Nebraska VR ABI Interview Form

Use this form to guide your interview with an individual answering "Yes" or "Not sure" to the ABI pre-screening question on their VR application.
Note: This interview may be completed at any time if you suspect or if the individual indicates they may have experienced an acquired brain injury (ABI).

Name: _____ Date: _____ VR Specialist: _____

Age: ☐ 0 – 22 years ☐ 23 – 59 years ☐ 60 years or older **Veteran:** ☐ Yes ☐ No

Living Setting: ☐ On their own/independent ☐ Homeless ☐ With parent or grandparent ☐ With immediate family
☐ With friends or other extended family ☐ Group home ☐ Prison or Jail/Justice involved setting ☐ Transitional living program or temporary housing
☐ Community Based Neurobehavioral Rehabilitation Services ☐ Nursing facility or in-patient rehabilitation setting ☐ Supervised living program
☐ Assisted living setting ☐ Other (Specify): _____

In Competitive, integrated employment: ☐ Yes ☐ No **In school or training:** ☐ Yes ☐ No

Step 1. Prompt the individual to think about **all incidents or illnesses** that may have occurred at any age, including those that they don't recall, but others may have told them about. In your lifetime (including childhood) have you ever **injured your head, face or neck** (e.g. from shaking, car or other moving vehicle accident, fall, fight, gunshot, explosion, contact sports or military service, etc.)?

Injury #1: _____ Age: _____ Were you hospitalized or treated in the ER? : ☐ Yes ☐ No
Did you lose consciousness? : ☐ Yes ☐ No If yes, for how long? _____
Were you dazed or did you have a memory gap at the time of injury? : ☐ Yes ☐ No If yes, for how long? _____

Injury #2: _____ Age: _____ Were you hospitalized or treated in the ER? : ☐ Yes ☐ No
Did you lose consciousness? : ☐ Yes ☐ No If yes, for how long? _____
Were you dazed or did you have a memory gap at the time of injury? : ☐ Yes ☐ No If yes, for how long? _____

Repeated impacts to your head (from shaking, contact sports, military service, etc.)? ☐ Yes ☐ No Were you hospitalized or treated in the ER? : ☐ Yes ☐ No
If yes, from approximately age _____ to age _____ Description: _____

In your lifetime (including childhood) have you ever experienced an **illness or event** that affected your brain (e.g. cancer, stroke, meningitis, West Nile virus, seizure disorder, tumor, drowning, poisoning, etc.)? : ☐ Yes ☐ No

Illness/Event #1 _____ Age: _____ Were you hospitalized or treated in the ER? : ☐ Yes ☐ No
Did you lose consciousness? : ☐ Yes ☐ No If yes, for how long? _____
Were you dazed or did you have a memory gap at the time of injury? : ☐ Yes ☐ No If yes, for how long? _____

Illness/Event #2: _____ Age: _____ Were you hospitalized or treated in the ER? : ☐ Yes ☐ No
Did you lose consciousness? : ☐ Yes ☐ No If yes, for how long? _____
Were you dazed or did you have a memory gap at the time of injury? : ☐ Yes ☐ No If yes, for how long? _____

Step 2. Determine the functional impact of noted injury(s), illness(s) or event(s) on the individual's everyday functioning by completing the challenges checklist on the next page with the individual.

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In the time since the injury(s), illness(s) or event(s), how often	Never	Seldom	Often	Depends	Comments
Do your memory problems interfere with getting things done on time?	☐	☐	☐	☐	
Do you get distracted and forget to finish a task?	☐	☐	☐	☐	
Do you struggle to remember what people have said to you?	☐	☐	☐	☐	
Do you repeat yourself because you don't remember what you told someone?	☐	☐	☐	☐	
Do you have difficulty staying organized or setting priorities?	☐	☐	☐	☐	
Do you have difficulty finding your notes or To Do Lists?	☐	☐	☐	☐	
Do you have difficulty estimating or managing time?	☐	☐	☐	☐	
Do you have difficulty keeping track of appointments?	☐	☐	☐	☐	
Do you feel exhausted or overwhelmed by your memory problems?	☐	☐	☐	☐	
Do you have difficulty finding documents or other information you need?	☐	☐	☐	☐	
Do you have difficulty getting ready for appointments or activities on time?	☐	☐	☐	☐	
Do you struggle to track completed tasks and those that still need to be done?	☐	☐	☐	☐	
Do you have difficulty completing multi-step tasks?	☐	☐	☐	☐	
Do you have difficulty following verbal (spoken) instructions?	☐	☐	☐	☐	
Do you have difficulty following written instructions?	☐	☐	☐	☐	
Do you have difficulty reading maps or understanding diagrams or charts?	☐	☐	☐	☐	
Do you feel stress trying to remember your assignments or plans for the day?	☐	☐	☐	☐	
Do you sense that your behavior or social skills cause you problems?	☐	☐	☐	☐	
Do you struggle to complete paperwork or steps to get the services you need?	☐	☐	☐	☐	
Do you struggle to make decisions, solve problems and have good judgment?	☐	☐	☐	☐	
Do you fear memory problems will make finding the job you want difficult?	☐	☐	☐	☐	
Do you have other concerns that are not listed?	☐	☐	☐	☐	

Comments/Observations:

_____

_____

Step 3. Discuss noted challenges with the individual and determine if referral for Vocational Evaluation and/or Assistive Technology Evaluation are appropriate. Include a copy of this completed form with referral. See VR Program Manual, Initial Meeting Chapter for additional guidance.

Step 4. Provide the individual with an age- and region-appropriate ABI resource brochure from the Brain Injury Advisory Council's website at: https://braininjury.nebraska.gov/brain-injury-registry-brochures-2021 and ask if they would like further help in connecting to services and supports in their community.

Step 5. Enter all data from this form in QE2.