COGNITIVE HEALTH
St John's Medical Center

Youth Athlete Concussion Baseline Testing

St John's Cognitive Health offers concussion baseline testing for youth athletes using the computerized cognitive test imPACT©. The imPACT test measures abilities in verbal and visual memory, processing speed, and reaction time, and provides comparison to standardized norms. It is appropriate for children ages 10 and up. The imPACT test is designed for use as part of a complete evaluation by a medical professional and can be helpful in determining when an athlete can return safely to physical activity and competition.

Baseline concussion tests are available for a $15 fee and can be scheduled by calling 307-739-7434. Baseline testing is administered at St. John's Cognitive Health, located in Suite 229 in the Professional Building just west of St. John's Hospital. Post-injury tests are recommended to occur 72 hrs - 1 week after head injury, but medical care should be sought immediately after the injury has occurred. Post-injury test results can be sent to a pediatrician or family practitioner, or care can be managed at St John's Family Health and Urgent Care.

Baseline testing is recommended for youth athletes at least every 2 years and each time a head injury is sustained.

Additional information about imPACT Test© can be found at www.impacttest.com.

Concussion Baseline Testing for 2016-2017 Season

Concussion baseline testing is provided to kids 10 years and older in order to get their individual cognitive baseline in areas of attention, memory, reaction time, and processing speed. In the event a person has a concussion, he or she can be retested to determine if it is safe to return to play. It's very important for kids to re-establish their baselines every 2 years to have current data for comparison. ImPACT © concussion computerized testing is used and takes about 30 minutes to complete.

Where: Testing is provided in the Cognitive Health offices in St. John's Physician Clinic, Suite 229, in the Professional Building west of St. John's Hospital.

When: Appointments will be available beginning **September 6th** on Tuesdays, Thursdays, and Fridays from 9am to the latest appointment time of 4pm. Testing is administered on the computer and takes about 30 minutes. Please call **307-739-7434** to schedule an appointment.

Cost: $15.00. Unfortunately it is not covered by most medical insurance plans. Cash, check, or credit card accepted.

Registration: Each person must complete a registration form for St. John's Physician Practices prior to taking the test. Children under 18 years of age must have a parent or guardian complete the registration form. A parent or guardian must accompany children under 18 years of age to testing and sign a consent form prior to testing.

More Information:

www.cdc.gov/concussion/headsup/youth.html

www.impacttest.com/audience/?parents-3

ST. JOHNS MEDICAL GROUP
PATIENT REGISTRATION

Family Health & Urgent Care

James Little Jr., MD
April North, MD
Jennifer Fritch, PA
Cecelia Tramburg, FNP-C
Layne Lash, FNP
Christian Dean, DO
Kim Mellick, NP

Cognitive Health

Martha Stearn, MD

Internal Medicine

Dennis Butcher, MD
Hayley Miller, MD
Sarah Peterson, RD

Ear, Nose & Throat

Martin Trott, MD
Rosanne Prince, Au.D.
Jennifer Almond, PA

Internal Medicine Wilson

Michael Menolascino, MD
Christine Turner, MD
Tessa J Enright, FNP-BC

General Surgery

Michael Rosenberg, MD F.A.C.S.

Randy Kjorstad, MD F.A.C.S.

Plastic & Reconstructive Surgery

John Payne, DO

Witness Initials

_____

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____

Sex (circle one): Male Female Marital Status (circle one): Single Married Divorced Widowed

Responsible Party (if different than patient):

Responsible Party (First & Last Name): _____ Relationship to Patient: _____

Address: _____ Phone_____

City: _____ State: _____ Zip: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____

Demographics:

Billing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary Care Physician: _____ Referring Physician: _____

How would you prefer to be reminded of upcoming appointments? (circle one): Home Phone Cell Phone Text

Do we have your permission to leave voice mails on phone numbers provided? (circle one): Yes No

Would you like to be able to access your medical records through our online Patient Portal? (circle one): Yes No

Emergency Contact Information:

First/Last Name: _____ Relation: _____Phone: _____

Patient Race (circle one): American Indian/Alaskan Asian Black/African American White Other: _____

Patient Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Refuse to Respond Other: _____

Primary Language (circle one): English Spanish Other: _____

Is the purpose of your visit today a work related injury? (circle one): Yes No If yes, Date of Injury: _____

Preferred Pharmacy (circle one): Albertson's (Sav-On) Smiths Kmart Stone Drug

Other, Please list Pharmacy Name and Location: _____

Employer: _____ Phone Number: _____

Primary Insurance Company: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Policy ID Number: _____ Policy Group Number: _____

Insured Name: _____ Relation to Patient: _____

Insured Social Security Number: _____ Insured Date of Birth: _____

Secondary Insurance Company: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Policy ID Number: _____ Policy Group Number: _____

Insured Name: _____ Relation to Patient: _____

Insured Social Security Number: _____ Insured Date of Birth: _____

I accept full responsibility for the above named patient or myself and agree to all charges for services rendered.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____