Hartford Hospital
A Hartford HealthCare Partner

6812

NEUROLOGY - ADMISSION HISTORY and PHYSICAL- INTRACEREBRAL HEMORRHAGE

Date: _____ Time: _____

CHIEF COMPLAINT:
HISTORY OF PRESENT ILLNESS:

Time of onset (or last seen normal): _____
Neurological Review of Systems:

ALLERGIES:

MEDICATIONS:
☐ see medication reconciliation sheet

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 HISTORY:

PAST SURGICAL HISTORY

SOCIAL HISTORY:
☐ Tobacco
☐ Heavy Alcohol
☐ Drugs:

FAMILY HISTORY

Pre-stroke mRS:
0: No symptoms at all
1: No significant disability despite symptoms; able to carry out all usual activities
2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3: Moderate disability; requiring some help, but able to walk without assistance
4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention

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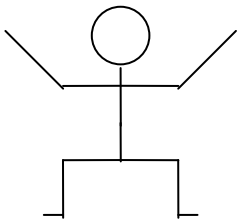
	Normal	Relevant Details (required if abnormal)
SENSORY		
Light Touch	☐	_____
Pinprick	☐	_____
Temperature	☐	_____
Vibration	☐	_____
Proprioception	☐	_____
Romberg	☐	_____
COORDINATION		
RAM	☐	_____
Finger - Nose	☐	_____
Heel - Shin	☐	_____
Tandem Walk	☐	_____

GAIT

REFLEXES



Toe: :Toe

NIHSS: _____

GCS score:_____

DATA

Neuroimaging: (date:_____ time first read:_____)

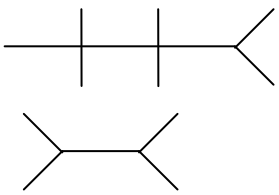
ICH volume: (_____x_____x_____)/2= _____mL

ICH SCORE:_____

Vascular imaging:

EKG:

CXR:



				UA
Ca	Mg	Phos	Troponin	
PT	INR	PTT	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

Acute intracerebral hemorrhage, ICH score: _____

Suspected etiology:

- ☐ Admit to Neurology in Neuro-ICU
- ☐ Close monitoring for signs of neurologic deterioration
- ☐ Consider for enrollment in ICH research studies
- ☐ Consult neurosurgery, check CTA head to r/o vascular lesion
- ☐ IV normal saline rate:_____
- ☐ Maintain INR < 1.3, PTT normal, plts > 100,000
- ☐ Continuous telemetry for detection of arrhythmias
- ☐ Repeat HCT or MRI in 24 hours
- ☐ Blood pressure control to < 150/90
- ☐ Head of 30 degrees, bedrest
- ☐ PT/OT/rehab when able to mobilize safely
- ☐ DVT prophylaxis with SCDs
- ☐ Swallowing evaluation prior to oral intake
- ☐ Check HbA1C if diabetic.
- ☐ Frequent glucose monitoring- cover with sliding scale insulin

Other medical issues:

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

Printed Name: _____ Pager Number: _____

ATTENDING NOTE

I have seen and examined this patient with/subsequent to the resident. I agree with his/her history, review of systems, family history, social history, physical examination, impression and plan as outlined in his/her note above with the following addendums:

History:

Physical Exam:

Test results:

Assessment and Plan:

Attending Signature: _____ Date: _____ Time: _____

Printed Name: _____ Pager Number: _____