

Standardized Assessment of Concussion (SAC)

ORIENTATION

Score: ____ / 5

What month is it?	0	<input type="checkbox"/>	1	<input type="checkbox"/>
What is the date?	0	<input type="checkbox"/>	1	<input type="checkbox"/>
What day of the week is it?	0	<input type="checkbox"/>	1	<input type="checkbox"/>
What year is it?	0	<input type="checkbox"/>	1	<input type="checkbox"/>
What time of day is it? (<i>w/in 1 hour</i>)	0	<input type="checkbox"/>	1	<input type="checkbox"/>

IMMEDIATE MEMORY

Score: ____ / 15

<u>Form A</u>	<u>Form B</u>	<u>Form C</u>	<u>Form D</u>
Elbow	Candle	Baby	Monkey
Apple	Paper	Monkey	Penny
Carpet	Sugar	Perfume	Blanket
Saddle	Sandwich	Sunset	Lemon
Bubble	Wagon	Iron	Insect

	Trial 1		Trail 2		Trail 3	
Word 1	0	<input type="checkbox"/>	1	<input type="checkbox"/>	0	<input type="checkbox"/>
Word 2	0	<input type="checkbox"/>	1	<input type="checkbox"/>	0	<input type="checkbox"/>
Word 3	0	<input type="checkbox"/>	1	<input type="checkbox"/>	0	<input type="checkbox"/>
Word 4	0	<input type="checkbox"/>	1	<input type="checkbox"/>	0	<input type="checkbox"/>
Word 5	0	<input type="checkbox"/>	1	<input type="checkbox"/>	0	<input type="checkbox"/>

NEUROLOGIC SCREENING

Loss of Consciousness: (*occurrence, duration*)

Retrograde Amnesia

Antegrade Amnesia

Strength

Sensation

Coordination

CONCENTRATION: *Digits Backwards*

Score: ____ / 5

Form A

4-9-3	6-2-9	0	<input type="checkbox"/>	1	<input type="checkbox"/>
3-8-1-4	3-2-7-9	0	<input type="checkbox"/>	1	<input type="checkbox"/>
6-2-9-7-1	1-5-2-8-5	0	<input type="checkbox"/>	1	<input type="checkbox"/>
7-1-8-4-6-2	5-3-9-1-4-8	0	<input type="checkbox"/>	1	<input type="checkbox"/>

Form B

5-2-6	4-1-5	0	<input type="checkbox"/>	1	<input type="checkbox"/>
1-7-9-5	4-9-6-8	0	<input type="checkbox"/>	1	<input type="checkbox"/>
4-8-5-2-7	6-1-8-4-3	0	<input type="checkbox"/>	1	<input type="checkbox"/>
8-3-1-9-6-4	7-2-4-8-6-5	0	<input type="checkbox"/>	1	<input type="checkbox"/>

Form C

1-4-2	6-5-8	0	<input type="checkbox"/>	1	<input type="checkbox"/>
1-8-3-1	3-4-8-1	0	<input type="checkbox"/>	1	<input type="checkbox"/>
4-9-1-5-3	6-8-2-5-1	0	<input type="checkbox"/>	1	<input type="checkbox"/>
3-7-6-5-1-9	9-2-6-5-1-4	0	<input type="checkbox"/>	1	<input type="checkbox"/>

Months in Reverse Order

Dec_Nov_Oct_Sept_Aug_Jul_Jun_May_Apr_Mar_Feb_Jan
 0 1

DELAYED RECALL

Score: ____ / 5

Word 1	0	<input type="checkbox"/>	1	<input type="checkbox"/>
Word 2	0	<input type="checkbox"/>	1	<input type="checkbox"/>
Word 3	0	<input type="checkbox"/>	1	<input type="checkbox"/>
Word 4	0	<input type="checkbox"/>	1	<input type="checkbox"/>
Word 5	0	<input type="checkbox"/>	1	<input type="checkbox"/>

SCORE TOTALS

Orientation = ____ / 5

Immediate Memory = ____ / 15

Concentration = ____ / 5

Delayed Recall = ____ / 5

Overall Score

/ 30