

**Neurologic Deficit**  
**(Ischemic Attack, CVA, Bell's Palsy)**

**Subjective Data:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Onset of Symptoms: \_\_\_\_\_ Duration of Symptoms: \_\_\_\_\_ Activity at Onset: \_\_\_\_\_

**Associated symptoms:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Generalized weakness/paralysis | <input type="checkbox"/> Disturbance of speech | <input type="checkbox"/> Loss of balance     | <input type="checkbox"/> Excessive tearing of eye |
| <input type="checkbox"/> Neck ache                      | <input type="checkbox"/> Pain behind ear       | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Confusion                |
| <input type="checkbox"/> Loss of bladder and/or bowel   | <input type="checkbox"/> Facial drooping       | <input type="checkbox"/> Loss of taste       | <input type="checkbox"/> Facial drooping          |
|   |  |  | <input type="checkbox"/> Drooling                 |

<b>Stroke- THINK F.A.S.T</b>	<b>Bell's Palsy - COWS</b>
<b>Face</b> - weakness on one side of the face and ask person to smile	<b>C</b> – close your eyes
<b>Arm</b> - weakness or numbness in one arm ask the person to raise both arms	<b>O</b> – open your eyes
<b>Speech</b> – slurred speech or trouble getting words out, ask the person to speak a simple sentence	<b>W</b> – wrinkle your forehead, raise your eyebrows
<b>Time</b> – note time when signals were first observed	<b>S</b> – smile

**Objective Data:** (clinically indicated VS)

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ FSBS \_\_\_\_\_ O2 Sats. \_\_\_\_\_

Respiration	LOC	Neurologic	Mental Status
<input type="checkbox"/> Even	<input type="checkbox"/> Awake	<input type="checkbox"/> Gait steady	<input type="checkbox"/> Oriented to place
<input type="checkbox"/> Uneven	<input type="checkbox"/> Alert	<input type="checkbox"/> Grips equal	<input type="checkbox"/> Oriented to date & time
<input type="checkbox"/> Labored	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Speech normal	<input type="checkbox"/> Can repeat "ball, flag, tree"
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Confused	<input type="checkbox"/> Pupils equal	<input type="checkbox"/> Can name a pen and watch
<input type="checkbox"/> Shallow	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Smile symmetrical	<input type="checkbox"/> Can repeat "no ifs and or buts"
<input type="checkbox"/> Deep	<input type="checkbox"/> Comatose	<input type="checkbox"/> Facial drooping	<input type="checkbox"/> Can draw a clock set to 2:30
<input type="checkbox"/> Rapid	<input type="checkbox"/> Follows commands	<input type="checkbox"/> Able to wrinkle forehead and close eyes	
	<input type="checkbox"/> Unable to follow commands	<input type="checkbox"/> Unable to wrinkle forehead and close eyes	
	<input type="checkbox"/> Knows month & age	<input type="checkbox"/> Loss of sense of taste	
	<input type="checkbox"/> Does not know month & age		

**NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IN ALL CASES OF NEUROLOGIC ADNORMALITIES: In cases of emergency call EMS.**

**Refer to Medical Provider If:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Facial drooping                  | <input type="checkbox"/> Weakness/numbness/paralysis    | <input type="checkbox"/> Blood Pressure elevation       |
| <input type="checkbox"/> Decreased level of consciousness | <input type="checkbox"/> Loss of consciousness          | (Systolic $\geq$ 185 mmHg or Diastolic $\geq$ 110 mmHg) |
| <input type="checkbox"/> Paralysis                        | <input type="checkbox"/> Unable to speak/slurred speech |   |

**Emergency department notification time:** \_\_\_\_\_ **Transport time:** \_\_\_\_\_

**Medical Provider/RN Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Sensory-perceptual alterations related to neurologic deficits.

**Plan:**

**Nursing Intervention Emergency:**

- Call EMS for altered state of consciousness, facial drooping and/or can't speak.
- Obtain VS, including FSBS, paying special attention to an elevated blood pressure.
- Assess offender's coordination of movement and ability to move upper and lower extremities.
- Check pupil size and reaction to light.
- Assess facial symmetry. Look for differences between features of right and left side of face (e.g. smile/frown, raise eyebrows) and presence/absence of eyelid drooping.
- Assess offender's ability to walk, observing gait and balance.
- Do not give offender anything to eat or drink.
- Have offender rest quietly on their weakened side so secretions can drain from the mouth.

**Progress Note:** \_\_\_\_\_

**Offender Education:**

- Instructed on treatment provided, follow-up sick call with medical provider after ER / hospitalization. Offender verbalizes understanding of instructions.

**LPN Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**RN/Provider Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Offender Name  
(Last, First)

DOC #