evaluation.

- 0 Variable did not exist (follow-up evaluation before 7/1/01)
- 8 N/A-person lives outside of the US
- 9 Unknown

CHARACTERS:

5 numeric

NOTE:

If the person has no residence, record the zip code of the area in which he/she is most likely to be.

EXAMPLE:

Person lives in New York City.

10011

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Added instruction in DEFINITION to obtain from the "best source". (This instruction was not added on 8/20/2001 as stated).
2002-07-01	Added code "8=NA (lives outside US).
2002-07-01	Changed code "99999" to "9" (so is not in valid range).
2002-04-01	Deleted code "88888=NA (expired in rehab)".
2002-01-01	Added code "0=variable did not exist".
2001-08-20	Instruction added to obtain data from "Best Source of Information".
2001-08-20	Purpose added.
2001-08-20	Note added about estimating zip code if homeless.
2001-07-01	Zip Code made into separate variable.
2001-01-01	Zip Code added to database.

EMPLOYMENT STATUS

Variable 211a

Date of last revision: 07/01/04

DEFINITION:

Code primary employment status in the month prior to the evaluation.

Determine primary status by using the following prioritization, regardless of the number of hours worked: competitive employment, degree-oriented education, taking care of house or family, job-directed/on-the-job training, supported employment, sheltered employment, non-directed coursework, volunteer work, retirement (age-related), retirement (disability-related), and no productive activity.

CODE:

- 02 Full-time student (regular class)
- 03 Part-time student (regular class)
- 04 Special education/other non-regular education
- 05 Competitively employed (minimum wage or greater, legal or illegal employment)
- 07 Taking care of house or family
- 08 Special employed (sheltered workshop, supportive employment, has job coach)
- 09 Retired (age)
- 10 Unemployed (looking for work in the *last 4 weeks)
- 11 Volunteer work
- 12 Retired (disability)
- 13 Unemployed (not looking for work in the *last 4 weeks, for any reason)
- 14 Hospitalized without pay during most of the *last 4 weeks
- 15 Retired (other)
- *66 Variable did not exist at time of data collection
- 77 Other
- 99 Unknown

CHARACTERS:

2 numeric

NOTE:

If patient is in the hospital at the time of follow-up, employment status is that status existing at the time of admission to the hospital.

Competitive subminimum wage employment such as babysitting, newspaper delivery, and piecework should be coded 77.

Code "09=Retired (age)" if respondent indicates that retirement was due to age (use respondent's definition).

Ignore non-employment sources of income such as pension, settlement, or disability income support.

If participant is in jail, code "77=other".

If participant works in a foreign country, assume wage is not subminimum unless there is information to the contrary.

If participant is employed for only part of the month prior to the follow-up evaluation, code employment status as during the majority of the work days during that month.

If person has been hired but has not begun work, code as employed.

Code education as full-time or part-time based on self-report.

EXAMPLE:

Patient was a homemaker at the time of evaluation, with no other employment status.

07

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, corrected the labels for codes 10, 13, 14: Replaced "4 weeks prior to injury" with "last 4 weeks".
2004-07-01	Added CODE 66=Variable did not exist at time of data collection. (This code has been used in the database for some time.)
2004-07-01	Removed "annual" from references to follow-up evaluation.
2004-07-01	In Variable History for 1/1/04 regarding "DATABASE" box, corrected a typo so prior text "...added that variable added..." has been changed to "...added that new variable added..."
2004-04-01	Added information to CHARACTERISTICS OF DATA about the employment calculated variable, which merges current data with data collected before the response categories were expanded.
2004-04-01	Moved prioritization list from NOTES to DEFINITION.
2004-04-01	Renamed "DATABASE" box as "CHARACTERISTICS OF DATA".
2004-01-01	Added DATABASE box. Added that the new variable was added and the old variable was kept in the database.
2004-01-01	Added note to code education as full-time or part-time based on self-report.
2003-10-01	Added note to code as employed if hired prior to evaluation but has not yet started work.
2003-01-01	Deleted Secondary Employment variable; instructions adjusted as needed.
2003-01-01	Deleted code "88=No secondary employment status".
2003-01-01	Added note to use priority list to determine primary status, regardless of hours worked.
2002-07-01	Added note about minimum wage in foreign country.
2002-07-01	Added note about coding if did not work all days in prior month.
2001-07-01	Replaced "at annual evaluation" with "in the month prior to the annual evaluation".
2001-07-01	For code 7, replaced "Homemaker" with "Taking care of house or family".
2001-07-01	For code 10, added "(looking for work in the last 4 weeks)".
2001-07-01	Added code "12=Retired (disability)".
2001-07-01	Added code "13=Unemployed (not looking for work in the last 4 weeks)".
2001-07-01	Added code "14 =Hospitalized without pay during most of the last 4 weeks".
2001-07-01	Added code "15=Retired (other)".
2001-07-01	Removed [i]source of income support for disability[/i] as a criterion for classification.
2001-07-01	Revised the prioritization list as follows: "taking care of house or family" replaces "home management (homemaker)", "job-directed/on-the-job training" reverses position with "supported employment", "volunteer work" replaces "volunteer activity", "retirement (age-related), retirement (disability-related)" replaces "active leisure/retirement, disability-related retirement".
2001-07-01	Added note that for the code"09=Retired (age)", accept the respondent's statement as to whether age was the cause of retirement.
1999-10-01	Added use of job coach to code 8.
1999-10-01	Added list to prioritize employment status if more than 1.
1999-04-02	Added clarification for some codes.
1995-07-01	Dropped reference to variable 112 so coding is consistent among employment-related vars.
1994-09-13	Dropped third employment status.
1994-08-19	Removed note regarding collecting data from subject and SO.
1994-08-19	Added code 88 and added 88's to example.
1994-08-19	Added notes to be consistent with V111a.

HOURS OF PAID COMPETITIVE EMPLOYMENT

Variable 211b

Date of last revision: 07/01/04

DEFINITION:

Average number of hours per week usually worked in all paid competitive jobs (minimum wage or greater) in the month prior to evaluation.

CODE:

?? Hours per week
66 Variable did not exist
88 NA- not currently competitively employed
99 Unknown

CHARACTERS:

2 numeric

NOTE:

Fractions are to be rounded to the nearest whole number. 0.5 should be rounded upward.

Code actual number of hours per week **only** for those cases coded 05 (competitively employed) in * V211a (employment status), otherwise this variable must be coded 88.

If patient was employed more than 98 hours per week, code as 98 hours.

If patient works two jobs, add all hours together to code.

Skip this question if the person is not currently competitively employed.

EXAMPLE:

Patient was employed 37.5 hours per week.

38

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Deleted references to primary and secondary employment status.
2004-07-01	Deleted references to "annual" evaluation.
2002-07-01	Added "currently" to code "8=NA".
2002-07-01	Added instruction to skip this question if the person is not currently competitively employed.
2002-04-01	Added "not competitively employed" to code "8=NA".
2002-01-01	Clarified instruction to code this variable if "05=competitive employment" is coded for either the primary or secondary status of V211a.
2001-08-20	Added code "66=Variable did not exist".
2001-07-01	In the definition, added "usually worked in all" prior to "paid competitive"; replaced "employment" with "jobs"; added "in the month prior to the" before "annual evaluation".
1999-04-02	Added note regarding coding hours greater than 98 and hours for more than one job.
1996-11-01	Corrected note.
1995-07-01	Added note clarifying when to code variable in relationship to variable V211a.
1994-08-19	Removed note regarding collecting data from subject and SO.

JOB STABILITY: WEEKS EMPLOYED

Variable 211d

Date of last revision: 07/01/04

DEFINITION:

AT 1 YEAR FOLLOW-UP: Number of weeks of competitive employment during the year after injury.

AT OTHER FOLLOW-UPS: Number of weeks of competitive employment in the last year.

CODE:

?? Number of weeks

66 Variable did not exist

88 N/A-no competitive employment *in the last year.

99 Unknown

CHARACTERS:

2 numeric

NOTE:

Include all weeks employed at minimum wage or higher.

Legal employment only.

Include vacation time and other types of leave if the person was paid during that time.

Partial weeks are rounded up to the nearest whole week.

Ask this question if the person has been competitively employed since the last evaluation, even if not currently competitively employed.

If employment is infrequent but on a regularly scheduled basis, or if it is related to a specific function, then code the number of weeks during which the person was employed. But, if days of employment were just random and the person might or might not do it again, then code the total number of weeks in which the person worked. (E.g., if the person worked 2 times a month for 9 months, then in the first situation 39 weeks should be coded. In the second situation 18 weeks should be coded.)

EXAMPLE:

Patient worked October 11 through December 21.

11

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In DEFINITION and CODES, changed time period from "since the last evaluation" to "in the last year"
2004-07-01	Removed reference to "annual" evaluation.
2003-01-01	Added note about coding infrequent employment.
2002-07-01	Added note to ask this question even if person is not currently competitively employed.
2002-07-01	Changed code 88 to "no competitive employment since last evaluation", from "not competitively employed".
2002-04-01	Added "not competitively employed during prior year" to code "8=NA".
2002-01-01	Added code "66=Variable did not exist".
2001-07-01	Variable added to database.

DISABILITY RATING SCALE

Variable 251

Date of last revision: 07/01/04

DEFINITION:

*Disability Rating Scale ratings are to be completed at every follow-up evaluation. Indicate ratings for all items. Information about the DRS is available from COMBI at these two links: Introduction to the DRS (<http://www.tbims.org/combi/drs/index.html>); Definition of DRS items (<http://www.tbims.org/combi/drs/drssyl.html>)

There are four acceptable versions of the DRS data collection form: 23b.DRS Rating Form (COMBI) (<http://tbims.org/combi/drs/drsrat.html>), PDF DRS form (COMBI) (<http://www.tbims.org/combi/drs/drs.pdf>), 23a.Disability Rating Scale Form (SCVMC 9/16/97) (http://syllabus/pdf/23a_DRS_form_SCVMC_1997.pdf), and 23h.DRS Form (SCVMC 9/2003) (http://syllabus/pdf/23h_DRS_SCVMC_2003.pdf). The version(s) your Center uses should be found in Appendix J.

CODE:

1. Eye Opening:

0 Spontaneous

1 To Speech

2 To Pain

3 None

7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9 Unknown, or assessment not done

2. Communication Ability (Verbal, writing, or letter board or sign - e.g. eye blink, head nod):

0 Oriented

1 Confused

2 Inappropriate

3 Incomprehensible

7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9 Unknown, or assessment not done

3. Motor Response:

0 Obeying

1 Localizing

2 Withdrawing

3 Flexing

4 Extending

5 None

7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9 Unknown, or assessment not done

Items 4,5,6,7 and 8 can be rated on a .5 scale. For example, if patient's feeding ability falls between 1.0 (Partial) and 2.0 (Minimal), use a rating of 1.5.

4. Feeding (cognitive ability only):

0.0 Complete

0.5 Between complete and partial

1.0 Partial

1.5 Between partial and minimal

2.0 Minimal

2.5 Between minimal and none

3.0 None

7.7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9.9 Unknown, or assessment not done

5. Toileting (cognitive ability only):

0.0 Complete

0.5 Between complete and partial

1.0 Partial

1.5 Between partial and minimal

2.0 Minimal

2.5 Between minimal and none

3.0 None

7.7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9.9 Unknown, or assessment not done

6. Grooming (cognitive ability only):

0.0 Complete

0.5 Between complete and partial

1.0 Partial

1.5 Between partial and minimal

2.0 Minimal

2.5 Between minimal and none

3.0 None

7.7 Not due this year [Code no longer used; data now collected in all follow-up years.]

9.9 Unknown, or assessment not done

7. Level of Functioning (physical and cognitive disability):

0.0 Completely Independent

0.5 Between completely indep and indep in special environ.

1.0 Independent in Special Environment

1.5 Between indep in special environ and mildly depend.

2.0 Mildly Dependent-limited assistance (non-resid helper)
2.5 Between mildly depend. and moderately dependent
3.0 Moderately Dependent-moderate assist (person in home)
3.5 Between moderately dependent and markedly dependent
4.0 Markedly Dependent-assist all major activities, all times
4.5 Between markedly dependent and totally dependent
5.0 Totally Dependent - 24 hour nursing care
9.9 Unknown, or assessment not done

8. "Employability" (As a full time worker, homemaker, or student):

0.0 Not Restricted

0.5 Between not restricted and selective jobs, competitive

1.0 Selected Jobs, Competitive

1.5 Between selected jobs and sheltered workshop

2.0 Sheltered Workshop, Non-competitive

2.5 Between sheltered workshop and not employable

3.0 Not Employable

9.9 Unknown, or assessment not done

CHARACTERS:

1 numeric

2 numeric

NOTE:

An example of an appropriate use of a .5 rating for the "Employability" item is: the individual, upon being discharged from inpatient rehabilitation, was placed with his former employer, who modified the job requirements because of reduced performance after the TBI (rating of 1). The individual, had he had to start over with a new, unfamiliar job, may have been more suited for a non-competitive sheltered workshop environment (rating of 2), but is able to function successfully in his present position due to extenuating circumstances. He falls between a rating of 1 and 2 and should be rated 1.5. There are times, especially in the "Employability" item, when a client does not fit in one category or another, but falls in between two descriptions. This is when to use the .5 rating, i.e., only when a case does not fit fairly well within an existing "whole number" category. The .5 ratings are available to increase the sensitivity of the scale.

Total score is calculated using a computer program.

Every effort should be made to obtain the DRS assessments, however, if any items cannot be assessed, use code 9. Do not leave blanks.

See: [Frequently Asked Questions about DRS \(COMBI\)](http://www.tbims.org/combi/drs/drsfaq.html) (<http://www.tbims.org/combi/drs/drsfaq.html>)

See: [DRS properties \(COMBI\)](http://www.tbims.org/combi/drs/drsprop.html) (<http://www.tbims.org/combi/drs/drsprop.html>)

TRAINING:

*It is the responsibility of each center to assure that all staff who perform DRS ratings (Form I and Form II) are trained and certified through the website at "www.tbims.org/combi/drs". All staff should be re-certified every other year. The Northern California TBI Model System (at Santa Clara Valley Medical Center) will send a reminder to individuals nearing the end of their two-year DRS credentialing. See: DRS training & testing (COMBI) (<http://www.tbims.org/combi/drs/drstat.html>) in Appendix J.

SOURCE:

Rappaport M, Hall KM, Hopkins K, Belleza T, Cope N. (1982). Disability Rating Scale for severe head trauma patients: Coma to community. Arch Phys Med & Rehabil, 63:118-123, rev 8/87. For an abstract of this article, see: [PubMed:Rappaport M, et al \(1987\)](http://pubmed.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=7073452).

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=7073452)

See: [Other References for DRS \(COMBI\)](http://www.tbims.org/combi/drs/drsref.html) (<http://www.tbims.org/combi/drs/drsref.html>)

EXAMPLE:

Patient has the following Disability Rating Scale scores:

1. Eye Opening 1
2. Communication Ability 1
3. Motor Response 0
4. Feeding 0.0
5. Toileting 0.0
6. Grooming 0.0
7. Level of Functioning 1.5
8. "Employability" 1.5

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	To TRAINING, added instructions regarding certification that are found in "22f.Data Quality Guidelines".
2004-07-01	In setting up the Live Syllabus, instructions for collection of Form I data had been copied into the DEFINITION. Corrected these instructions.
2004-07-01	Removed references to "annual" evaluation.
2004-07-01	In CODES, added back in the codes for "Not due this year", followed by statement that the codes are no longer used.
2004-04-01	Added link from source article to PubMed.
2004-04-01	Added links to COMBI.
2003-01-01	Deleted "less dynamic schedule" instruction (not needed due to less frequent data collection).
2003-01-01	Deleted code "7=Not due this year".
2002-04-01	Corrected code for "Not due this year" for #4-6: changed from "7" to "7.7" (was correct on Form I and in database).
2002-01-01	Added code "7 =Not due this year" for #1-6.
2001-07-01	Added instruction that the first 6 items of the DRS have been classified as "less dynamic" variables and are to be obtained in years 1,2,5,10, and every 5 years thereafter.
1998-09-01	Added note regarding .5 ratings.
1995-01-01	Dropped total score.
1995-01-01	Added NOTE and reference to Appendix J.
1994-09-13	Removed comment about completing DRS annually until two normal ratings have occurred.
1994-09-13	Revised items 4-8 to a .5 scale.
1994-09-13	Dropped date of assessment.

FUNCTIONAL INDEPENDENCE MEASURE (FIM)

Variable 252

Date of last revision: 07/01/04

DEFINITION:

The FIM is a measure of disability. It is intended to measure what the person with the disability actually does, not what he or she ought to be able to do, or might be able to do if certain circumstances were different.

FIM data are to be collected according to the current (4/1/04) *IRF-PAI coding instructions IRF-PAI Coding Instructions: 4/1/2004 version (<http://www.cms.hhs.gov/providers/irfpps/irfpaimanual040104.pdf>), supplemented by any further instructions in your syllabus. Information about the FIM can be found in the IRF-PAI manual in section III, pages 40-57, Appendix H, and pages 29-34. A copy of the FIM-related sections of this manual should be in your syllabus, in Appendix A. If it is not possible for your Center to follow the correct manual, notify the TBINDC.

*Information about the FIM is available from COMBI at these two links: Introduction (COMBI) (<http://www.tbims.org/combi/FIM/index.html>); Background (COMBI) (<http://www.tbims.org/combi/FIM/fimbg.html>).

CODE:

- 7 Complete Independence (Timely, Safely)
- 6 Modified Independence (Extra time, device)
- 5 Supervision
- 4 Minimal Assist (subject does 75% or more of task)
- 3 Moderate Assist (50 - 74% of task)
- 2 Maximal Assist (25 - 49% of task)
- 1 Total Assist (subject does less than 25% of task)
- 8 Not due this year [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown

Items 8b and 9b

- 7 No accidents
- 6 No accidents, uses device (catheter, ostomy)
- 5 One accident in the past 7 days
- 4 Two accidents in the past 7 days
- 3 Three accidents in the past 7 days
- 2 Four accidents in the past 7 days
- 1 Five or more accidents in the past 7 days
- 8 Not due this year [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown - assessment not done
- 66 Variable did not exist

Item 14: Primary mode of locomotion

- w Walking
- c Wheelchair
- 8 Not due this year [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown

Item 17: Primary mode of comprehension

- a Auditory comprehension > 50% of the time
- v Visual comprehension > 50% of the time
- b Both used equally
- 8 Not due this year [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown

Item 18: Primary mode of expression

- v Verbal expression > 50% of the time
- n Nonverbal expression > 50% of the time
- b Both used equally
- 8 Not due this year [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown

CHARACTERS:

- 1 numeric
- 2 numeric
- 1 alpha-numeric

NOTE:

All FIM items must be scored. Record what patient actually does. Every effort should be made to obtain the FIM assessments, however, if any items are not assessed, use code 9. Do not leave blanks.

According to the UDS Procedures for Scoring the FIM, "if the subject would be put at risk for injury if tested or does not perform the activity, enter 1". Use this same rule for the TBI Model Systems FIM data collection.

If at follow-up evaluation, patient is walking AND using a wheelchair, code 14 (mode) as the more frequently used mode of locomotion. Do not use the code "b=Both" (as is indicated by UDS instructions). Use all sources of information to determine the more frequent mode of locomotion at the time of evaluation and code either "w" or "c" as appropriate. If more frequent mode of locomotion cannot be determined, code "9".

For #8 (Bladder Management), if patient does not void (e.g., renal failure and on hemodialysis), assign code "7=Complete independence".

According to new FIM instructions (effective 1/1/02), all FIM items now have an "assessment time period". The person's score on a given FIM item is determined by his/her functional level during this "assessment time period"--a specified number of days prior to the evaluation. (FIM instructions prior to 1/1/02 did not indicate an assessment time period.) The assessment time period for all FIM items (except 8b and 9b-see below) is 3 days. Scoring reflects the patient's *poorest (most dependent) functioning* during the assessment time period¹. The evaluation is therefore not a snap-shot of the patient's performance at the time of evaluation, but a summary of performance over the entire assessment time period.

Wearing of eyeglasses causes Comprehension to be scored "6" only if the person's primary form of comprehension is visual (rather than auditory, which is usually primary).

"Level of assistance" (part a) and "Frequency of accidents" (part b) are recorded for #8 (Bladder Management) and #9 (Bowel Management). For items 8b and 9b, the assessment time period is 7 days--that is, the number of accidents is counted across the 7 days prior to the patient's FIM evaluation. If information is not available from the entire 7-day period, then record over the number of days (at least the 3 days prior to evaluation) for which information is available. No adjustment in scoring is made when the when the assessment time period is shorter than 7 days.

*See: Properties of the FIM instrument (COMBI) (<http://www.tbims.org/combi/FIM/fimprop.html>)

¹ However, the current training manual qualifies this, as follows: "The patient's score on measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, a patient who can routinely ambulate more than 150 feet throughout the day with supervision (score of 5 for FIM Locomotion: Walk/Wheelchair item), but who is observed to ambulate only 20 feet at night to use the toilet because that is the distance from his/her bed, should receive a Walk score of 5 rather than a lower score" (IRF-PAI Training Manual 1/16/02, page III-4).

TRAINING:

FIM training will follow guidelines from the Uniform Data System (UDS). It is the responsibility of each center to assure that all staff who perform FIM assessments (Form I and Form II) are certified by a recognized credentialing organization (e.g., UDS, e-Rehab) and remain certified for the duration of the time that they collect data/assess patients for the TBIMS National Database.

SOURCE:

Uniform Data System for Medical Rehabilitation
232 Parker Hall
SUNY South Campus
3435 Main Street
Buffalo, New York 14214 3007
(716) 829 2076; FAX (716) 829 2080

The IRF-PAI instructions for the FIM are disseminated through the website of The Centers for Medicare and Medicaid Services. For information about the CMMS, go to: <http://www.cms.hhs.gov/researchers/projects/APR/2003/facts.pdf>.

EXAMPLE:**SELF CARE ITEMS:**

- 2 1. Feeding
- 1 2. Grooming
- 2 3. Bathing
- 3 4. Dressing Upper Body
- 3 5. Dressing Lower Body
- 2 6. Toileting

SPHINCTER CONTROL:

- 4 8. Bladder Management
 - 4 a. Level of assistance
 - 5 b. Frequency of accidents
- 5 9. Bowel Management
 - 6 a. Level of assistance
 - 5 b. Frequency of accidents

MOBILITY ITEMS

Transfers technique:

- 3 10. Bed, Chair, Wheelchair
- 4 11. Toilet
- 3 12. Tub or Shower

Locomotion:

- 3 14. Walking/Wheelchair (1/2/9)
- 3 15. Stairs

COMMUNICATIONS:

- 7 17. Comprehension (1/2/3/9)
- 6 18. Expression (1/2/3/9)

PSYCHOSOCIAL ADJUSTMENT ITEMS:

- 6 22. Social Interaction

COGNITIVE FUNCTION:

- 5 26. Problem Solving
- 4 27. Memory

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In TRAINING, added instructions regarding certification that are found in "22f.Data Quality Guidelines".
2004-07-01	In CODES, added back in the code for "Not due this year", plus a statement that the code is no longer used.
2004-07-01	In DEFINITION fixed the link to the current (4/1/2004) IRF-PAI manual and added a description of where to look in the manual for FIM-related information.
2004-04-01	Updated link to IRF-PAI manual (4/1/04 version).
2004-04-01	Added links to COMBI.
2004-01-01	Added note about scoring Comprehension when person wears eyeglasses.
2003-01-01	Deleted "less dynamic schedule" instruction (because FIM is now collected in all years due to reduced schedule).
2003-01-01	Deleted codes for "Not due", because data are now being collected in all follow-up years (due to less dynamic follow-up schedule).
2002-07-01	Updated SOURCE.
2002-07-01	Improved DEFINITION: added first two sentences; added reference to SOURCE; made explicit the requirement to follow current instructions.
2002-07-01	Added note to record what participant actually does.
2002-07-01	Added note about coding of #8 if participant does not void.
2002-07-01	Added note about assessment time period, including that score is to reflect poorest functioning.

Date of last Revision	Description
2002-07-01	Added note about coding 8a, 8b, 9a, 9b, including coding of 8b and 9b if information is not available for the full 7-day assessment time period.
2002-07-01	Added code "66=Variable did not exist".
2002-04-01	Corrected the "mode" codes for #14, 17, 18 (alphabetic rather than numeric).
2002-04-01	In DEFINITION, added reference Center's instruction manual.
2002-04-01	For #8 and #9, added function modifier items "a=Level of assistance" and "b=Frequency of accidents", the codes for 8b and 9b, and examples for 8a,b & 9a,b.
2002-04-01	Added note about coding 14 (mode of locomotion) if patient both walks and uses wheelchair.
2002-04-01	Corrected code 4 "Minimal Assist" that ptn does greater than or equal to 75% rather than greater than 75%.
2002-04-01	Updated SOURCE.
2002-01-01	Added code "8=Not due" to #14 & 18 in these pages.
2001-07-01	Added definition of FIM.
2001-01-01	Changed collection schedule to years 1,2,5,10 and every 5 years thereafter.
1999-10-01	Revised note and unknown code used if patient does not perform activity.
1999-07-01	Deleted FAM items.
1998-04-15	Added note how to code optional FAM items not collected.
1998-04-01	Added note that the 12 FAM items are now optional for collection.
1995-07-01	Dropped mode of locomotion code "b" for item #14.
1995-03-24	Added unknown code for mode items 14,17 and 18.
1994-09-13	Added unknown code.
1994-09-13	Added notes for coding clarification.
1994-09-13	Deleted date of assessment.
1994-09-13	Updated source to include FIM Version 4.0.
1994-09-13	Updated descriptors for #16, 23, and 25.

DRUG USE
Variable 292a1

Date of last revision: 07/01/04

DEFINITION:

Index of drug use; asked of best source at every follow-up evaluation. "During the last 12 months (or during the time since your injury -- if year 1 follow-up) did you use any illicit or non-prescription drugs?"

CODE:

1 No

2 Yes

*7 Not due this year. [Code no longer used; data now collected in all follow-up years.]

8 No other drug use. [Code no longer used; data not collected on use of specific drugs.]

9 Unknown

CHARACTERS:

1 numeric

NOTE:

*A report on substance use that is based on TBIMS data can be found on COMBI: Problematic Substance Use Identified in the TBIMS National Dataset (<http://www.tbims.org/combi/subst/index.html>)

EXAMPLE:

Person with brain injury used marijuana in past year.

2

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added back in code for "Not due this year", plus a statement that the code is no longer used.
2004-07-01	Removed references to "annual" follow-up.
2004-04-01	Added NOTE regarding the report in COMBI that uses TBIMS data on substance use.
2003-01-01	Deleted v292a1 1a-f (questions about specific drugs used).
2003-01-01	Removed references to this variable as being asked of the person with TBI and added instruction to ask of best source at every annual evaluation.
2003-01-01	Deleted code "7=This variable not due this year"
2003-01-01	Deleted the question that identified respondent as the person with TBI or significant other.
1999-10-01	Revised time period from 6-12 months to 12 months.
1997-01-01	Expanded variable, moved alcohol questions to separate variable.

ALCOHOL USE

Variable 292a2

Date of last revision: 07/01/04

DEFINITION:

A "drink" is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. (See: 20a.Standard Drink Chart (http://syllabus/pdf/20a_Standard_drink_chart.pdf) in Appendix G.)

- 1) During the past month, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor?
- 2) During the past month, how many days per week or per month did you drink any alcoholic beverages, on the average?
- 3) A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average?
- 4) Considering all types of alcoholic beverages, how many times during the past month did you have five or more drinks on an occasion?

CODE:

Item 1):

1 No (autofills items 2-4 with 66=N/A)

2 Yes

*5 Not due this year [Code no longer used; data now collected in all follow-up years.]

7 Refused (autofills items 2-4 with 7=Refused)

8 Variable did not exist when data collected (autofills items 2-4 with 88=Variable did not exist).

9 Unknown/Don't know/Not sure (autofills items 2-4 with 99=Unknown/Don't know/Not sure)

Item 2):

a) ## enter number of days per week

b) ## enter number of days per month

a)& b)

55 Not due this year. [Code no longer used; data now collected in all follow-up years.]

66 N/A-Not Applicable (use for item not answered; use for both items if item 1=No)

77 Refused

88 Variable did not exist when data collected

99 Unknown/Don't know/Not sure

Item 3):

enter number of drinks

55 Not due this year. [Code no longer used; data now collected in all follow-up years.]

66 N/A - Not Applicable (use only if item 1=no)

77 Refused

88 Variable did not exist when data collected

99 Unknown/Don't know/Not sure

Item 4):

enter number of times

00 None

55 Not due this year. [Code no longer used; data now collected in all follow-up years.]

66 N/A (use only if item 1 = no)

77 Refused

88 Variable did not exist when data collected

99 Unknown/Don't know/Not sure

CHARACTERS:

2 numeric

1 numeric

NOTE:

Base the data recorded for these questions on self-response. Do not be influenced by information about drinking habits that may be available from hospital records, etc.

Code the higher score if a range is given.

Probe for size of drink and adjust scoring according to answer received.

A report on substance use that is based on TBIMS data can be found on COMBI: [Problematic Substance Use Identified in the TBIMS National Dataset \(http://www.tbims.org/combi/subst/index.html\)](http://www.tbims.org/combi/subst/index.html)

SOURCE:

Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System User's Guide*. Atlanta: U.S. Department of Health and Human Services, 1998. National Household Survey on Drug Abuse. Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

EXAMPLE:

During the past month, person with brain injury had a single glass of wine with dinner every night, but never consumed more than that amount.

- 1) 2
- 2a) *66
- 2b) 30
- 3) 1
- 4) 00

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Corrected EXAMPLE so 2a is "66".
2004-07-01	In CODES, added back in the code for "Not due this year" plus statement that this code is no longer used.
2004-04-01	Added "Unknown" to code "Don't know/Not sure"
2004-04-01	Reversed the codes for "Refused" (was 9, now 7) and "Unknown/Don't know/Not sure" (was 7, now 9)
2004-04-01	Added a NOTE that a report on alcohol use based on TBIMS data is on COMBI.
2004-01-01	Added coding instruction for item 2 that 66 should be scored for the item not answered.
2004-01-01	Added note to code the higher score if a range is given.
2004-01-01	Added note to probe for size of drink and adjust scoring according to answer received.
2003-10-01	Added note that scores for these questions should be based on self-reports and should not be influenced by information available clinically in the Model System.
2003-10-01	Added note referring to Appendix G for more information.
2003-01-01	Removed references to this variable as being asked of the person with TBI.
2003-01-01	Deleted codes for "This variable not due this year".
2003-01-01	Deleted the question that identifies respondent as the person with TBI or significant other.
2002-04-01	In CODES, corrected autofills so will occur when #1 = 1, 5, 7, 8, or 9. Revised format of autofill information.
2001-01-01	Added/revised coding instructions.
1999-10-01	Dropped QFVI, replaced with alcohol questions from NHSDA and BRFSS module 13.
1997-01-01	Moved drug question to separate variable.
1996-04-01	Added code for additional CIQ questions not due this year.
1994-09-13	Added Appendix G including standard drink chart.
1994-08-12	Added note for coding someone who does not drink at all.
1994-08-12	Corrected example.
1994-08-12	Added full reference for Cahalan/Cisin article.

Date of last Revision	Description
1991-03-21	QFVI added to Form II.

MOTORIZED TRANSPORTATION

Variable 292b

Date of last revision: 07/01/04

DEFINITION:

Indicates the primary mode of motorized vehicular transportation, according to the best source of information (person with brain injury unless unavailable or unreliable).

CODE:

- 1 Drives vehicle
- 2 Rides with someone else
- 3 Public transit
- 4 Special bus or van service
- 5 NA-no/negligible motorized transportation
- *7 Not due this year. [Code no longer used; data now collected in all follow-up years.]
- 8 Not Applicable
- 9 Unknown

CHARACTERS:

- 1 numeric

NOTE:

This variable incorporates V293b.

EXAMPLE:

Person with brain injury uses scheduled public bus service five days per week.

3

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added back in the code for "Not due this year" plus a statement that this code is no longer used.
2003-01-01	Deleted code "7=NA, these questions not due this year" (because the new reduced data collection schedule results in their being due every year).
2003-01-01	Deleted the question that identifies respondent as the person with TBI or significant other.
2002-10-14	Added "motorized" to variable label and to definition.
2002-10-14	Added code "5 NA-no/negligible motorized transportation".
2001-07-01	V292b became a "Best source of information" variable, incorporating V293b. (This "best source" variable was originally named V300b, but reverted to V292b before a change in the database occurred.)
1998-04-15	Split "N/A" code into "N/A, not due this year" and "N/A, no SO".
1996-04-01	Added code for additional CIQ questions not due this year.
1996-04-01	Dropped items 3 & 4.
1996-04-01	Revised codes 1 & 2.
1995-07-01	Dropped item "2=advanced notice for transportation required".
1994-08-19	Clarified what "little/no advanced notice" refers to.
1994-08-19	Corrected example.
1994-08-19	Clarified that items 2-4 refer to the primary mode of transportation.

INCOME AND SOURCE

Variable 292c

Date of last revision: 07/01/04

DEFINITION:

Family income of person with brain injury and sources * of non-employment income for person with brain injury at follow-up evaluation as reported by the best source of information, which is the person with brain injury unless he or she is considered unreliable or is not available.

(1) What is your total family income (approximate combined income of all members of the household)?

(2a) Do you receive income from the following sources? (This applies only to the person with the brain injury.)

(a) Supplemental Security Income (SSI)

(b) Supplemental Security Disability (SSD)

(c) Temporary Assistance to Needy Families (TA or TANF) (Formerly, Aid to Families with Dependent Children - AFDC)

(d) State/Local Welfare (incl. General Relief, Home Relief)

(e) Unemployment Insurance

(f) Workers' Compensation

(g) Private Insurance

(h) Income from Settlement

(i) Other non-employment sources

(2b (a-i)) DELETED - How much income a month do you receive from each source?

CODE:

Item (1):

01 \$9,999 or less

02 \$10,000-\$19,999

03 \$20,000-\$29,999

04 \$30,000-\$39,999

05 \$40,000-\$49,999

06 \$50,000-\$59,999

07 \$60,000-\$69,999

08 \$70,000-\$79,999

09 \$80,000-\$89,999

10 \$90,000-\$99,999

11 \$100,000 or more

55 Data collected before codes 06-11 existed; data exist in calculated variable "income".

*66 Not due this year. [Code no longer used; data now collected at all follow-ups.]

77 Refused

88 N/A-no salary

99 Unknown

Items (2a: a-i):

1 No

2 Yes

*7 Not due this year. [Code no longer used; data now collected in all follow-up years.]

9 Unknown

CHARACTERS:

2 numeric

1 numeric

NOTE:

For source: "Settlement", exclude legal fees to be paid out of the settlement.

This variable can be collected along with V211I.

EXAMPLE:

Person with brain injury has an annual family income of \$16,500, and receives \$1,274.35 a month from an account established with money obtained through a lawsuit associated with the injury.

- (1) 02
- (2a) (1) 1
- (2) 1
- (3) 1
- (4) 1
- (5) 1
- (6) 1
- (7) 1
- (8) 2
- (9) 1

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In DEFINITION, removed reference to amount of income from supplemental sources.
2004-07-01	In CODES, added back the codes for "Not due this year" plus a statement that the codes are no longer used.
2004-04-01	Added CODES for (2a).
2004-04-01	Corrected number of characters (was 10 iems, 1 character each).
2004-04-01	Corrected example so item (1) has two characters (rather than one).
2004-04-01	Replaced reference to "annual evaluation" with "follow-up evaluation".
2004-01-12	Added to code label for code 55: "data exist in calculated variable "inc"".
2003-01-01	Deleted v292c2b variables (amount of income from non-employment sources) and made appropriate changes in syllabus.
2003-01-01	Deleted code "66=Not due" (because this variable is always collected in the new, less frequent follow-up schedule).
2003-01-01	Deleted the question that identifies respondent as the person with TBI or significant other.
2002-04-01	Corrected example so code is "99998" rather than "8".
2002-04-01	Added code "55= Data collected before codes 06-11 existed". (Data on such cases are available only in a calculated variable that merges current data with data based on the original 01-06 codes.)
2002-04-01	Updated CODE 3 label to replace "AFDC" with "TA".
2002-01-01	Added note that this variable can be collected along with V211i.
2002-01-01	In example, changed "0" to "8" in 2b when 2a = 1(No).
2002-01-01	Added note about calculated variable that includes new and old cases.
2002-01-01	Added code "99995 Variable did not exist".
2002-01-01	Corrected syllabus: code 99998 changed from "NA not due this year" to "NA no income from this source", which matches Form II.
2001-10-01	Added income codes to match V211i.
2001-08-20	Added note about excluding legal fees from settlement amount.
2001-07-01	Added amount of income obtained monthly from each non-employment source.
2001-07-01	Integrated with V293c to create a "best source of information" variable. (Initially, was named V300c, but reverted to V292c plus V292c1 before variable was renamed in the database.)
1998-04-15	Changed code N/A, not due this year or no SO.
1996-04-01	Added code 7 for additional CIQ questions not due this year.
1994-08-19	Clarified #1 by adding "total" family income.
1994-08-19	Removed statement from #2 "in addition to employment income".

ARRESTS

Variable 292e

Date of last revision: 07/01/04

DEFINITION:

Determine if the person with brain injury has been arrested during the past year.

- (1) In the past year, have you been arrested?
- (2) If yes for #1, how many times? [DROPPED]
- (3) If yes for #1, how many were drug/alcohol related? [DROPPED]

CODE:

Item (1)

- 1 No
- 2 Yes
- *7 Not due this year. [Code no longer used; data now collected in all follow-up years.]
- 9 Unknown

CHARACTERS:

1 numeric

NOTE:

If person is arrested post-injury for a crime allegedly committed pre-injury, code as "1=No".

EXAMPLE:

Person with brain injury reports he/she was arrested and charged for breaking and entering.

2

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added back in the code for "Not due this year" plus a statement that this code is no longer used.
2004-04-01	Removed deleted items from CHARACTERS box.
2004-04-01	Improved wording in NOTE about coding if person arrested for pre-injury crime. Does not affect data already collected. (Previously stated: "If person is arrested post-injury for a crime allegedly committed pre-injury, record the arrest as occurring pre-injury.")
2003-10-01	Changed lookback period from "since the last interview" to "In the past year".
2003-01-01	Deleted variables 292e2 (number of arrests) and 292e3 (number of arrests that were for drug-related offenses).
2003-01-01	Replaced "during the last year" with "Since the last interview in [month, year]".
2003-01-01	Removed references to this variable being asked of the person with TBI.
2003-01-01	Deleted code "7=This variable not collected this year".
2003-01-01	Deleted notes related to number of arrests and number that were drug/alcohol related.
2003-01-01	Deleted the question identifying respondent as the person with TBI or significant other.
2001-08-20	Added note about pre-injury crimes in which the arrest is post-injury.
1998-04-01	Changed code description and example to reflect how to code when no arrests are drug/ETOH related.
1997-04-01	Expanded items 2-3 to 2 characters, clarified wording #3.
1997-01-01	Expanded variable.
1996-04-01	Added code for additional CIQ questions not due this year.

Date of last Revision	Description
1994-08-19	Added clarification to description to refer to current follow-up period.
1994-08-19	Corrected example.

PSYCHIATRIC PROBLEMS

Variable 292f

Date of last revision: 07/01/04

DEFINITION:

Determine if the person with brain injury has had any of the following psychiatric problems during the past year; according to the best source of information, which is the person with brain injury unless she or he is considered unreliable or is unavailable:

- (1) Suicide attempt(s).
- (2) Psychiatric hospitalization(s).

CODE:

Item (1): Attempted suicide in the past year?

- 1 No
- 2 Yes
- 7 Not due this year. [Code no longer used; data now collected in all follow-up years.]
- 0 Variable not in existence when data collected on this case
- 9 Unknown

Item (2): Any psychiatric hospitalizations in the past year?

- 1 No
- 2 Yes
- 7 Not due this year. [Code no longer used; data now collected in all follow-up years.]
- 0 Variable not in existence when data collected on this case
- 9 Unknown

CHARACTERS:

- 1 numeric

EXAMPLE:

Person with brain injury reports he/she has not attempted suicide, has not had any psychiatric hospitalizations.

- (1) 1
- (2) 1

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added back in the code for "Not due this year" plus a statement that this code is no longer used.
2003-10-01	Replaced "Since the last interview in [month,year]", with "In the past year".
2003-01-01	Replaced "during the last year" with "Since the last interview in [month, year].
2003-01-01	Deleted code "7=This variable not collected this year".
2003-01-01	Deleted the question identifying respondent as the person with TBI or significant other.
2001-08-20	Variable V292f and V293f combined to create V300d (best source of information). But, V300d not added to database. Instead, the variable number was reverted to V292f (in combination with V292f1).
1997-01-01	Variable added to database.

SATISFACTION WITH LIFE SCALE (SWLS) -FOR PERSON WITH BRAIN INJURY

Variable 292g

Date of last revision: 07/01/04

DEFINITION:

The person with brain injury should rate his/her satisfaction with life at the time of the follow-up evaluation by indicating his/her level of agreement with the five questions below.

- (1) In most ways my life is close to my ideal.
- (2) The conditions of my life are excellent.
- (3) I am satisfied with my life.
- (4) So far I have gotten the important things I want in life.
- (5) If I could live my life over, I would change almost nothing.

For more information, see: Introduction to the SWLS (COMBI) (<http://www.tbims.org/combi/swls/index.html>).

CODE:

- 1 Strongly disagree
- 2 Disagree
- 3 Slightly disagree
- 4 Neither agree nor disagree
- 5 Slightly agree
- 6 Agree
- 7 Strongly agree

*8 Not due this year. [Code no longer used; data now collected in all follow-up years.]

- 0 Variable not in existence when data collected
- 9 Unknown
- 10 N/A - no data from person w/ TBI

CHARACTERS:

2 numeric

NOTE:

See: [SWLS Frequently Asked Questions/Tips \(COMBI\)](http://www.tbims.org/combi/swls/swlsfaq.html) (<http://www.tbims.org/combi/swls/swlsfaq.html>)

See: [SWLS Properties \(COMBI\)](http://www.tbims.org/combi/swls/swlsprop.html) (<http://www.tbims.org/combi/swls/swlsprop.html>)

SOURCE:

Diener E, Emmons R, Larsen J, Griffin S. (1985). The Satisfaction With Life Scale. *J Personality Assessment*, 49(1), 71-75.

Pavot W, Deiner E. (1993). Review of the Satisfaction With Life Scale. *Psychological Assessment*. 5(3), 164-172.

(<http://syllabus/pdf/>)

EXAMPLE:

1. In most ways my life is close to my ideal. [2]
2. The conditions of my life are excellent. [4]
3. I am satisfied with my life. [6]
4. So far I have gotten the important things I want in life. [6]
5. If I could live my life over, I would change almost nothing. [2]

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	In CODES, added back in the code for "Not due this year" plus a statement that this code is no longer used.
2004-07-01	Removed reference to "annual" evaluation.
2004-04-01	Added links to COMBI.
2003-10-01	Added CODE "10=N/A-no data from person w/ TBI"
2003-01-01	Deleted code "8=This variable not collected this year".
1998-04-01	Dropped quality of life and health questions, added Satisfaction With Life Scale (self-assessment by person with brain injury).
1997-01-01	Quality of Life and Health - new variable added to database.

GLASGOW OUTCOME SCALE - EXTENDED

Variable 296

Date of last revision: 07/01/04

DEFINITION:

The Glasgow Outcome Scale-Extended is given at the time of follow up evaluation. For information about the GOS-E, see: [Introduction to the GOS-E \(COMBI\)](#)

(<http://tbims.org/combi/gose/index.html>). For coding instructions, see: [28a.Instructions for Rating GOS-E](#) (http://syllabus/pdf/28a_Instructions_GOS-E.pdf) in Appendix O.

CODE:

*DATA COLLECTORS: Collect and record all subscale scores unless instructed to skip some of them by the skip instructions on the Form II.

*DATA ENTRY: Enter into the database all subscale scores that do not autofill. For each case that you enter, check to be sure that the autofilled total score in the database is the same as the total score that has been recorded on the Form II. Notify your Data Manager of all discrepancies between total scores autofilled by the database and total scores as recorded on the Form II.

*DATA MANAGERS: If errors in calculating the total score turn up on the Form II, provide your data collector(s) with more training in scoring the GOS-E and in calculating the total score. Contact the TBINDC if you have questions.

Total score:

- 1 DEAD
- 2 VEGETATIVE STATE
- 3 LOWER SEVERE DISABILITY
- 4 UPPER SEVERE DISABILITY
- 5 LOWER MODERATE DISABILITY
- 6 UPPER MODERATE DISABILITY
- 7 LOWER GOOD RECOVERY
- 8 UPPER GOOD RECOVERY
- 9 UNKNOWN
- 0 VARIABLE DID NOT EXIST

Subscores:

Scores for 1,2a,2b,2c,3a,3b,4a,4b,5a,6a,6c,7a,7c,8a:

- 1 NO
- 2 YES
- 8 N/A-deceased
- 9 UNKNOWN

Scores for 5b:

- 1 Reduced work capacity
- 2 Able to work only in a sheltered workshop or non-competitive job, or currently unable to work
- 9 Unknown

Scores for 6b:

- 1 Participate a bit less: at least half as often as before injury
- 2 Participate much less: less than half as often
- 3 Unable to participate: rarely, if ever, take part
- 9 Unknown

Scores for 7b:

- 1 Occasionally - less than weekly
- 2 Frequent or constant - once a week or more but tolerable
- 3 Constant - daily and intolerable
- 9 Unknown

CHARACTERS:

- 1 numeric

NOTE:

Every effort should be made to obtain the GOS-E assessment, however, if it can not be assessed, use code 9. Do not leave blank.

GOS-E is a "best source" variable. Not necessary to ask the 2 "supplemental" questions about seizures and source of disability (not present on data collection form).

GOS data (collected prior to GOS-E data) have been saved. GOS-E data can be collapsed onto the GOS scale if analyses require.

Added answer boxes to individual items, for convenience of data collectors.

See: [Frequently Asked Questions for GOS-E \(COMBI\)](http://www.tbims.org/combi/gose/gosefaq.html) (<http://www.tbims.org/combi/gose/gosefaq.html>)

See: [Properties of the GOS-E instrument \(COMBI\)](http://www.tbims.org/combi/gose/goseprop.html) (<http://www.tbims.org/combi/gose/goseprop.html>)

*After entering a case's GOS-E data into the database, be sure to check the accuracy of the total score on the Form II by using the procedure described in CODE.

SOURCE:

JT Wilson, L Pettigrew, G Teasdale. Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for their use. *Journal of Neurotrauma*, Vol. 15 No. 8, 1998. For an abstract of this article, see: [PubMed link: JT Wilson, et. atl. \(1998\)](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9726257) (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9726257)

For additional references, see: [GOS-E References \(COMBI\)](http://www.tbims.org/combi/gose/goseref.html) (<http://www.tbims.org/combi/gose/goseref.html>)

EXAMPLE:

Patient has constant, daily childish psychological problems.

5 (Lower Moderate Disability)

VARIABLE HISTORY:

Date of last Revision	Description
2004-07-01	Clarified instructions in CODE for double-checking the accuracy of the total score.
2004-07-01	Added NOTE to use the procedure in CODE to check the accuracy of the total score.
2004-07-01	Removed instruction to enter only the overall score into the database.
2004-04-01	Added database procedure that double-checks data collector's coding of overall rating score
2004-04-01	Added instructions in NOTES for double-check procedure.
2004-04-01	In syllabus, added "unknown" codes for 5b, 6b, 7b.
2004-04-01	Added link from source publication to PubMed.
2004-04-01	Added links to COMBI.
2003-10-01	Added answer boxes to individual items. (To assist in data collection; individual item data are not entered into the database.)
2003-01-01	Deleted subscore variables.
2002-10-14	Now shows the codes for 5b,6b,7b as different than the codes for the other items.
2002-10-14	Removed initial question from data collection form that asked if ptn is deceased.
2002-10-14	Added note that the two supplemental items are no longer on the data collection form.
2002-07-01	Added "8=N/A-deceased" to item codes.
2002-01-01	Added note that the 2 "supplemental" questions are not required.
2001-10-01	New administration and scoring instructions added to Form II.

Date of last Revision	Description
2001-10-01	Revised the reference to Appendix O in DEFINITION.
2001-10-01	Added new overview and instructions in Appendix O.
2001-10-01	Removed references to the GOS-E Structured Interview (superseded by new instructions in Form II).
2001-10-01	Added note that GOS-E is a "best source" variable.
2001-08-20	Corrected code labels, as follows: Added DEAD=1; Changed VEGETATIVE STATE 1->2, LSD 2->3, USD 3->4, LMD 4->5, UMD 5->6, LGR 6->7, UGR 7->8, UNK 8->9.
2001-07-01	Instructions for data collection have been modified so questions 2b,5b,6b,7b, and 8b are not asked (coded 8=N/A) if participant has no disability.
2001-07-01	Added codes "8=N/A, no disability" and "9=unknown".
2001-07-01	Corrected code labels: added "Upper GR" to 8a(1); added "Lower GR" to 8a(2).
2001-01-01	Subscores to be entered into database.
2000-07-01	Adopted extended version of Glasgow Outcome Scale (Glasgow Outcome Scale-Extended).
1999-04-02	Added note regarding scoring persons not employed prior to injury.
1998-09-01	Added ABIC checklist for scoring GOS, amended example and source.
1998-04-01	Variable added to database.

SUPERVISION RATING SCALE (SRS)

Variable 297

Date of last revision: 07/01/04

DEFINITION:

The Supervision Rating Scale is used to rate the amount of supervision that the person with brain injury actually receives by choosing one of the thirteen categories below. This rating is determined by the interviewer with information from the person with TBI and/or others at the time of the follow-up evaluation. "Supervision" means that someone is responsible for being with the person with brain injury. For more information, see: [Introduction to SRS \(COMBI\)](http://www.tbims.org/combi/srs/index.html) (<http://www.tbims.org/combi/srs/index.html>).

A copy of the SRS data collection form is available at: [SRS Rating Form \(COMBI\)](http://www.tbims.org/combi/srs/srsrat.html) (<http://www.tbims.org/combi/srs/srsrat.html>).

CODE:

Level 1 - INDEPENDENT

01 - The person with brain injury lives alone or independently. Other persons can live with the person with brain injury, but they cannot take responsibility for supervision (for example, a child or elderly person).

02 - The person with brain injury is unsupervised overnight. The person with brain injury lives with one or more persons who could be responsible for supervision (for example, a spouse or roommate), but they are all sometimes absent overnight.

Level 2 - OVERNIGHT SUPERVISION

03 - The person with brain injury is only supervised overnight. One or more supervising persons are always present overnight but they are all sometimes absent for the rest of the day.

Level 3 - PART-TIME SUPERVISION

04 - The person with brain injury is supervised overnight and part-time during waking hours, but is allowed on independent outings. One or more supervising persons are always present overnight and are also present during part of waking hours every day. However, the person with brain injury is sometimes allowed to leave the residence without being accompanied by someone who is responsible for supervision.

05 - The person with brain injury is supervised overnight and part-time during waking hours, but unsupervised during working hours. Supervising persons are all sometimes absent for enough time for them to work full-time outside the home.

06 - The person with brain injury is supervised overnight and during most waking hours. Supervising persons are all sometimes absent for periods longer than one hour, but less than the time needed to hold a full-time job away from home.

07 - The person with brain injury is supervised overnight and during almost all waking hours. Supervising persons are all sometimes absent for periods shorter than one hour.

Level 4 - FULL-TIME INDIRECT SUPERVISION

08 - The person with brain injury is under full-time indirect supervision. At least one supervising person is always present, but the supervising person does not check on the person with brain injury more than once every 30 minutes.

09 - Same as #8 plus requires overnight safety precautions (for example, a deadbolt on outside door).

Level 5 - FULL-TIME DIRECT SUPERVISION

10 - The person with brain injury is under full-time direct supervision. At least one supervising person is always present and the supervising person checks on the person with brain injury more than once every thirty minutes.

11 - The person with brain injury lives in a setting in which the exits are physically controlled by others (for example, a locked ward).

12 - Same as #11 plus a supervising person is designated to provide full-time line-of-sight supervision (for example, an escape watch or suicide watch).

13 - The person with brain injury is in physical restraints.

OTHER CODES

00 - Variable did not exist (cases prior to 4/1/98).

99 - Unknown

CHARACTERS:

2 numeric

NOTE:See: [Frequently Asked Questions for SRS \(COMBI\)](http://www.tbims.org/combi/srs/srsfaq.html) (<http://www.tbims.org/combi/srs/srsfaq.html>)See: [Properties of SRS \(COMBI\)](http://www.tbims.org/combi/srs/srsprop.html) (<http://www.tbims.org/combi/srs/srsprop.html>)**SOURCE:**

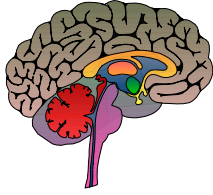
Boake, C. Supervision Rating Scale: A measure of functional outcome from brain injury. Archives of Physical Medicine and Rehabilitation. 1996;77(8):765-772. For an abstract, see: [PubMed link to Boake et. al \(1996\)](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=8702369) (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=8702369)

EXAMPLE:

The patient is supervised overnight and during the day, however his spouse works full-time outside the home during the day.

05**VARIABLE HISTORY:**

Date of last Revision	Description
2004-07-01	Removed reference to "annual" evaluation.
2004-04-01	Added link to PubMed.
2004-04-01	Added links to COMBI.
2001-07-01	Corrected errors that were implemented on 7/1/00 in the Form II, as follows: the heading [u]"Overnight supervision"[/u] replaces [u]"Independent at night"[/u]; for code 03 the label "Supervised only at night" replaces "Usually supervised during day"; for code 04 the label "Supervised at night and selected day times" replaces "Supervision always at night and at selected day times"; for code 05 the label "Supervised and night and part-time during day; not supervised during working hours (full time)" replaces "Supervised at night, and most day times, except during work"; the heading [u]"Full time indirect supervision"[/u] replaces [u]"Full time supervision"[/u]; for code 08 the label "Full time indirect supervision; does not check more than once every 30 minutes" replaces "Full time direct supervision, at least every 30 minutes"; for code 09 the label "Same as 08, and requires overnight safety precautions (lock, etc.)" replaces "Same as 08, and requires special safety precautions (lock, etc.)"; for code 10 the label "Full time direct supervision; checked more than once every thirty minutes" replaces "Full time supervision, more than once every thirty minutes"; for code 11 the label "Full time direct supervision in confined, controlled setting" replaces "Full time supervision in confined, controlled setting".
1998-09-01	Dropped code "77=not due", added code "00=variable did not exist".
1998-04-01	Variable added to database.



TRAUMATIC BRAIN INJURY MODEL SYSTEMS NATIONAL DATABASE SYLLABUS

**Funded by the National Institute on
Disability and Rehabilitation Research,
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Grant # H133A011403**

**Traumatic Brain Injury Model Systems
National Data Center
Kessler Medical Rehabilitation Research and
Education Corporation**

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Version 9.6
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00d.Title page.040614a

**TRAUMATIC BRAIN INJURY MODEL SYSTEMS
DATA COLLECTION FORM FOR INITIAL HOSPITALIZATION AND REHABILITATION - FORM I**
Use for cases first admitted to System acute hospital 7/1/2004 or later, until replaced by a newer Form I.

100. SYSTEM/SUBJECT ID: - **ENTER INTO DATABASE 9.6**

101. a. DATES: (MM DD YYYY)

08/08/8888=N/A 09/09/9999=Unknown

Injury: / / ER admit: / /

Acute d/c: / / Rehab adm: / /

Rehab d/c: / / Death: / /

102. SHORT TERM REHABILITATION INTERRUPTIONS:

08/08/8888=N/A 09/09/9999=Unknown

	Interruption Date				Return Date											
	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y
1 st Interrupt	<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"/>	<input type="text"/>	<input type="text"/>
2 nd Interrupt	<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"/>	<input type="text"/>	<input type="text"/>

103. PATIENT BIRTHDATE:

/ /

09/09/9999=Unknown

104. SEX:

1=Female 2=Male 9=Unknown

OBTAIN FROM BEST SOURCE (*person with TBI, unless unreliable or unavailable*)

105. RACE:

1=White 3=Asian/Pacific Islander 5=Hispanic origin 7=Other, unclassified
2=Black 4=Native American 9=Unknown

107. MARITAL STATUS:

1=Single (never married) 3=Divorced 5=Widowed 9=Unknown
2=Married/Cohab>=7 yrs 4=Separated 7=Other

108. PRIMARY PERSON LIVING WITH:

Injury	<input type="text"/>	01=Alone	06=Child>=21/other relative	11=Personal care attendant
Rehab Discharge	<input type="text"/>	02=Spouse	07=Roommate	77=Other
		03=Parent	08=Significant other	88=N/A-expired
		04=Sibling	09=Other patients	99=Unknown
		05=Child<21	10=Other residents	

109. RESIDENCE:

Injury: Rehab Discharge:

01=Private	03=Adult Home	05=Hotel	07=Acute Care	09=Hosp-Other	77=Other	
02=Nursing home	04=Correctional	06=Homeless	08=Rehabilitation	10=Sub-acute	88=Pt expired	99=Unk

109a. ZIP CODE:

8=N/A-expired or lived outside US 9=Unknown

Injury: Rehab Discharge:

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110a. YEARS OF EDUCATION:

07a.Form I Data Collection V9.6.040615

01= \leq 1 yr	04=4 yrs	07=7 yrs	11=11 yrs/12 yrs, no diploma	14=Associate degree	17=Work twd Master's, no dpl
02=2 yrs	05=5 yrs	08=8 yrs	12=HS diploma	15=Work twd Bach., no dpl	18=Master's degree
03=3 yrs	06=6 yrs	09=9 yrs	13=Work twd Assoc, no dpl	16=Bachelor's degree	19=Work twd Doctoral, no dpl
	10=10 yrs		77=Other	99=Unknown	20=Doctoral level

110b. GED: 1=No 2=Yes 3=NA-HS diploma or attended college 9=Unknown

111a. EMPLOYMENT STATUS:

Primary:

Secondary:

02=Full time student	11=Volunteer
03=Part time student	12=Retired (disability)
04=Special education	13=Unempl (not looking)
05=Competitively employed	14=Hospitalized, no pay
07=Taking care of house or fam.	15=Retired (other)
08=Special employed	77=Other
09=Retired (age)	88=No secondary employment
10=Unemployed (looking)	99=Unknown

CODING PRIORITY:

competitively empl, degree-oriented ed, taking care of house/fam, job-directed/on-the-job training, supported empl, sheltered empl, non-directed coursewrk, volunteer wrk, retiremt (age), retiremt (disab), no productive activity.

111b. HOURS/WEEK PAID COMPETITIVE EMPLOYMENT: 88=N/A-not currently competitively employed
 (enter hours only if V111a=05 for primary or secondary, otherwise code=88) 99=Unknown

If V111a=05 for primary or secondary, go to 111d.

If V111a NOT=05 for primary or secondary, ask: In the year before injury, were you ever competitively employed? If YES, go to 111d.

If NO and 111a=08 for primary or secondary, code 88 in 111d and 111i, then go to 112.

If NO and 111a NOT=08, code 88 in 111d, 111i, and 112, then go to 121.

111d. WEEKS EMPLOYED IN PAID COMPETITIVE EMPLOYMENT: 88=N/A-no comp emplmt
 In the year before your injury, how many weeks were you competitively employed? 99=Unknown

111i. ANNUAL EARNINGS OF PERSON:

What is your best estimate of your total annual salary from all jobs for the year prior to the injury?
 (cue patient that salary = total earnings from all competitive employment, but not from nonemployment sources.)

01=\$9,999 or less (employed)	07=\$60,000-\$69,999	77=Refused
02=\$10,000-\$19,999	08=\$70,000-\$79,999	88=N/A-no competitive employment
03=\$20,000-\$29,999	09=\$80,000-\$89,999	99=Unknown
04=\$30,000-\$39,999	10=\$90,000-\$99,999	
05=\$40,000-\$49,999	11=\$100,000 or more	
06=\$50,000-\$59,999		

112. CENSUS OCCUPATIONAL CATEGORY:
 (enter only if V111a=05 or 08 for primary or secondary, otherwise code=88)

01=Exec/Admin/Manager	05=Admin support/Clerical	09=Farming/Forestry/Fishing	14=Military
02=Professional specialty	06=Private household	10=Precision Production/Craft/Repair	
03=Technicians/support	07=Protective service	11=Machine Operators/Assemblers/Inspectors	88=N/A
04=Sales	08=Service other	12=Transportation/Material Moving	99=Unknown
		13=Handlers/Equip Clean/Helpers/Laborers	

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CLINICAL ASSESSMENTS

121. HISTORY OF TBI: 1=No 2=Yes 9=Unknown

130a. DATE ABLE TO FOLLOW SIMPLE MOTOR COMMANDS: / /
 (if person was always able to follow simple motor commands, code date of admission to ER)
 M M D D Y Y Y Y

07/07/7777=Never able to follow simple motor commands
 09/09/9999=Unknown

131h. ASSOCIATED INJURIES-SPINAL CORD INJURY: 1=No 2=Yes 9=Unknown

133a. CAUSE OF INJURY: (see syllabus for detailed list of causes within each code)

01=Motor vehicle (auto racing=18)	11=Assaults w/ blunt instrmt	17=Air sports
02=Motorcycle, moped	12=Other violence	18=Other sports (incl. auto racing)
03=Bicycle	13=Water sports	19=Fall (incl. jumping, being pushed)
04=ATV, go-kart, dune buggy	14=Field/Track	20=Hit by falling/flying object
05=Other vehicular (incl. aircraft)	15=Gymnastic	21=Pedestrian
10=gunshot wound	16=Winter sport	77=Other unclassified 99=Unknown

133b. E-CODES: E . E . 888.8=N/A 999.9=Unknown

134. ETOH BLOOD LEVEL: millig/dl 888=Not tested 999=Unknown

135. INTRACRANIAL CT DIAGNOSIS: (see syllabus for codes)

a. Extent of Compression:

b. Pathology: 1. 2. 3. 4.

5a1. 5b1. 5c1. 5d1. 5e1.

a2. b2. c2. d2. e2.

a3. b3. c3. d3. e3.

6a. 6b. 6c.

7a1. 7a2. 7a3. 7b1. 7b2. 7b3. 7c1. 7c2. 7c3.

c. Intraparenchymal Fragments: 1=No fragments 2=Yes, fragments 8=Not Done 9=Unknown

137. BRAIN INJURY ICD.9 CODES: 888.88=No further codes 999.99=Unknown

a. . b. . c. .

d. . e. . f. .

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100. SYSTEM/SUBJECT ID: - ENTER INTO DATABASE 9.6

139. GLASGOW COMA SCALE:

ED Admission

a. Eye Opening	<input type="text"/>	4=Spontaneous 3=To Voice	2=To Pain 1= None	7=Chemical Coma/Paralysis/Sedated* 9=Unknown
b. Verbal	<input type="text"/>	5=Oriented 4=Confused 3=Inapp. Words	2=Incomp Words 1=None	8=Intubated 9=Unknown 7=Chemical Coma/Paralysis/ Sedated*
c. Motor	<input type="text"/>	6=Obeys Commands 5=Localizes pain 4=Withdraw from pain	3=Flexion to pain 2=Extension to pain 1=None	7=Chemical Coma/Paralysis/ Sedated* 9=Unknown
d. Total (a+b+c)	<input type="text"/> <input type="text"/>	77=Chemical Coma/Paralysis/Sedated; Chem Coma/Paralysis/Sedated* & Intubated 88=Intubated 99=Unknown		

*code "7" & "77" if administered any of the following: midazolam (VERSED), lorzaepam (ATIVAN), vecuronium (NORCURON), pentobarbital (NEMBUTAL).

140. REVISED TRAUMA SCORE AT ADMISSION TO ED:

a. Respiratory Rate	<input type="text"/> <input type="text"/> <input type="text"/>	(#/minute)	888=Unmeasurable	999=Unknown
c. Systolic Blood Pressure.	<input type="text"/> <input type="text"/> <input type="text"/>	(mm Hg)	888=Unmeasurable	999=Unknown

144 a. DATE EMERGED FROM PTA (MM/DD/YYYY):

(if person was never in PTA, code date of admission to ER)

/ /

08/08/8888=Still had PTA or unconsciousness at TBI system discharge
09/09/9999=Unknown

b. METHOD OF PTA DETERMINATION

1=Chart Review 2=GOAT 3=GOAT-R 4=O-LOG 8=NA

146. ICD-9-CM CAUSE(S) OF DEATH CODES:

a. Primary cause	ICD-9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	777.77 Expired cause unknown 888.88 N/A-alive/no other internal cause/external cause 999.99 Unknown if expired
b. Secondary cause	ICD-9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
c. E-code	E	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	777.7 Expired cause unknown 888.8 NA-alive/not an external cause of death 999.9 Unknown if expired

148h. CRANIAL COMPLICATIONS-INTRACRANIAL HYPERTENSION:

1=No 2= \leq 24hr 3=peaks > 24hr 4=Sustained>24hrs
8=not monitored 9=Unknown

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ENTER INTO DATABASE 9.6

151. DISABILITY RATING SCALE:

	<u>Rehab</u> <u>Admit</u>		<u>Rehab</u> <u>Disch</u>		
1. Eye Opening	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0=Spontaneous 2=To Pain 9=Unknown 1=To Speech 3=None
2. Communication Ability	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0=Oriented 2=Inappropriate 4=None 1=Confused 3=Incomprehensible 9=Unknown
3. Motor Response	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0=Obeying 2=Withdrawing 4=Extending 1=Localizing 3=Flexing 5=None 9=Unknown
4. Feeding	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.0=Complete 1.5=Btw partial/minimal 3.0=None 0.5=Btw complete/partial 2.0=Minimal 1.0=Partial 2.5=Btw minimal/none 9.9=Unknown
5. Toileting	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
6. Grooming	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
7. Level of Functioning	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.0=Completely Independent 3.0=Moderately Dependent 0.5=Btw Comp, Indep/Spec Environ 3.5=Btw Mod Dep/Mark Dependent 1.0=Independent-Special Environ 4.0=Markedly Dependent 1.5=Btw Spec Envir/Mild Dependent 4.5=Btw Mark Dep/Tot Dependent 2.0=Mildly Dependent 5.0=Totally Dependent 2.5=Btw Mild Dep/Mod Dependent 9.9=Unknown
8. "Employability"	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.0= Not Restricted 2.0=Sheltered Wrkshop/Non-comp 0.5= Btw not restrict/select jobs 2.5=Btw Sheltered/Not Employable 1.0= Selected Jobs/Competitive 3.0=Not Employable 1.5= Btw select jobs/sheltered wkshp 9.9=Unknown

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152. FUNCTIONAL INDEPENDENCE MEASURE:

SELF CARE ITEMS:

ADMISSION DISCHARGE

1. Feeding	<input type="text"/>	<input type="text"/>
2. Grooming	<input type="text"/>	<input type="text"/>
3. Bathing	<input type="text"/>	<input type="text"/>
4. Dressing Upper Body	<input type="text"/>	<input type="text"/>
5. Dressing Lower Body	<input type="text"/>	<input type="text"/>
6. Toileting	<input type="text"/>	<input type="text"/>

7=Complete Independence (Timely, safely)
 6=Modified Independence (Extra time, device)
 5=Supervision (pt does 100%)
 4=Minimal Assistance (pt ≥75% of task)
 3=Moderate Assistance (pt 50-74% of task)
 2=Maximum Assistance (pt 25-49% of task)
 1=Total Assistance (pt <25% of task)
 0=Activity does not occur. (Use only at admission and only for #1-6,10-15; else use code "9".)
 8=N/A, pt walking/not using wheelchair. (only for item #14b)
 9=Unknown / assessed at >72 hours / activity does not occur (see instructions in code "0", above).
 66=Data not available with new (1/1/02) scoring. (Use only at admission and only for #1-8a, 9, 9a, 10-15)

SPHINCTER CONTROL:

8. Bladder Management	<input type="text"/>	<input type="text"/>
a. Level of assistance.....	<input type="text"/>	<input type="text"/>
b. Frequency of accidents.....	<input type="text"/>	<input type="text"/>
9. Bowel Management	<input type="text"/>	<input type="text"/>
a. Level of assistance.....	<input type="text"/>	<input type="text"/>
b. Frequency of accidents	<input type="text"/>	<input type="text"/>

MOBILITY ITEMS:

Transfer Technique

10. Bed, Chair, Wheelchair	<input type="text"/>	<input type="text"/>
11. Toilet	<input type="text"/>	<input type="text"/>
12. Tub or Shower	<input type="text"/>	<input type="text"/>

Locomotion

14a. Walking on admission	<input type="text"/>	<input type="text"/>
14b. Wheelchair on admission	<input type="text"/>	<input type="text"/>
14. Walking/Wheelchair-discharge (w/c/9)	<input type="text"/>	<input type="text"/>
15. Stairs	<input type="text"/>	<input type="text"/>

Use with 8b and 9b
 7=No accidents
 6=No accidents; uses device (catheter, ostomy)
 5=One accident in the past 7 days
 4=Two accidents in the past 7 days
 3=Three accidents in the past 7 days
 2=Four accidents in the past 7 days
 1=Five or more accidents in the past 7 days
 9= Unknown / assessed at >72 hours
 66=Variable did not exist

COMMUNICATIONS:

17. Comprehension ...(a/v/b/9)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
18. Expression (v/n/b/9)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PSYCHOSOCIAL ADJUSTMENT ITEMS:

22. Social Interaction	<input type="text"/>	<input type="text"/>
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COGNITIVE FUNCTION:

26. Problem Solving	<input type="text"/>	<input type="text"/>
27. Memory	<input type="text"/>	<input type="text"/>

TRAUMATIC BRAIN INJURY MODEL SYSTEMS
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170m1. STATUS OPERATIONS-CRANIOTOMY/CRANIECTOMY:

1=Neither 2=Craniotomy 3=Craniectomy 4=Both (separate procedures)
 9=Unknown

176. CHARGES:

a. Acute Hospitalization (Dollars only)\$, 999999=Unknown
 b. Inpatient Rehabilitation (Dollars only)\$,

178. PAYOR SOURCE:

a. Acute care Primary..... Secondary.....
 b. Rehabilitation Primary..... Secondary.....

01=Medicare (unk if traditional or managed care)	11=PPO
02=Medicaid (unk if traditional or managed care)	12=CHAMPUS
03=Workers Comp	14=Free Care
04=BC/BS	15=Medicare (traditional)
05=Private Insurance	16=Medicaid (traditional)
06=HMO	17=Medicare (managed care)
07=Self-Pay	18=Medicaid (managed care)
08=State Crippled Child	77=Other
09=Dept of Rehabilitation	88=N/A
10=No-fault	99=Unknown

192a1. PREMORBID DRUG USE:

1) Use of illicit/non-prescription drugs 1=No 2=Yes 9=Unknown

192a2. PREMORBID ALCOHOL USE: (Use the higher score if a range is given. Probe for size of drink and adjust scoring accordingly)

1) During the month before the injury, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor? 1=No 2=Yes 7=Refused 9=Unknown/Don't know/Not sure

2) During the month before the injury, how many days per week or per month did you drink any alcoholic beverages, on the average? (enter data into one of the following; code the other "66")

Enter number of days per week: **OR** Enter number of days per month:

66=N/A-Not Applicable 77= Refused 99=Unknown/Don't know/Not sure

3) A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average?

Enter number of drinks:

66=N/A-Not Applicable 77= Refused 99=Unknown/Don't know/Not sure

4) Considering all types of alcoholic beverages, how many times during the month before the injury did you have five or more drinks on an occasion?

Enter number of times:

00=None 66=N/A-Not Applicable 77=Refused 99=Unknown/Don't know/Not sure

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100. SYSTEM/SUBJECT ID: - ENTER INTO DATABASE 9.6

192h. PREMORBID HISTORY OF PENAL INCARCERATIONS WITH CONVICTION FOR FELONY:

1=No 2=Yes 9=Unknown

192i(3). PREMORBID HISTORY OF LEARNING AND/OR BEHAVIOR PROBLEMS IN SCHOOL:

Officially classified as Special Education student

1=No 2=Yes 9=Unknown

*** END ***

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

Follow-up evaluations are done in years 1, 2, 5, 10 and every fifth year thereafter. All items are collected at every follow-up. Items not collected due to skip instructions must be filled in with the appropriate "N/A" code.

20Aa. LIVING STATUS: a. ICD-9-CM Primary . 777.77=Expired cause unknown
 888.88=N/A-alive/no other internal cause/external cause
 999.99=Unknown if expired
 b. ICD-9-CM Secondary .
 777.7 =Expired cause unknown
 c. E-code E . 888.8 =NA-alive/not an external cause of death
 999.9 =Unknown if expired

20Ab. METHOD OF INTERVIEW DATA COLLECTION – PERSON WITH TBI :
 1=In-person interview 2=Telephone interview 3=Questionnaire mailing 8=No interview data provided by person w/ TBI

20Ac. METHOD OF INTERVIEW DATA COLLECTION – SIGNIFICANT OTHER:
 1=In-person interview 2=Telephone interview 3=Questionnaire mailing 8=No interview data provided by SO

20Ad. REASON PERSON WITH TBI NOT PROVIDING DATA:
 03=Physically or cognitively unable 07=Lost to follow-up
 04=Not available 08=Language barrier 88=N/A-data provided by person with TBI
 05=Stated refusal 09=Expired 99=Unknown reason why no data provided by person w/ TBI
 06=No response to contact

20Ae. IDENTITY OF SIGNIFICANT OTHER:
 01=Spouse 04=Adult child 08=Friend
 02=Parent(s) 05=Boy/girlfriend 09=Professional caregiver
 03=Sibling 07=Other relative 77=Other 88=N/A-no SO interviewed

201. DATES: (MM/DD/YYYY)
 Follow-up evaluation Date: / / 05/05/5555=N/A-withdrew authorization
 06/06/6666=N/A-deceased
 07/07/7777=N/A-other
 09/09/9999=Unknown date of evaluation
 Date of Death: / / 07/07/7777=Person expired, unk date
 08/08/8888=N/A-alive
 09/09/9999=Unknown if person expired

QUESTIONS FOR BEST SOURCE (person with TB unless unreliable/unavailable)

207. MARITAL STATUS: 1=Single (never married) 3=Divorced 5=Widowed 9=Unknown
 2=Married/Cohabit >= 7yrs 4=Separated 7=Other

208. PRIMARY PERSON LIVING WITH:
 01=Alone 05=Child aged <21 09=Other patients
 02=Spouse 06=Child >= 21/other rel 10=Other residents
 03=Parent(s) 07=Roommate/friend 11=Personal care attendant
 04=Sibling 08=Significant other 77=Other 99=Unknown

209. RESIDENCE:
 01=Private 05=Hotel 09=Other hospital
 02=Nursing home 06=Homeless 10=Subacute care
 03=Adult Home 07=Acute hospital 77=Other
 04=Correct. Inst. 08=Rehab hospital 99=Unknown

209a. ZIP CODE: 8=N/A-lives outside US 9=Unknown 12a.Form II Data Collection V9.6.040615

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

210a. YEARS OF EDUCATION:

- | | | | |
|-------------------|-------------|--|---------------------------------------|
| 01= \leq 1 year | 06=6 years | 11=11 years/ 12 years, no diploma | 16=Bachelors degree |
| 02=2 years | 07=7 years | 12= High school diploma | 17=Work toward Master’s dgr, no dpl |
| 03=3 years | 08=8 years | 13=Work toward Associate’s dgr, no dpl | 18=Master’s degree |
| 04=4 years | 09=9 years | 14=Associate’s degree | 19=Work toward doctoral level, no dpl |
| 05=5 years | 10=10 years | 15=Work toward Bachelor’s degree, no dpl | 20=Doctoral level degree |
| | | | 77=Other 99=Unknown |

210b. GED:

- 1=No 2=Yes 3=N/A-HS diploma or attended college 9=Unknown

211a. EMPLOYMENT STATUS:

CODING PRIORITY: competitively empl, degree-oriented ed, taking care of house/fam, job-directed/on-the-job training,

supported empl, sheltered empl, non-directed coursewrk, volunteer wrk, retiremt (age), retiremt (disab), no productive activity.

- | | | | |
|---------------------------|---------------------------------|--------------------------|--------------------|
| 02=Full-time student | 07=Taking care of house or fam. | 11=Volunteer | 15=Retired (other) |
| 03=Part-time student | 08=Special employment | 12=Retired (disability) | 77=Other |
| 04=Special education | 09=Retired (age) | 13=Unempl. (not looking) | 99=Unknown |
| 05=Competitively employed | 10=Unemployed (looking) | 14=Hospitalized, no pay | |

211b. HOURS (PER WEEK) PAID COMPETITIVE EMPLOYMENT:

(Enter data if 211a=05, otherwise enter the correct missing data code.)

- 88=N/A-not currently compet. employed
99=Unknown

If 211a NOT=05, ask: Have you ever been competitively employed since your injury?

If YES, go to 211c

If NO and 211a NOT=08, go to 221

If NO and 211a=08, go to 212

211c. DATE OF FIRST COMPETITIVE EMPLOYMENT:

(Obtain this answer only once. Estimate day, if unknown.)

M M D D Y Y Y Y

1) When did you begin competitive employment following your injury?

/ /

08/08/8888 = N/A-no post-injury competitive employment

09/09/9999 = Unknown date of evaluation

08/08/8899 = N/A-employment started prior to last annual evaluation

If competitive employment started prior to this year, ask: Have you been competitively employed in the past year?

If YES, go to 211d

If NO and 211a NOT=05 or 08, go to 221

If NO and 211a=08, go to 212

211d. WEEKS OF PAID COMPETITIVE EMPLOYMENT:

1) Ask at one year: During the year after your injury and since you began competitive employment, how many weeks have you worked?

- 88=NA-no compet. employmt
99=Unknown

Ask other years: In the past year since your return to work, during how many weeks were you competitively employed?

211i. ANNUAL EARNINGS OF PERSON:

(Enter data if V211a=05, otherwise enter the correct missing data code.)

1) What is your total annual salary, based on all jobs held at the time of annual evaluation?

(cue respondent that salary=total earnings from all competitive employment, but not from nonemployment sources.)

- | | | | |
|-------------------------------|----------------------|----------------------|---------------------------------------|
| 01=\$9,999 or less (employed) | 05=\$40,000-\$49,999 | 09=\$80,000-\$89,999 | 77=Refused |
| 02=\$10,000-\$19,999 | 06=\$50,000-\$59,999 | 10=\$90,000-\$99,999 | 88=N/A-not currently compet. employed |
| 03=\$20,000-\$29,999 | 07=\$60,000-\$69,999 | 11=\$100,000 or more | 99=Unknown |
| 04=\$30,000-\$39,999 | 08=\$70,000-\$79,999 | | |

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

212. CENSUS OCCUPATIONAL CATEGORY:

(Enter data if V211a=05 or 08, otherwise code 88)

- | | | |
|---------------------------|--------------------------------------|--|
| 01=Exec/Admin/Manager | 06=Private household | 11=Machine Operators/Assemblers/Inspectors |
| 02=Professional specialty | 07=Protective services | 12=Transportation/Material Moving |
| 03=Technicians/support | 08=Service, other | 13=Handlers/Equip Cleaner/Helpers/Laborers |
| 04=Sales | 09=Farm/Forest/Fish | 14=Military |
| 05=Adm support/Clerical | 10=Precision Production/Craft/Repair | 88=N/A |
| | | 99= Unknown |

CLINICAL ASSESSMENTS

221. DATE OF SUBSEQUENT TRAUMATIC BRAIN INJURY:

M M Y Y Y Y
 /

77/7777=had subsequent TBI date unknown
 88/8888=no subsequent TBI

99/9999=unknown if subsequent TBI

248f. MORBIDITY VARIABLES - CRANIAL: (collect until 12/31/04)

Any seizures since last evaluation? 1=No 2=Yes 9=Unknown

QUESTIONS FOR BEST SOURCE

251. DISABILITY RATING SCALE:

1. Eye Opening.....	<input type="checkbox"/>	0=Spontaneous 2=To Pain 1=To Speech 3=None 9=Unknown
2. Communication Ability.....	<input type="checkbox"/>	0=Oriented 2=Inappropriate 4=None 1=Confused 3=Incomprehensible 9=Unknown
3. Motor Response	<input type="checkbox"/>	0=Obeying 2=Withdrawing 4=Extending 1=Localizing 3=Flexing 5=None 9=Unknown
4. Feeding	<input type="checkbox"/> <input type="checkbox"/>	0.0=Complete 1.5=Btw Partial/Minimal 3.0=None 0.5=Btw Complete/Partial 2.0=Minimal 1.0=Partial 2.5=Btw Minimal/None 9.9=Unknown
5. Toileting	<input type="checkbox"/> <input type="checkbox"/>	
6. Grooming	<input type="checkbox"/> <input type="checkbox"/>	
7. Level of Functioning	<input type="checkbox"/> <input type="checkbox"/>	0.0=Completely Independent 3.0=Moderately Dependent 0.5=Btw Comp. Indep/Spec Environ 3.5=Btw Mod Dep/Mark Dependent 1.0=Indep in Special Environment 4.0=Markedly Dependent 1.5=Btw Spec Envir/Mild Dependent 4.5=Btw Mark Dep/Tot Dependent 2.0=Mildly Dependent 5.0=Totally Dependent 2.5=Btw Mild Dep/Mod Dependent 9.9=Unknown
8. "Employability"	<input type="checkbox"/> <input type="checkbox"/>	0.0=Not Restricted 2.0=Sheltered Workshop/Non-competitive 0.5=Btw not restricted/Selected jobs 2.5=Btw Sheltered/Not Employable 1.0=Selected Jobs/Competitive 3.0=Not Employable 1.5=Btw selected jobs/sheltered wkshp 9.9=Unknown

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – **FORM II**

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

297. SUPERVISION RATING SCALE (Refer to variable page for definitions and clarification.)

Independent

01=Alone, Independent

02=Unsupervised at night, sometimes during day

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Overnight supervision

03=Supervised only at night

Part Time supervision

04=Supervised at night and selected day times.

05=Supervised at night and part-time during day; not supervised during working hours (full time)

06=Supervised at night and most of day except for few unsupervised hours.

07=Only unsupervised for periods less than one hour at a time.

Full-time indirect supervision

08=Full time indirect supervision; does not check more than once every 30 minutes

09=Same as 08, and requires overnight safety precautions (lock, etc.)

Full time direct supervision

10=Full time direct supervision; checked more than once every thirty minutes

11=Full time direct supervision in confined, controlled setting.

12=Same as 11, but with constant visual watch

13=Person is in physical restraints.

99=Unknown

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

252. FUNCTIONAL INDEPENDENCE MEASURE:

SELF CARE ITEMS:

- 1. Feeding
- 2. Grooming
- 3. Bathing
- 4. Dressing Upper Body
- 5. Dressing Lower Body
- 6. Toileting

7=Complete Independence (Timely, safely)
 6=Modified Independence (Extra time, device)
 5=Supervision
 4=Minimal Assistance (pt ≥75% of task)
 3=Moderate Assistance (pt 50-74% of task)
 2=Maximum Assistance (pt 25-49% of task)
 1=Total Assistance (pt <25% of task; doesn't do)
 9=Unknown/assessment not done
 66=Variable did not exist (8a,9a only)

SPHINCTER CONTROL:

- 8. Bladder Management.....
- a. Level of assistance
- b. Frequency of accidents
- 9. Bowel Management.....
- a. Level of assistance
- b. Frequency of accidents

Use with 8b and 9b

7=No accidents
 6=No accidents; uses device (catheter, ostomy)
 5=One accident in the past 7 days
 4=Two accidents in the past 7 days
 3=Three accidents in the past 7 days
 2=Four accidents in the past 7 days
 1=Five or more accidents in the past 7 days
 9=Unknown/assessment not done
 66=Variable did not exist (8b,9b only)

MOBILITY ITEMS:

Transfer Technique

- 10. Bed, Chair, Wheelchair
- 11. Toilet
- 12. Tub or Shower

Locomotion

- 14a. Walking/Wheelchair (w/c/9).....
- 15. Stairs

COMMUNICATIONS:

- 17. Comprehension...(a/v/b/9).....
- 18. Expression.....(v/n/b/9).....

PSYCHOSOCIAL ADJUSTMENT ITEMS:

- 22. Social Interaction

COGNITIVE FUNCTION:

- 26. Problem Solving.....
- 27. Memory

273. REHOSPITALIZATION(S): (code one reason for each hospitalization in the past year) 1.

- 00=Rehabilitation (inpatient) 05=Orthopedic
- 01=Seizures 06=General Health Maintenance or OB/GYN
- 02=Neurologic disorder (non-seizure) 07=Other not specified above
- 03=Psychiatric 08=NA-no rehospitalizations or no further rehospitalizations
- 04=Infectious 09=Unknown--rehospitalized but reason is unknown
- 99=Unknown if rehospitalized

- 2.
- 3.
- 4.
- 5.

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

296. GLASGOW OUTCOME SCALE – EXTENDED: (see Appendix O for administration and coding guidelines)

Take into account all available information.

Enter data into boxes that are not skipped per instructions.

1. Is the head-injured person able to obey simple commands, or say any words ? 2=Yes 1=No
If NO, skip rest of questions, code GOS-E = 2 “VS”. 9=Unknown
- 2a. Is the assistance of another person at home essential every day for some activities of daily living? 2=Yes 1=No
If NO, skip to 3a. 9=Unknown
- 2b. Do they need frequent help or someone around at home most of the time ? 9=Unknown
 1=No 2=Yes
- 2c. Was assistance at home essential before the injury ? 2=Yes 1=No
*If NO, skip rest of questions, code GOS-E=3 “LSD” if 2b=2,
 or code GOS-E=4 “USD” if 2b=1.* 9=Unknown
- 3a. Are they able to shop without assistance ? 2=Yes 1=No
If YES, skip to 4a. 9=Unknown
- 3b. Were they able to shop without assistance before the injury ? 2=Yes 1=No
If YES, skip rest of questions, code GOS-E=4 “USD”. 9=Unknown
- 4a. Are they able to travel locally without assistance ? 2=Yes 1=No
If YES, skip to 5a. 9=Unknown
- 4b. Were they able to travel without assistance before the injury ? 2=Yes 1=No
If YES, skip rest of questions, code GOS-E=4 “USD”. Unknown
- 5a. Are they currently able to work to their previous capacity ? 2=Yes 1=No
If YES, skip to 6a. 9=Unknown
- 5b. How restricted are they ? *Choose one.* 9=Unknown
 1=Reduced work capacity
 2=Able to work only in a sheltered workshop or non-competitive job,
 or currently unable to work.
- 5c. Were they either working or seeking employment before the injury (answer ‘yes’) or were they doing neither (answer ‘no’) ? 2=Yes 1=No
*If YES, skip rest of questions, code GOS-E=5 “LMD” if 5b=2
 or code GOS-E=6 “UMD” if 5b=1.* 9=Unknown
- 6a. Are they able to resume regular social and leisure activities outside home ? 2=Yes 1=No
If YES, skip to 7a. 9=Unknown
- 6b. What is the extent of restriction on their social and leisure activities ? *Choose one.* 9=Unknown
 1=Participate a bit less: at least half as often as before injury
 2=Participate much less: less than half as often
 3=Unable to participate: rarely, if ever, take part.

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

296. GLASGOW OUTCOME SCALE – EXTENDED (cont.)

Enter data into boxes that are not skipped per instructions.

6c. Did they engage in regular social and leisure activities outside the home before the injury ? 2=Yes 1=No
*If YES, skip rest of questions, code GOS-E=5 “LMD” if 6b=3,
 or code GOS-E=6 “UMD” if 6b=2,
 or code GOS-E=7 “LGR” if 6b=1.* 9=Unknown

7a. Have there been psychological problems which have resulted in ongoing family disruption or disruption of friendships ? 2=Yes 1=No
If NO, skip to 8a 9=Unknown

7b. What has been the extent of disruptions or strain ? *Choose one.* 9=Unknown
 1=Occasional – less than weekly.
 2=Frequent or constant – once a week or more but tolerable.
 3=Constant – daily and intolerable.

7c. Were there problems with family or friends before the injury ? 2=Yes 1=No
*If NO, skip rest of questions, code GOS-E=5 “LMD” if 7b=3,
 or code GOS-E=6 “UMD” if 7b=2,
 or code GOS-E=7 “LGR” if 7b=1.* 9=Unknown

8a. Are there any other current problems relating to the injury which affect daily life ? 2=Yes 1=No
If NO, skip 8b, code GOS-E=8 “UGR”. 9=Unknown

8b. Were similar problems present before the injury ? 2=Yes 1=No
If NO, code GOS-E=7 “LGR”. 9=Unknown
*If YES: If pre and post injury status essentially equal, code GOS-E=8 “UGR”,
 or if pre and post injury status not essentially equal, use judgement to code GOS-E*

The patient’s overall rating is based on the lowest outcome category indicated on the scale. Refer to guidelines in Appendix O for further information concerning administration and scoring.

- 0=Variable didn’t exist
- 1=Dead
- 2=Vegetative State (VS)
- 3=Lower Severe Disability (LSD)
- 4=Upper Severe Disability (USD)
- 5=Lower Moderate Disability (LMD)
- 6=Upper Moderate Disability (UMD)
- 7=Lower Good Recovery (LGR)
- 8=Upper Good Recovery (UGR)
- 9=Unknown

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

292a1(1). DRUG USE:

During the last 12 months did you use any illicit or non-prescription drugs? 1=No
2=Yes 9=Unknown

292a2. ALCOHOL USE:

(Use the higher score if a range is given. Probe for size of drink, and adjust scoring accordingly.)

1) During the past month, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor?

1=No 2=Yes 7= Refused 9= Unknown/Don't know/not sure

2) During the past month, how many days per week or per month did you drink any alcoholic beverages, on the average? *(Enter data into one of the following; code the other "66")*

Enter number of days per week : **OR** Enter number of days per month:

66=N/A 77= Refused 99= Unknown/Don't know/Not sure

3) A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average? Enter number of drinks:

66=N/A 77= Refused 99= Unknown/Don't know/Not sure

4) Considering all types of alcoholic beverages, how many times during the past month did you have five or more drinks on an occasion? Enter number of times:

00=None 66=N/A 77= Refused 99=Unknown/Don't know/Not sure

292b. TRANSPORTATION: Primary motorized transport mode

1=Drives vehicle 3=Public transit 5=N/A-no motorized transp. 8=N/A
2=Rides w/someone else 4=Special bus 9=Unknown

292c. INCOME AND SOURCE: (1) Family income

01=\$9,999 or less	05=\$40,000-\$49,999	09=\$80,000-\$89,999	77=Refused
02=\$10,000-\$19,999	06=\$50,000-\$59,999	10=\$90,000-\$99,999	88=N/A-not employed
03=\$20,000-\$29,999	07=\$60,000-\$69,999	11=\$100,000 or more	99=Unknown
04=\$30,000-\$39,999	08=\$70,000-\$79,999		

(2) Person with brain injury's non-employment income:

1=No 2=Yes 9=Unknown

a) SSI SSD TA/TANF (formerly AFDC) Welfare Unemp Ins Work Comp Pvt Ins Settlement Other

292e(1). ARRESTS:

In the past year, have you been arrested ? 1=No 2=Yes 9=Unknown

TRAUMATIC BRAIN INJURY MODEL SYSTEMS

DATA COLLECTION FORM FOR ANNUAL FOLLOW-UP EVALUATION – FORM II

Use for cases with follow-up completion date or window closing date (if no contact) 7/1/04 or later, until replaced by a newer Form II

200. SYSTEM/SUBJECT ID : - - **ENTER INTO DATABASE 9.6**

292f. PSYCHIATRIC PROBLEMS:

- 1) Attempted suicide in the past year ?
- 2) Any psychiatric hospitalizations in the past year ?

<input type="text"/>	1=No 2=Yes 9=Unk
<input type="text"/>	

QUESTION FOR PERSON WITH BRAIN INJURY ONLY

292g. SATISFACTION WITH LIFE:

- 1) In most ways my life is close to my ideal.....
- 2) The conditions of my life are excellent.....
- 3) I am satisfied with my life.....
- 4) So far I have gotten the important things I want in life.....
- 5) If I could live my life over, I would change almost nothing

1=Strongly disagree
2=Disagree
3=Slightly disagree
4=Neither agree nor disagree
5=Slightly agree
6=Agree
7=Strongly agree
9=Unknown
10= N/A-no data from person w/ TBI

*** END ***

SYLLABUS CHANGES for 3rd QUARTER 2004 (V9.6)

Some format changes and minor edits listed below as occurring for 3rd quarter of 2004 may have already been present in the early May release of the live syllabus.

Var/Topic	Date due	In Var History?	Description	Job done?	Syllab do?	DC form done?	done?	done
IVPs								
	04Q3	y	Many Var Changes Boxes say an instruction was added “to collect from best source”, but the instruction isn’t on the IVP. CHECK AND FIX.	X	X	X		
	04Q3	y	Add back in all codes for “Variable not due this followup”, followed by parenthetical stating that the codes are no longer used.	X	X	X		
	(04Q3)	y	Add note to each 192 var that these vars were first collected in 1/1997 but MSs were encouraged to retroactively collect this data during follow-ups with older cases. So, there will be data for some cases that were enrolled prior to 1997.	X	X	X		
FORM I								
100	04Q3	n	Indicate that GA and MO are also defunded.	X	X	X		
111i	04Q3	y	In VAR HIST for 7/1/2002, change “year prior to evaluation” to “year prior to injury”	X	X	X		
131	04Q3	n	METAVARIABLE-ASSOCIATED INJURIES. Delete. [Copy info in SOURCE box to SOURCE box in 131h. Move deletion information to deletion list.]	X	X	X		
131h	04Q3	n	Add SOURCE box. Enter “ASIA” (move from 131-no new info added)	X	X	X		
144a	04Q3	n	Remove instruction to use GOAT in neuropsych exam.	X	X	X		
144a	04Q3	y	Add links to COMBI	X	X	X		
146	04Q3	y	Make consistent with V20Aa: For ICD-9-CM and E-code, add CODE “777.7(7)=Person expired but cause of death unknown”. ICD-9-CM code 888.88: reword to “Not applicable—Person alive, or no other internal cause of death indicated, or death due to external causes”. E-code 888.8: reword to “Not applicable—Person alive, or death not due to external causes”.	X	X	X	X	X
148	04Q3	n	METAVARIABLE-CRANIAL COMPLICATIONS. Delete. [No info to copy to other vars. Make sure deletion info is on List of deleted vars.]	X	X	X		
151	04Q3	y	Add to TRAINING: info about certification (copy from 22f.Data Quality Guidelines.)	X	X	X		
152	04Q3	y	Add to TRAINING: info about certification (copy from 22f.Data Quality Guidelines.)	X	X	X		
152	04Q3	Y	Fix link to 4/1/2004 IRF-PAI manual	X	X	X		
152	04Q3	n	Add FAM items to list of deleted variables.	X	X	X		

SYLLABUS CHANGES for 3rd QUARTER 2004 (V9.6)

Some format changes and minor edits listed below as occurring for 3rd quarter of 2004 may have already been present in the early May release of the live syllabus.

Var/Topic	Date due	In Var History?	Description	Job done?	Syllab do?	DC form done?	done?	done
170	04Q3	n	METAVARIABLE - STATUS OPERATIONS ACUTE. Delete. [No info to copy to vars. Make sure deletion info is on List of deleted vars.]	X	X	X		
192	04Q3	n	METAVARIABLE – PREMORBID HISTORY. Delete. [No info to to other IVPs.]	X	X	X		
192	04Q3	n	In DEFINITION, change h/her to his/her.	X	X	X		
192a2	04Q3	y	Change EXAMPLE—either 2a or 2b should be 66.	X	X	X		
192a2	04Q3	Y	Move note about data prior to 1/1/97 to CHARACTERISTICS OF DATA	X	X	X		
192h	04Q3	Y	Added to CHARACTERISTICS OF DATA a note about cases existing prior to date variable added to database.	X	X	X		
192i	04Q3	y	Delete references to the dropped items (1,2,4).	X	X	X		
192i	04Q3	y	Correct EXAMPLES so codes for deleted items (1,2,4) are not shown. Perhaps rewrite the example to retain the current info.	X	X	X		
192i	04Q3	Y	Add to CHARACTERISTICS OF DATA an explanation of data existing prior to 1/1/97.	X	X	X		
FORM II								
02	04Q3	y	Change var number from 001 to 02.	X	X	X		
20A	04Q3	n	METAVARIABLE – ADMINISTRATIVE CODES. Delete. [No information to move to other places, since list of deleted vars has been created.]	X	X	X		
20Aa	04Q3	y	ICD-9-CM code 888.88: reword to “Not applicable—Person alive, or no other internal cause of death indicated, or death due to external causes.” E-code 888.8: reword to “Not applicable—Person alive, or death not due to external causes”.	X	X	X	X	X
200	04Q3	y	In DEFINITION, replace “annual” with “follow-up” (or other word)	X	X	X		
200	04Q3	y	In EXAMPLE, replace “annual” with “follow-up” (or other word)	X	X	X		
207	04Q3	y	In DEFINITION, replace “annual” with “follow-up” (or other word)	X	X	X		
207	04Q3	y	In DEFINITION, add note that this is a best source variable. Correct the VAR HIST box.	X	X	X		
208	04Q3	y	In DEFINITION, replace “annual” with “follow-up” (or other word)	X	X	X		
208	04Q3	y	In DEFINITION, add a note that this is a best source variable. Correct the VAR HIST box.	X	X	X		
209	04Q3	y	Add that this is a best source variable. Correct the VAR HIST box.	X	X	X		
209a	04Q3	y	Add that this is a best source variable. Correct the VAR HIST box.	X	X	X		

SYLLABUS CHANGES for 3rd QUARTER 2004 (V9.6)

Some format changes and minor edits listed below as occurring for 3rd quarter of 2004 may have already been present in the early May release of the live syllabus.

Var/Topic	Date due	In Var History?	Description	Job done?	Syllab do?	DC form done?	done
210a	04Q3	n	In NOTE, "has" should be "as".	X	X	X	
210b	04Q3	n	In NOTE, "h/she" should be "he/she".	X	X	X	
211a	04Q3	y	Change code labels that state "4 weeks prior to injury" to "last 4 weeks".	X	X	X	
211a	04Q3	y	Add 66 code (var did not exist)	X	X	X	
211a	04Q3	y	In DEFINITION, replace "annual" with "follow-up" (or other word)	X	X	X	
211a	04Q3	y	In NOTES, replace "annual" with "follow-up" (or other word)	X	X	X	
211a	04Q3	y	In VARIABLE HISTORY, change "added that variable added" to "added that new variable added".	X	X	X	
211b	04Q3	y	In DEFINITION, remove reference to "annual" evaluation.	X	X	X	
211b	04Q3	y	In NOTES, remove reference to "secondary" employment status.	X	X	X	
211d	04Q3	y	In DEFINITION, replace "annual" with "follow-up" (or other word)	X	X	X	
211d	04Q3	y	In DEFINITION, replace "since the last evaluation" with "in the last year"	X	X	X	
211d	04Q3	y	In CODES 8, change "since the last evaluation" to "in the last year"	X	X	X	
248	04Q3	n	METAVARIABLE – MEDICAL MORBIDITY: CRANIAL. Delete. No info to move to other places, since list of deleted vars has been created.]	X	X	X	
251	04Q3	y	In DEFINITION, in two places replace "annual" with "follow-up" (or other word)	X	X	X	
251	04Q3	y	For items 1-3, add the code "7=Not due this year". After the code label, insert "(This code is no longer used.)"	X	X	X	
251	04Q3	y	For item 6, add the code "7.7=Not due this year". After the code label, insert "(This code is no longer used.)"	X	X	X	
251	04Q3	y	Add to TRAINING: info about certification (copy from 22f.Data Quality Guidelines.)	X	X	X	
251	04Q3	y	In setting up the LS, Form I instructions were incorrectly copied into DEFINITION. Replace Form I instructions with instructions for Form II.	X	X	X	
252	04Q3	Y	Fix link to 4/1/2004 IRF-PAI manual	X	X	X	
252	04Q3	y	Add to TRAINING: info about certification (copy from 22f.Data Quality Guidelines.)	X	X	X	
252	04Q3	y	Add code"8=Not due this year". After the code label, insert "(This code is no longer used.)"	X	X	X	

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Var/Topic	Date due	In Var History?	Description	Job done?	Syllab do?	DC form done?		
292	04Q3	n	METAVARIABLE – COMMUNITY INTEGRATION QUESTIONS. Delete. No info to be added to what already exists in other IVPs.	X	X	X		
292a1	04Q3	y	In DESCRIPTION, replace “annual” with “follow-up”	X	X			
292a1	04Q3	y	Add code “7=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
292a2	04Q3	y	Add code “5(55)=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
292a2	04Q3	y	Change EXAMPLE—either 2a or 2b should be 66.	X	X	X		
292b	04Q3	y	Add code “7=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
292c	04Q3	y	Remove from DEFINITION the word “amount” (regarding part 2a).	X	X	X		
292c(1)	04Q3	y	Add code 66=Not due this year. After the code label, insert “(This code is no longer used.)”	X	X	X		
292c(2a)	04Q3	y	Add code “7=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
292e	04Q3	y	Add code “7=Not due this year”; After the code label, insert “(This code is no longer used.)”	X	X	X		
292f	04q3	y	Add code “7=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
292g	04Q3	y	In DESCRIPTION, replace “annual” with “follow-up” (or other word)	X	X	X		
292g	04Q3	y	Add code “8=Not due this year”. After the code label, insert “(This code is no longer used.)”	X	X	X		
296	04Q3	y	Revise note about subscale scores so the data collector and data entry person treat them as an accuracy check for the overall score.	X	X	X		
296	04Q3	y	Remove instruction to enter only the overall score into the datbase.	X	X	X		
297	04Q3	y	In DEFINITION, replace “annual” with “follow-up” (or other word)	X	X	X		
DOCS								
00c	04Q3	n	Delete. This memo became obsolete when LS was implemented. (In the future, replace this with instructions for accessing the live syllabus, etc.)	X	X	X		

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Var/Topic	Date due	In Var History?	Description	Job done?	Syllab do?	DC form done?	done?	done
Syllabus Changes		n	Update this with all changes made for the quarter.					
UPDATE VERSION # EACH QTR								
		n	Footer in live syllabus					
		n	Form I data collection form	X			X	X
		n	Form II data collection form	X			X	X
		n	Premorbid Hist-Patient	X			X	X
		n	Premorbid Hist-Family	X			X	X
			Title page: update the date.	X	X	X		
		n						
CONTACT INFO								
	04Q3	n	Change Jerry Wright's title to "Research Manager"	X				
	04Q3	n	Change Laura Jamison's title to "Research Associate".	X				
MAYBE NEXT QTR								
101a		Y	Add CODE "07/07/7777 = patient still in inpatient rehab at time of data submission"		X		X	
101a		Y	Add NOTE to replace "07/07/7777" with date of discharge once patient is discharged.					
101a		Y	Add to CHARACTERISTICS OF DATA that cases with "07/07/7777" in "Date discharged from inpatient rehabilitation facility" are not included in the Missing Data Report.					

Detailed_list_of_changes.9.6www.040615

