NEUROLOGY - INITIAL EVALUATION/CONSULTATION

Date: ________________ Time: ________________

REQUESTED BY_________________________________________

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

Neurological Review of Systems:

ALLERGIES:    REVIEW OF SYSTEMS:  Normal  Abnormal (Elaborate)
MEDICATIONS:  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:
NEUROLOGY - INITIAL EVALUATION/CONSULTATION

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

CONSTITUTIONAL
* Vital Signs: BP _____/_____ T _____ Tmax _____ HR _____ RR _____ Wt ____ 
(3 or more)
* Appearance Normal Relevant Details (especially if abnormal) 

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
  \Fundii
* - 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
NEUROLOGY - INITIAL EVALUATION/CONSULTATION

SENSORY

- Light Touch
- Pinprick
- Temperature
- Vibration
- Proprioception
- Romberg

Relevant Details (especially if abnormal)

COORDINATION

- RAM
- Finger - Nose
- Heel - Shin
- Tandem Walk

GAIT

REFLEXES

- If relevant:
  - NIHSS: __________
  - or
  - ABCD2: __________
  - or
  - ICH Score: __________

Toe: ______  Toe

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".
NEUROLOGY - INITIAL EVALUATION/CONSULTATION

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: _______________