TREATMENT TEAM

This is likely the first group of medical providers that are assigned to the injured. It may be comprised of a neurologist, nero-surgeon, orthopedic surgeon, respiratory team, ER team of nurses, and other needed specialists. This team may follow though after the initial injury in Emergency Room through ICU and possibly after the injured is transferred to the medical floor.

- **Physiatrist**
  After a person is admitted to intensive care or to a hospital floor. They will be assigned a physiatrist, also called a PM&R (physical medicine and rehabilitation specialist). This physician may be in charge of their care as an in-patient, then also as an out-patient. He will consult with the neurologist and surgeons who may be involved. After discharge it is best to continue to see the PM&R specialist he/she will be your medical coordinator and give you the appropriate referrals to aide in your recovery.
- **Neuropsychiatrist**
  This is a professional educated in diagnosing injuries to the brain. This is usually accomplished by administering a neuropsychological exam. This is an approximately eight hour-long exam given by the neuropsychiatrist to aid in the diagnosis of a head injury. It is important to have this exam if you are experiencing disturbing signs or symptoms of the head injury. This is sometimes done in the rehabilitation process and/or after discharge from the hospital.
- **Internal Hospital Case Manager (also called discharge planner)**
  A person who works at the hospital (usually a nurse or social worker). Their job is to help you decide where you will go after discharge from the hospital. Be aware that the hospital may have alliances with certain providers. You may be directed towards referrals that may not be the best available. This is a good time to have an independent case manager help you choose the best discharge plan for you. An independent case manager would allow you or your family to investigate options available before the day of discharge comes.
- **Physical Therapists**
  A specialized professional to assist you to maintain or regain the strength and mobility of the body.
  Occupational Therapist
  A specialized professional to assist you to maintain or regain you ability to do “ADLs” (activities of daily living) such as dressing, brushing teeth, use of arms, etc.
- **Speech Therapist**
  A specialized professional that works with two major areas. The ability to swallow food, speak, and the ability to think. They assist with evaluating and treating the injuries to the brain. These therapists in the hospital setting will probably not be the same people that will work with you after discharge. After discharge you may be sent home or to a facility.

FACILITIES

- **Treatment Team Facilities**
  You should be set up with a rehabilitation facility that includes the above therapists if necessary for your recovery. Remember that there may be many facilities to choose from. It is best to have a friend or family member tour the facilities available to choose the best for you. A case manager can give you suggestion of known facilities with good reputations and qualifications as well as taking families on tours of appropriate facilities.
- **Sub Acute Facilities**
  These are in-patient facilities to which a patient is sometimes admitted after hospitalization, if the care needed cannot be safely preformed at their home. There may be more than one facility available. Be sure to ask about the options and possibly tour them before the decision is made. Your case manager should arrange for these tours.
- **Group Homes**
  These are specialized homes that are available for discharge from a hospital or sub acute facility. These homes are for persons who need more care than the family can give, or if no other living arrangements are available or appropriate. An order for this type of housing needs to be written by your physician. There are many levels of group homes. This is a very important decision regarding your care. Be sure to have your case manger give you the options available and ask her for tours to evaluate what is best for the type of care you need. Check for the certifications and accreditations that a facility has achieved. These homes are sometimes used as a transitional move before returning home to live.

GOING BACK TO WORK OR SCHOOL

- **Vocational therapist**
  A specialist that coordinates the return to work so that the transition is successful for you and your employer.
- **Educational specialist**
  Specialist in the school system (pre-school to college level). They assist with the transition back to school. They may use testing to evaluate your needs and suggest how the school can support you with other specialists.
- **Tutors**
  Teachers trained to teach at home until you are ready to attend school again (for school through college level).
- **Individualized Education Plan (I.E.P.)**
  In Michigan the school system is responsible to provide students (pre-school to 12th grade) with the services necessary for success in their education. This includes early childhood. An IEP is initiated by the parents and/or case manager to have the school district assess the needs of the student and provide the coordination of services necessary. Call your school district for further information. Most parents find that their case manger is very helpful in this rather complicated process.