Hartford Hospital
A Hartford HealthCare Partner

6913

NEUROLOGY - INITIAL EVALUATION/CONSULTATION

Date: _____ Time: _____

REQUESTED BY_____

CHIEF COMPLAINT:
HISTORY OF PRESENT ILLNESS:

Neurological Review of Systems:

ALLERGIES:
MEDICATIONS:

REVIEW OF SYSTEMS:	Normal	Abnormal (Elaborate)
Psychiatric:	☐	_____
Constitutional:	☐	_____
Skin:	☐	_____
Respiratory:	☐	_____
Cardiovascular:	☐	_____
GI:	☐	_____
GU:	☐	_____
Endocrine:	☐	_____
Musculoskeletal:	☐	_____
Hematology	☐	_____

☐ All other systems reviewed and are negative

PAST MEDICAL AND SURGICAL HISTORY:
☐ HTN
☐ HYPERLIPIDEMIA
☐ Afib
☐ CAD
☐ DM (IDDM or NIDDM)
☐ Migraines with or without aura

FAMILY HISTORY:
☐ Stroke ☐ Muscle disorder
☐ ICH ☐ Nerve disorder
☐ Brain tumor ☐ clots/bleeding disorder
☐ Cancer

SOCIAL HISTORY:
☐ Tobacco:
☐ Alcohol:
☐ Drugs:

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EXAMINATION

Problem Focused: 1-5 * elements; Expanded Problem Focused: 6+ * ; Detailed: 12+ *;
Comprehensive: all * elements, plus one cardiovascular element

CONSTITUTIONAL

* Vital Signs: (3 or more) BP _____/_____ T _____ Tmax _____ HR _____ RR _____ Wt ____

	Normal	Relevant Details (especially if abnormal)
* Appearance	☐	_____
Cardiovascular		
Neck	☐	_____
Heart	☐	_____
Peripheral vasc.	☐	_____
Other		
Pulmonary	☐	_____
GI	☐	_____
MENTAL STATUS		
* Attention	☐	_____
* Orientation	☐	_____
* Memory	☐	_____
* Language	☐	_____
Visuospatial	☐	_____
Executive	☐	_____
* Fund of knowledge	☐	_____
CRANIAL NERVES		
/Visual Acuity	☐	_____
*- Visual Fields	☐	_____
\Fundi	☐	_____
*- Pupils	☐	_____
\Eye Movements	☐	_____
* V (Trigeminal)	☐	_____
* VII (Facial)	☐	_____
* VIII (Hearing and balance)	☐	_____
* IX, X (Palate and gag)	☐	_____
* XI (Shrug)	☐	_____
* XII (Tongue)		
MOTOR		
* Bulk, Tone	☐	_____
Pronator Drift	☐	_____
/ RUE strength	☐	_____
*- LUE strength	☐	_____
\ RLE strength	☐	_____
\ LLE strength	☐	_____
Toe/Heel Walk	☐	_____

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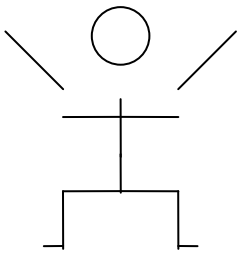
	Normal	Relevant Details (especially if abnormal)
SENSORY		
Light Touch	☐	_____
Pinprick	☐	_____
Temperature	☐	_____
Vibration	☐	_____
Proprioception	☐	_____
Romberg	☐	_____
COORDINATION		
RAM	☐	_____
Finger - Nose	☐	_____
Heel - Shin	☐	_____
Tandem Walk	☐	_____
GAIT		

REFLEXES



Toe: :Toe

If relevant:
NIHSS: _____
or
ABCD2:_____
or
ICH Score:_____

DATA

Neuroimaging: ☐HCT ☐MRI date:_____ time:_____

Other Radiology:

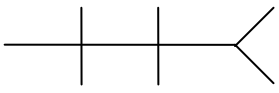
Neurophysiology:

CSF: Position _____ Opening Pressure _____

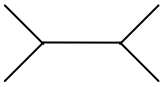
Tube # ___ protein _____ glucose _____

Tube # ___ RBC _____ WBC _____ Differential EKG

Tube # ___ RBC _____ WBC _____ Differential UA



Ca Mg Phos HbA1C Troponin



PT INR PTT Lipids CK/MB

"The Point of Care Reference Range Form is located in the laboratory section of all inpatient medical records. For outpatient and procedural areas, it is located in an area of the chart designated by the department".

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ASSESSMENT AND PLAN

☐ I have considered the patients home medications when writing admission orders

Resident/APRN Signature: _____ Date: _____ Time: _____

Printed Name: _____ Pager Number: _____

ATTENDING NOTE

I have seen and examined this patient with/subsequent to Dr. _____. I agree with his/her history, review of systems, family history, social history, physical examination, impression and plan as outlined in his/her note dated _____.

History remarkable for:

Physical Exam remarkable for:

Test results:

Assessment and Plan:

Attending Signature: _____ Date: _____ Time: _____

Printed Name: _____ Pager Number: _____