NEUROLOGY - ADMISSION HISTORY and PHYSICAL- STROKE/TIA

Date: ________________  Time: ________________

CHIEF COMPLAINT:
HISTORY OF PRESENT ILLNESS:

Time of onset (or last seen normal): _________

Neurological Review of Systems:

<table>
<thead>
<tr>
<th>ALLERGIES:</th>
<th>REVIEW OF SYSTEMS:</th>
<th>Normal</th>
<th>Abnormal (Elaborate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>see medication reconciliation sheet</td>
<td><strong>Psychiatric:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>Constitutional:</strong></td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Skin:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>Respiratory:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>Cardiovascular:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>GI:</strong></td>
<td>☐</td>
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<td></td>
<td><strong>GU:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>Endocrine:</strong></td>
<td>☐</td>
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<td></td>
<td><strong>Musculoskeletal:</strong></td>
<td>☐</td>
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<tr>
<td></td>
<td><strong>Hematology</strong></td>
<td>☐</td>
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<tr>
<td>☐ All other systems reviewed and are negative</td>
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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
**NEUROLOGY - ADMISSION HISTORY and PHYSICAL - STROKE/TIA**

**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)

<table>
<thead>
<tr>
<th>* Appearance</th>
<th>Normal</th>
<th>Relevant Details (especially if abnormal)</th>
</tr>
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<tbody>
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**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 (Tounge)

### MOTOR
* Bulk, Tone
  Pronator Drift
/ RUE strength
* LUE strength
  \ RLE strength
  \ LLE strength
Toe/Heel Walk
**NEUROLOGY - ADMISSION HISTORY and PHYSICAL - STROKE/TIA**

### SENSORY

<table>
<thead>
<tr>
<th>Normal</th>
<th>Relevant Details (especially if abnormal)</th>
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<tbody>
<tr>
<td>Light Touch</td>
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<tr>
<td>Pinprick</td>
<td></td>
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<tr>
<td>Temperature</td>
<td></td>
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<tr>
<td>Vibration</td>
<td></td>
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<tr>
<td>Proprioception</td>
<td></td>
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<tr>
<td>Romberg</td>
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</table>

### COORDINATION

<table>
<thead>
<tr>
<th>Normal</th>
<th>Relevant Details (especially if abnormal)</th>
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<tbody>
<tr>
<td>RAM</td>
<td></td>
</tr>
<tr>
<td>Finger - Nose</td>
<td></td>
</tr>
<tr>
<td>Heel - Shin</td>
<td></td>
</tr>
<tr>
<td>Tandem Walk</td>
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</table>

### GAIT

<table>
<thead>
<tr>
<th>Normal</th>
<th>Relevant Details (especially if abnormal)</th>
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### REFLEXES

![Reflexes Diagram]

NIHSS: __________

ABCD2: __________

Toe: __________

### DATA

- **Neuroimaging:** [ ] HCT [ ] MRI  date:__________  time first read:__________

- **Vascular imaging:**
  - **EKG:**
  - **CXR:**

<table>
<thead>
<tr>
<th>UA</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ca</td>
<td>Mg</td>
<td>Phos</td>
<td>HbA1C</td>
<td>Troponin</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>INR</td>
<td>PTT</td>
<td>Lipids</td>
<td>CK/MB</td>
<td></td>
</tr>
</tbody>
</table>

"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 - ADMISSION HISTORY and PHYSICAL- STROKE/TIA

ASSESSMENT AND PLAN

☐ I have considered the patient's home medications when writing admission orders

☐ Acute cerebral infarction or ☐ TIA

If IV tPA given, time: __________ weight: __________ dose: __________

IV tPA candidate? ☐ Yes ☐ No If no Why not? __________

If > 60 min between arrival and when tPA given, why? __________

☐ Admit to Neurology

☐ Antithrombotic Rx: __________ ☐ hold x 24 hours if given tPA

☐ Statin: __________

☐ IV normal saline, rate ______

☐ Check lipids, RPR, ESR

☐ HbA1C if diabetic

☐ TSH if new-onset afib

☐ Check vascular imaging and TTE

☐ Continuous telemetry for detection of arrhythmias

☐ Close monitoring for signs of neurologic deterioration

☐ Permissive HTN for now to < 200/100 (<180/105 if given tPA)

☐ Head of bed flat, bedrest

☐ Head of 30 degrees, activity as tolerated

☐ PT/OT/rehab when able to mobilize safely

☐ Swallowing evaluation prior to oral intake

☐ DVT prophylaxis with SCDs and SC heparin (SCDs alone if given tPA)

☐ 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: ______________