



6812

NEUROLOGY - ADMISSION HISTORY and PHYSICAL- INTRACEREBRAL HEMORRHAGE

Date: _____ Time: _____

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

Time of onset (or last seen normal): _____

Neurological Review of Systems:

ALLERGIES:

MEDICATIONS:

☐ see medication reconciliation sheet

REVIEW OF SYSTEMS:

Normal

Abnormal (Elaborate)

Psychiatric:

☐

Constitutional:

☐

Skin:

☐

Respiratory:

☐

Cardiovascular:

☐

GI:

☐

GU:

☐

Endocrine:

☐

Musculoskeletal:

☐

Hematology

☐

☐ All other systems reviewed and are negative

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY

SOCIAL HISTORY:

☐ Tobacco

☐ Heavy Alcohol

☐ Drugs:

FAMILY HISTORY

Pre-stroke mRS:

0: No symptoms at all

1: No significant disability despite symptoms; able to carry out all usual activities

2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3: Moderate disability; requiring some help, but able to walk without assistance

4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention



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EXAMINATION

Problem Focused: 1-5 * elements; Expanded Problem Focused: 6+ * ; Detailed: 12+ * ;

Comprehensive: all * elements, plus one cardiovascular element

CONSTITUTIONAL

* Vital Signs: BP ____/____ T ____ Tmax ____ HR ____ RR ____ Wt ____
(3 or more)

	Normal	Relevant Details (required if abnormal)
* Appearance	<input type="checkbox"/>	_____
Cardiovascular		
Neck	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____
Peripheral vasc .	<input type="checkbox"/>	_____
Other		
Pulmonary	<input type="checkbox"/>	_____
GI	<input type="checkbox"/>	_____

MENTAL STATUS

* Attention	<input type="checkbox"/>	_____
* Orientation	<input type="checkbox"/>	_____
* Memory	<input type="checkbox"/>	_____
* Language	<input type="checkbox"/>	_____
Visuospatial	<input type="checkbox"/>	_____
Executive	<input type="checkbox"/>	_____
* Fund of knowledge	<input type="checkbox"/>	_____

CRANIAL NERVES

/Visual Acuity	<input type="checkbox"/>	_____
* - Visual Fields	<input type="checkbox"/>	_____
\Fundi	<input type="checkbox"/>	_____
* - Pupils	<input type="checkbox"/>	_____
\Eye Movements	<input type="checkbox"/>	_____
* V (Trigeminal)	<input type="checkbox"/>	_____
* VII (Facial)	<input type="checkbox"/>	_____
* VIII (Hearing and balance)	<input type="checkbox"/>	_____
* IX, X (Palate and gag)	<input type="checkbox"/>	_____
* XI (Shrug)	<input type="checkbox"/>	_____
* XII (Tongue)	<input type="checkbox"/>	_____

MOTOR

* Bulk, Tone	<input type="checkbox"/>	_____
Pronator Drift	<input type="checkbox"/>	_____
/ RUE strength	<input type="checkbox"/>	_____
* - LUE strength	<input type="checkbox"/>	_____
\RLE strength	<input type="checkbox"/>	_____
\LLE strength	<input type="checkbox"/>	_____
Toe/Heel Walk	<input type="checkbox"/>	_____



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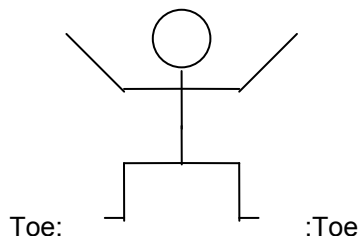
NEUROLOGY - ADMISSION HISTORY and PHYSICAL- INTRACEREBRAL HEMORRHAGE

	Normal	Relevant Details (required if abnormal)
SENSORY		
Light Touch	<input type="checkbox"/>	_____
Pinprick	<input type="checkbox"/>	_____
Temperature	<input type="checkbox"/>	_____
Vibration	<input type="checkbox"/>	_____
Proprioception	<input type="checkbox"/>	_____
Romberg	<input type="checkbox"/>	_____

COORDINATION		
RAM	<input type="checkbox"/>	_____
Finger - Nose	<input type="checkbox"/>	_____
Heel - Shin	<input type="checkbox"/>	_____
Tandem Walk	<input type="checkbox"/>	_____

GAIT

REFLEXES



NIHSS: _____

GCS score: _____

DATA

Neuroimaging: (date: _____ time first read: _____)

ICH volume: (____x____x____)/2= _____ mL

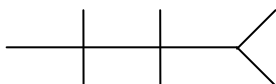
ICH SCORE: _____

Vascular imaging:

EKG:

CXR:

UA

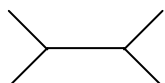


Ca

Mg

Phos

Troponin



PT

INR

PTT

CK/MB



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ASSESSMENT AND PLAN ☐ I have considered the patients home medications when writing admission orders

Acute intracerebral hemorrhage, ICH score: _____

Suspected etiology: _____

- ☐ Admit to Neurology in Neuro-ICU
- ☐ Close monitoring for signs of neurologic deterioration
- ☐ Consider for enrollment in ICH research studies
- ☐ Consult neurosurgery, check CTA head to r/o vascular lesion
- ☐ IV normal saline rate: _____
- ☐ Maintain INR < 1.3, PTT normal, plts > 100,000
- ☐ Continuous telemetry for detection of arrhythmias
- ☐ Repeat HCT or MRI in 24 hours
- ☐ Blood pressure control to < 150/90

- ☐ Head of 30 degrees, bedrest
- ☐ PT/OT/rehab when able to mobilize safely
- ☐ DVT prophylaxis with SCDs
- ☐ Swallowing evaluation prior to oral intake
- ☐ Check HbA1C if diabetic.
- ☐ Frequent glucose monitoring- cover with sliding scale insulin

Other medical issues: _____

Resident/APRN Signature: _____ Date: _____ Time: _____

Printed Name: _____ Pager Number: _____

ATTENDING NOTE

I have seen and examined this patient with/subsequent to the resident. I agree with his/her history, review of systems, family history, social history, physical examination, impression and plan as outlined in his/her note above with the following addendums:

History: _____

Physical Exam: _____

Test results: _____

Assessment and Plan: _____

Attending Signature: _____ Date: _____ Time: _____

Printed Name: _____ Pager Number: _____