

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

Stroke- THINK F.A.S.T	Bell's Palsy - COWS
Face - weakness on one side of the face and ask person to smile	C – close your eyes
Arm - weakness or numbness in one arm ask the person to raise both arms	O – open your eyes
Speech – slurred speech or trouble getting words out, ask the person to speak a simple sentence	W – wrinkle your forehead, raise your eyebrows
Time – note time when signals were first observed	S – 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"/> Gait unsteady
<input type="checkbox"/> Uneven	<input type="checkbox"/> Alert	<input type="checkbox"/> Grips equal	<input type="checkbox"/> Grips unequal
<input type="checkbox"/> Labored	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Speech normal	<input type="checkbox"/> Speech slurred
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Confused	<input type="checkbox"/> Pupils equal	<input type="checkbox"/> Pupils unequal
<input type="checkbox"/> Shallow	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Smile symmetrical	<input type="checkbox"/> Smile asymmetrical
<input type="checkbox"/> Deep	<input type="checkbox"/> Comatose	<input type="checkbox"/> Facial drooping	<input type="checkbox"/> Pain behind the ear
<input type="checkbox"/> Rapid	<input type="checkbox"/> Follows commands	<input type="checkbox"/> Able to wrinkle forehead and close eyes	<input type="checkbox"/> Can't 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"/> Loss of sense of taste
	<input type="checkbox"/> Knows month & age		
	<input type="checkbox"/> Does not know month & age		
			<input type="checkbox"/> Oriented to place
			<input type="checkbox"/> Oriented to date & time
			<input type="checkbox"/> Can repeat "ball, flag, tree"
			<input type="checkbox"/> Can name a pen and watch
			<input type="checkbox"/> Can repeat "no ifs and or buts"
			<input type="checkbox"/> Can draw a clock set to 2:30

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

NOTIFY MEDICAL PROVIDER 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 Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

- Sensory-perceptual alterations related to neurologic deficits.

Plan: Nursing Intervention Emergency:

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- 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.
- Education/Intervention: Instructed on treatment provided, follow-up sick call with medical provider after ER / hospitalization. Offender verbalizes understanding of instructions.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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