# Philadelphia BrainSTEPS Consulting Team

Office of Prevention and Intervention
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## Permission for Consultation

**Student Name:** _____ **Date of Birth:** _____

**School Building:** _____ **Current Age:** _____

**Regular Education or Special Education (circle one)** **Date of Injury:** _____

**Grade Prior to Injury:** _____ **Current Grade:** _____

**Medical Diagnosis:** _____

**Parent Name:** _____ **Date:** _____

**Address:** _____ **Phone:** _____

_____ **Email:** _____

Dear Parent:
Your child or adolescent has been referred to the Philadelphia BrainSTEPS Team. The Philadelphia BrainSTEPS Team provides consultation to family and schools as students prepare to re-enter the educational system following an acquired brain injury. The reason for this referral is:

_____

_____

The purpose of this consultation is to assist school personnel in better understanding effects of an acquired brain injury and how to accommodate possible changes in cognitive or psychosocial performance through provision of appropriate accommodations. The following consultative procedures are recommended:

- Record Review (Medical, Neuropsychological, Educational)
- Interviews (Parents, Teacher, Student, Family)
- Observation (s)
- Screening Measure
- Consultation (Educational Team, BrainSTEPS Team, Medical Team)
- Team Meeting participation (including recommendations and accommodations)

If you agree with the consultation, Check YES and return to the Philadelphia BrainSTEPS Team

_____ YES I agree to the proposed consultation by the BrainSTEPS Team.

_____ NO I do not agree to the proposed consultation.

_____ _____

**Parent Signature** **Date**

BrainSTEPS
Strategies Teaching Educators, Parents, & Students
A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM

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Has your child had a history of any of the following diagnosed ***PRIOR*** to their brain injury occurring?

| | |
|---|---|
| History of prior concussions | Y or N |
| Other type of brain injury that occurred after birth | Y or N Describe: _____ |
| History of migraines | Y or N |
| Family history of migraines | Y or N |
| History of learning disabilities | Y or N Describe: _____ |
| History of depression: | Y or N |
| History of anxiety | Y or N |
| History of panic disorder or panic attacks | Y or N |
| History of suicidal ideation | Y or N |
| History of attempted suicide | Y or N |
| History of mental health or emotional disorders | Y or N |
| History of sleep disorders or sleep issues | Y or N |
| History of seizures | Y or N |
| History of attention disorders (ADHD, ADD) | Y or N |
| History of vision issues | Y or N Describe: _____ |
| History of dyslexia | Y or N |
| History of motion sickness | Y or N |
| History of therapy (OT/PT/SLP, hearing, vision, counseling) | Y or N Describe: _____ |

**Please list medications take prior to brain injury:**

**Please circle what your child has experienced *SINCE* his/her brain injury:** (Diagnosed not required)

Migraines Depression Anxiety Panic attacks Suicidal Ideation Attempted Suicide
Emotional Outburst Social withdrawal from friends Fatigue Sleep Issues Therapy
Seizures Spacy/Foggy Attention Issues Vision issues Dyslexia Motion Sickness Lazy Eye

**Please list current medications:**

_____ _____

**Parent Signature** **Date**