## PUPIL SIZE SCALE


**Pupil Reaction:** Brisk = ++ Sluggish = + None = - Closed or Swollen Shut = C

**Glasgow Coma Scale**

| DATE / TIME: INITIAL: | | | | | | | | | | | | **Key: Medications** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EYES OPEN | Spontaneous | 4 | | | | | | | | | | S - SEDATIVE |
| | To Speech | 3 | | | | | | | | | | P - PARALYTIC |
| | To Pain | 2 | | | | | | | | | | T - TRANQUILIZER |
| | None | 1 | | | | | | | | | | P - PAIN MED |
| | | | | | | | | | | | | U - UNTESTABLE |
| BEST VERBAL RESPONSE | Alert / Oriented | 5 | | | | | | | | | | T - TRACH / ENDO |
| | Confused | 4 | | | | | | | | | | S - SLURRING DYSPHASIA |
| | Inappropriate Words | 3 | | | | | | | | | | R - RECEPTIVE |
| | Incomprehensible Sounds | 2 | | | | | | | | | | E - EXPRESSIVE |
| | None | 1 | | | | | | | | | | |
| BEST MOTOR RESPONSE | Obeys Command | 6 | | | | | | | | | | RECORD BEST RESPONSE FROM EITHER ARM |
| | Localizes Pain | 5 | | | | | | | | | | |
| | Withdraws Pain | 4 | | | | | | | | | | |
| | Flexion (Pain) | 3 | | | | | | | | | | |
| | Extension (Pain) | 2 | | | | | | | | | | |
| | None | 1 | | | | | | | | | | |
| **COMA SCALE TOTAL:** | | | | | | | | | | | | |

**STROKE ASSESSMENT**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time / Date: | | | | | | | | | | | |
| | Initial: | | | | | | | | | | | |
| **KEY:** | ✓ Normal Assessment * Abnormal - See Focus Note > Previously Described Abnormal | | | | | | | | | | | |
| **Level of Consciousness** | Alert | | | | | | | | | | | |
| | Fully Arousable | | | | | | | | | | | |
| | Briefly Arousable | | | | | | | | | | | |
| | Opens Eyes Only | | | | | | | | | | | |
| | Unresponsive | | | | | | | | | | | |
| | Orientation | | | | | | | | | | | |
| **Speech** | Clear | | | | | | | | | | | |
| | Dysarthric | | | | | | | | | | | |
| | Expressive Aphasia | | | | | | | | | | | |
| | Receptive Aphasia | | | | | | | | | | | |
| **Pupils React** | (R) Size - Reaction | | | | | | | | | | | |
| | (L) Size - Reaction | | | | | | | | | | | |
| | Blink | | | | | | | | | | | |
| **Facial Movement** | Wrinkles / Forehead | | | | | | | | | | | |
| | Opens / Closes Eyes | | | | | | | | | | | |
| | Smiles / Shows Teeth | | | | | | | | | | | |
| | Tongue Movement | | | | | | | | | | | |
| | Swallow / Gag Intact | | | | | | | | | | | |
| **Bilateral Touch** | Shoulders | | | | | | | | | | | |
| | Lower Leg / Foot | | | | | | | | | | | |
| **Hand Grasp to Command** | R | | | | | | | | | | | |
| | L | | | | | | | | | | | |
| **Wiggles Toes to Command** | R | | | | | | | | | | | |
| | L | | | | | | | | | | | |

| Initial | Name | Initial | Name | Initial | Name | Initial | Name |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

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# COMMUNITY MEDICAL CENTER

## STROKE ASSESSMENT / GLASGOW COMA SCALE NEUROLOGICAL GUIDELINES FLOW SHEET

# NEUROLOGIC GUIDELINES FLOW SHEET - STROKE PATHWAY

**DIRECTIONS FOR USE:**

1. Enter correct time and date on line.
2. Record all neurological information vertically.
3. Record ✔ for all correct responses.
4. Record * for abnormal responses and/or significant change from the baseline and expand further in Progress Notes.
5. Motor response to commands requires the ability to interpret verbal commands and perform specific movements on request such as "put out your tongue" or "let go of my hand."

## GLASGOW COMA SCALE:

Record patient's single best response in each category. Several attempts at each level may be necessary. If the patient is untestable in a certain category, record "U" and provide explanation in the nurses' Notes section of the chart, i.e. U = Inability to open or close eyes from periorbital edema, lid paralysis or protruding eyes.

**Eyes Open: (Assessment of the stimulus required to induce eye opening)**

| | |
|---|---|
| Spontaneous: | With no further stimulation, patient has eyes open. |
| To Voice: | If patient's eyes are unopened, a request to "open your eye" should be spoken. If his eyes are then opened, the action can be considered a response to voice stimulation. |
| To Pain: | If verbal stimulation is unsuccessful in eliciting eye opening, the standard stimulus is applied. |
| None: | No eye opening. |

**Best Verbal Response:**

| | |
|---|---|
| Alert/Oriented: | After patient is aroused, ask who he is, where he is and what year and month are. If accurate answers are obtained, patient is recorded as oriented. |
| Confused: | Although patient is unable to give correct answers to previous questions, he is capable of producing phrases, sentences and even conversational exchanges. |
| Inappropriate Words: | Patient speaks or exclaims only a word or two (often curses). Such a response is usually obtained only by a physical stimulus rather than a verbal stimulus. |
| Incomprehensible Sounds: | Patient's response consists of groans, moans or indistinct mumbling and does not contain any intelligible words. |
| None: | Prolonged and, if necessary, repeated stimulation does not produce any phonation. |

**Best Motor Response:**

| | |
|---|---|
| Obeys Command: | This requires ability to comprehend instructions, usually given in some form of verbal commands but sometimes by gestures and writing. Patient is required to perform specific movements requested. |
| Localizes Pain: | If patient does not obey commands, painful stimulus may be applied, e.g., firm pressure to sternum or nail bed for five seconds. If patient localizes pain he reach to and/or tries to remove source of pain. |
| Withdraws: | After painful stimulation: elbow flexes, rapid movement, no muscle stiffness, arm is drawn away from the trunk. |
| Flexion Response: | After painful stimulation: elbow flexes, slow movement, accompanied by stiffness, forearm and hand held against body. (Decorticate) |
| Extension Response: | After painful stimulation: legs and arms extend, accompanied by stiffness, internal rotation of shoulder and forearm. (Decerebrate) |
| Coma Scale Total: | Total score from each of the 3 seconds of the Coma Scale to arrive at total Glascow Coma Score. (Glascow Coma Scale less than 8 = coma) |

## STROKE ASSESSMENT:

**Level of Consciousness:**

| | |
|---|---|
| **Alert** | Patient awake, alert, eyes open at patient initiation without outside stimulation. |
| **Fully Arousable** | Becomes alert and remains awake and alert when name called. |
| **Briefly Arousable** | Patient's eyes open in response to speech (command), but falls back to sleep. |
| **Opens Eyes Only** | Eyes open only to noxious painful stimuli. |
| **Unresponsive** | Patient's eyes do not open, or if eyes are open it is due to flaccid muscles. |
| **Orientation** | ✔ If appropriate and oriented to person, place, time (anyone can forget the day).<br>*If confused, inappropriate, incomprehensible, or none. Document in Progress Notes more specifically. |

**Speech:** (Assess quality of speech)

| | |
|---|---|
| **Clear** | Speech clear, no slurring of words or searching for words to express thoughts. |
| **Dysarthric** | Difficulty articulating words. Words are slurred. |
| **Expressive Aphasia** | May be able to understand phrases/follow commands, but not able to express words. Words or phrases may make little or no sense. |
| **Receptive Aphasia** | Not able to comprehend words spoken; confusion in following commands. Responds inappropriately when spoken to. Make sure patient does not have hearing impairment; or have hearing aids or that interpreter is available. |
| **Pupils React:** | If eyes are swollen shut or otherwise untestable, write the letter "U" in the size space.<br>**NOTE: Measure pupil size before testing for light reaction.** |
| **Facial Movement:** | ✔ If able to do: wrinkle forehead, open and close eyes, smile and show teeth, put out tongue, and swallow.<br>* If unable to do, or if asymmetry occurs (one side weaker than other). |
| **Bilateral Touch:** | ✔ If patient feels examiner touch shoulders and numbness absent.<br>✔ If patient feels examiner touch lower leg/foot and numbness absent.<br>* If sensation not perceived, or numbness present. |
| **Hand Grasp:** | ✔ If patient able to squeeze and release examiner's hand on command, and strength is equal and strong.<br>* If not able to follow command or if grasp is weak (one weaker than the other, or bilaterally weak). |
| **Wiggles Toes:** | ✔ If able to wiggle toes on both feet to command<br>* If not able to wiggle toes on both feet. |