

Neurological Flow Sheet

Vital Signs and Neuro Checks:

- q 15 mins. X (1) hour
- q 30 mins. X (1) hour
- q 1 hour X (4) hours, then
- q 4 hours X (24)hours

(Progress along this time schedule **ONLY** if signs are stable)

Date:																			
Time:																			
Level of Consciousness:																			
Movement:																			
Hand Grasps:																			
Pupil Size: Rt.																			
Pupil Size: Lt.																			
Pupil Reaction: Rt.																			
Pupil Reaction: Lt.																			
Speech:																			
B/P:																			
Pulse:																			
Respiration:																			
Temperature:																			
See Nurse's Notes: *																			
Initials:																			

KEY:

Level of Consciousness

1. Fully Conscious - awake, aware, oriented
2. Lethargic - responds slowly to verbal stimuli
3. Obtund - very drowsy, responds to touch stimuli
4. Stupor - responds only to painful stimuli
5. Coma - absent response to stimuli

Hand Grasp

1. Equal and strong
2. R weakness
3. L weakness
4. None

Speech

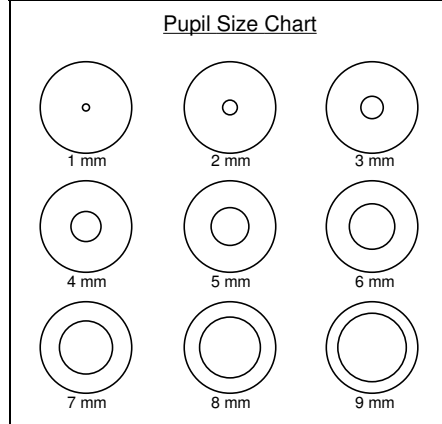
1. Clear
2. Slurred
3. Rambling
4. Aphasic

Movement

1. All 4 extremities
2. Arms only
3. R arm only
4. L arm only
5. R leg only
6. L leg only
7. No movement/unusual movement

Pupil Reaction

1. Brisk
2. Sluggish
3. Fixed



Notify MD IMMEDIATELY of signs and symptoms of Intracranial Pressure!!!

Resident Name:	Room #	Physician:	Medical Rec. #
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