Nurse Neurological Assessment Sheet

Patient's full name: xxxxxxxxxxxxxxxxxxxxxxxxx

Date and time assessed: January 31, 2022 | 1:00pm

Patient's date of birth: xxxxxxxxxxxxxxxxxxxxxxxx

Nurse's full name: xxxxxxxxxxxxxxxxxxxxxxxxxxxx

What you need: a penlight; Snellen chart; tongue depressor; cotton wisp or applicator; percussion hammer; coins and paper clips for patients to touch; vanilla, mint, or coffee for patients to smell; pinches of sugar and salt, and lemon for patients to taste

Perform safety and clerical nurse work:

- ☑ Perform hand hygiene and ensure their hands are totally clean
- ☑ Inspect the room for any transmission-based precautions
- ☑ Introduce themself to the patient, what their role is, what they're about to do, and how long it'll take to conduct the assessment
- ☑ Confirm the patient's ID using their full name and date of birth
- ☑ Explain the process of the assessment to the patient
- ☑ Ask the patient for any questions they might have regarding the assessment

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Subjective Assessment

I.

Are you experiencing any current neurological concerns such as headache, dizziness, weakness, numbness, tingling, tremors, loss of balance, or decreased coordination?

Headaches, dizziness, numbness, tremors. They mentioned they are not confident about their balance and coordination.

Have you experienced any difficulty swallowing (dysphagia) or speaking (dysphasia)?

No difficulty swallong. They have difficulty speaking sometimes and it is evident. They start to slur or mumble after a short while.

Have you experienced any recent falls?

None.

Have you ever experienced a neurological condition such as a stroke, transient ischemic attack, seizures, or head injury?

They're here to inquire about this. They fear that they had a stroke, but they're not sure.

Are you currently taking any medications, herbs, or supplements for a neurological condition?

None. It's their first time to get themselves checked for a neurological condition.

II. Notes about the patient…

Please note the patient's behavior, language, mood, hygiene, and choice of dress while asking the questions listed above. They should also note down if the patient has any hearing or visual deficits. If the patient has glasses or hearing aids, the nurse must ensure they are in place, if needed.

Objective Assessment

1. **Level of Alertness**

Assess their level of alertness. Are they awake and alert, lethargic, obtunded, stuporous, or unresponsive. If they are unresponsive, perform the steps of the AVPU Scale or the Glasgow Coma Scale.

2. **Orientation**

Assess the patient's orientation through the following questions:

- What is your name?
- Where are you right now?
- Why did you come to the hospital?
- What is the month and/or year?
- What day of the week is it?

3. **Mini-Mental State Exam (MMSE)**

Conduct the Mini-Mental State Exam (MMSE) to check on their cognition.

4. **PERRLA Eye Exam**

Assess if the pupils are equal in size, if they are perfectly round if they react to light, and if the eyes can change focus normally. You must also check if the eyes can move in all directions, and if they can direct their eyes to follow instructions like following your finger.

5. **Motor Strength and Sensations**

Assess the motor strength and sensations of the patients by specifically looking at their hand grasps, the strength and resistance of the upper and lower body, and sensations in their extremities.

6. **Balance and Coordination**

Have the patient walk with an assistive device, and while they're walking, note down observations related to their gait, arm swings, coordination, ability to tandem walk, tiptoe, and walk on heels.

7. **Cranial Nerves**

Assess the patient's twelve cranial nerves using various assessments and items.

Safety Precautions after the Assessment:

- [ ] The call light is within the reach of the patient
- [ ] The patient's bed is low and locked and the side rails are secured
- [ ] The table is within the patient's reach
- [ ] The room is risk-free from falls by scanning the room and clearing any obstacles
- [ ] Perform hand hygiene

Additional Comments