FOCUSED NEUROLOGICAL ASSESSMENT

ASSESS LEVEL OF CONSCIOUSNESS

- Full consciousness: Awake and JAJapan B.
- Lethargia; sleeps frequently but arwalkierne easily.
 - Obtunded: extreme drowsiness. requires vigorous stimulation to weaken...
 - Stupor: minimal movement. responds inappropriately. Is awake briefly with vigorous stimulation or painful stimuli.
- Comatose: does not respond to verbal and tactile stimuli. May respond appropriately to painful schirmun.





ASSESS DRIENTATION

- Oriented x3: understands spoken and written language and responds appropriately.
- Oriented x2: Mild confusion, guesses date, may be able to recognize time of year. My not be able to follow instructions. May have memory deficits.
- Oriented x1; confused, unable to give date or time. unable to verbalize where or who they are. Has memory deficits and can be restless or agitated.
- Disoriented: patient does not answer appropriately or at all. May be halfucinating or agitated. Unable to follow directions.

PEERLA

- Test pupil response, size, symmetry, shape. They should be equal and reactive to light.
- Shine the penlight into each pupil, Constriction should be brisk and equal.
- Bilateral dilation can be caused by cerebral anoxia or anticholinergic medications. Be sure to assess the client's medication list and other symptoms.
- Bilateral constriction can be caused by: intracranial

hemorrhage, opiates, or organophosphates.

ASSESS MUSCLE STRENGTH & FUNCTION Have the patient move all extremities.

- Have the patient squeeze your fingers.
- Hold your hands up for the patient to push and pull your hands.
- Have the patient hold their arms to their eyes. Note any drifts.
- Have the patient dorsiflex and plantar flex. Have the patient raise their legs without merchantament.

Muscle strength scale

- 0 : No muscle movement.
- 1: Visible muscle movement, no joint movement.
- 2: Movement at the Joint but not against gravity.
- 3: Movement against gravity but not resistance.
- 4: Movement against resistance but less than normal
- 5: Normal strength.

Eve response Spontaneously

3 On command To pain No response Score.

Verbal response

Allert and oriented 4 Confused Inappropriate Incomprehensible 1 secons.

Motor response Follows direction 65

Localizes pain Withdrawal from pain 4 Abnormal flexion Abnormal extension 2 No response sicione....

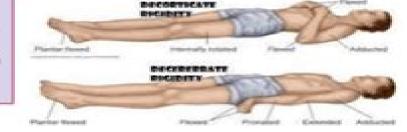


CRANTAL NERVES

- I: offactory : Smell, have the client identify familiar smells. II : Optic: Visual acuity, use snellen eye chart, assess
 - peripheral vision. III: Oculomotor: Pupillary reaction, assess PERRLA.
- IV: Trochlear: Eve movement, patient follows finger without
- V: Trigeminal: Facial sensation, touch patient's face, have them open their mouth.
- VI: Abducens: Motor function, patient follows finger without moving head.
- VII: Facial: Taste and face movement, have patient smile and puff cheeks, have patient differentiate between sweet and
 - VIII: Acoustic: Hearing and balance, snap fingers close to patient's ear, have patient stand with feet together, arms at side and eyes closed for 5 seconds.
- DC: Glossopharyngeal: Swallowing and voice, have the patient swallow and say "ah"
- X: Vagus: Gag reflex, use a tongue depressor to swab and ellicit a gag reflex.
- XI: Spinal accessory: Neck motion, have patient shrug and turn their head against resistance.
- XII: Hypoglossal: Tongue movement, have patient stick their tongue out and move it around.
- Brain trick to remember the order of cranial nerves. OOO to touch and feel a great velvet super hero"

POSTURING

- Decorticate: An abnormal posturing in which a person is stiff with bent arms, clenched fists. and legs held out straight.
- Decerebrate : An abnormal body posture that involves the arms and legs being held straight out, the toes being pointed downward, and the head and neck being arched backwards





Ensheng Dong

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