# Cerebellum Function Test

| **Clinician Information** | |
|---|---|
| Name: | |
| Title / Position: | |
| License Number: | |
| Contact Information: | |
| Date of Evaluation: | Time of Evaluation: |
| **Patient Information** | |
| Name: | |
| Age: | |
| Gender: Male Female Other: | |
| Date of Birth: | |
| Patient ID: | |
| Referring Physician: | |
| **Medical History** | |
| Current Medications: | |
| | |
| Past Neurological History: | |
| | |
| Recent Injuries / Accidents: | |
| | |
| Family History of Neurological Disorders: | |
| | |

| Evaluation Purpose |
| --- |
| Reason for Evaluation: |
| |
| Specific Concerns: |
| |

## Cerebellum Function Tests

| 1. Gait and Stance |
| --- |
| *Instructions: Observe the patient walking, turning, and standing with feet together (eyes open and then closed).* |
| Observations: |
| |
| Findings:<br>☐ Normal Abnormal Specify: |
| **2. Romberg Test** |
| *Instructions: Patient stands with feet together and eyes closed for 30 seconds.* |
| Observations: |
| |
| Findings:<br>☐ Stable Unstable |
| **3. Finger-to-Nose Test** |
| *Instructions: Patient alternately touches their nose and the clinician's finger with eyes open, then closed.* |
| Observations: |
| |
| Findings:<br>☐ Accurate Inaccurate (Specify errors: ) |

### 4. Heel-to-Shin Test

*Instructions: Patient slides the heel of one foot down the shin of the opposite leg while lying down.*

Observations:

Findings:

☐ Smooth Clumsy / Interrupted

### 5. Rapid Alternating Movements (Dysdiadochokinesia)

*Instructions: Patient performs rapid alternating movements with hands, such as pronation-supination.*

Observations:

Findings:

☐ Coordinated Uncoordinated

### 6. Rebound Phenomenon of Stewart-Holmes

*Instructions: Clinician holds and suddenly releases the patient's flexed arm, observing for excessive rebound movement.*

Observations:

Findings:

☐ Present Absent

### 7. Speech Evaluation

*Instructions: Assess for dysarthria by having the patient read or repeat phrases.*

Observations:

Findings:

☐ Normal Slurred Scanning Speech

| **Overall Assessment** | | |
| --- | --- | --- |
| Summary of Findings: | | |
| | | |
| Impression: | Normal Cerebellar Function | Abnormal Cerebellar Function |
| Specific Areas of Concern: | | |
| | | |
| **Recommendations** | | |
| Further Diagnostic Testing: | | |
| Referral to Specialists: | | |
| Therapeutic Interventions: | | |
| | | |
| Follow-Up: | Scheduled | As Needed |
| **Clinician's Signature** | | |
| | | |
| Date: | | |

## Patient Consent for Evaluation

I, ______________________________ , consent to the cerebellum function tests as described above.

| **Patient's Signature:** |
| --- |
| |
| Date: |