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NEURO: Mental Status: Alert and

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oriented x3. Language is fluent with good comprehension. Cranial Nerve: Pupils are equal, round, and reactive to light. Visual fields are intact to confrontation. Normal fundi. Ocular movements are intact. Face is symmetric at rest and with activation with intact sensation throughout.

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missing a potentially serious ...

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NEURO: Mental Status: Alert and
oriented x3. Language is fluent with
good comprehension. Cranial Nerve:

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Pupils are equal, round, and reactive to light. Visual fields are intact to confrontation. Normal fundi. Ocular

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motor and sensory function, pupillary response, reflexes, the cerebellum, and vital signs. However, unless you work in a neuro unit, you won't typically need to perform a sensory and cerebellar assessment. Nursing Assessment Gathering Data Assessment Techniques

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docuMentation 1. Write treatment,
escalation process and outcome in the
clinical record 2. Write date, signature
and designation with each entry

Facility: _____ Adult NeurologicAI

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Observation chart (incorporating the
Glasgow coma scale) COMPLETE ALL
DETAILS OR AFFIX PATIENT LABEL
HERE FAMILY NAME MRN GIVEN
NAME MALE FEMALE

~~ADULT NEUROLOGICAL
OBSERVATION CHART - Education~~

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Package ... Documentation Example

Sample Abnormal Documentation .

While you won't use all of these elements in documenting an abnormal neuro exam, here are some examples of neurological abnormalities you may find and record. Abnormals on a neurological exam may include:

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Confused, disoriented; Somnolent,
lethargic; Disoriented to (person, time,
place, situation)

~~Documenting a Neuro Exam, Decoded
| ThriveAP~~

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Sample Write-Ups Sample

Neurological H&P CC: The patient is a
50-year-old right-handed woman with

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a history of chronic headaches who complains of acute onset of double vision and right eyelid droopiness three days ago. History of present illness: ... Assessment: In summary, the patient is a 50-year-old woman with longstanding headaches who has ...

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Sample Write-Ups Example

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response is any reflex observed on one side of the body when the other side has been stimulated.

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NEUROLOGICAL ASSESSMENT FLOW SHEET. DATE: TIME: (Military Time)

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EYES 4= SPONTANEOUS. OPEN 3= To SPEECH. 2= To PAIN. 1= NONE. C= Eyes CLOSED by Edema. BEST 5= ORIENTED. VERBAL 4= CONFUSED.

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Neurological. Cranial Nerve
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different, but assessment is great! 0;
Increased ICP ' s, herniation, etc. for
indepth information about ICP, coma,
herniation, assessments 0; Neuro

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assessment refresher Neuro
assessment refresher 0; OB/GYN links.
Fetal Circulation and Congenital Heart
Defects 0

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Assessing the motor function of the patient during a neurological assessment needs to be individualised, and the techniques used are dependent on the patient ' s

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condition. For example, if the patient is conscious, the assessment is made by observing their motor response to commands such as squeeze my hands.

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