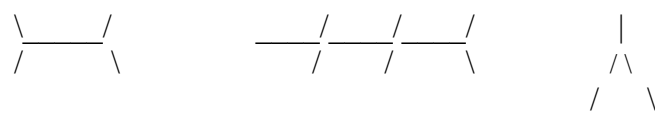


Patient Identification

Attending Physician Key Findings Date:	Date: _____ Time: _____ ICU day #: _____		
	Interval History:		
	Medications:		
	IVs and rate:	Vent:	Lines/Tubes & Day Inserted IV line Central line NGT PEG
♦Vital Signs: T: _____ Tmax: _____ BP: _____ P: _____ RR: _____			
♦ General Appearance: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ Neck/Carotids: <input type="checkbox"/> NL <input type="checkbox"/> Abnl LUNGS: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ CVS: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ABD: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ EXT/PV: <input type="checkbox"/> NL <input type="checkbox"/> Abnl OTHER: NEUROLOGICAL: <input type="checkbox"/> awake, alert <input type="checkbox"/> comatose ♦ MS <input type="checkbox"/> OPTH <input type="checkbox"/> Memory <input type="checkbox"/> FK <input type="checkbox"/> A/C <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ Speech <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> dysarthria ♦ language <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> Aphasia <input type="checkbox"/> Fluent <input type="checkbox"/> Nonfluent brainstem reflexes present: <input type="checkbox"/> pupil OD ____ OS ____ reactive to light OD ____ OS ____ <input type="checkbox"/> corneals <input type="checkbox"/> oculocephalics <input type="checkbox"/> gag <input type="checkbox"/> cough ♦ Optic Fundus: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ Visual Fields: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ Brainstem reflexes: <input type="checkbox"/> corneal <input type="checkbox"/> oculocephalic <input type="checkbox"/> gag <input type="checkbox"/> cough <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ CN: ♦ <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 6 ♦ <input type="checkbox"/> 5 ♦ <input type="checkbox"/> 7 ♦ <input type="checkbox"/> 8 ♦ <input type="checkbox"/> 9 ♦ <input type="checkbox"/> 10 ♦ <input type="checkbox"/> 11 ♦ <input type="checkbox"/> 12 <input type="checkbox"/> NL <input type="checkbox"/> Abnl DYSPHAGIA: <input type="checkbox"/> present <input type="checkbox"/> absent ♦ MOTOR: ♦ strength <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ tone <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> pronator drift present on <input type="checkbox"/> R <input type="checkbox"/> L ♦ SENSORY: <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> neglect <input type="checkbox"/> sensory extinction ♦ DTR: <input type="checkbox"/> NL <input type="checkbox"/> Abnl TOES: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ COORDINATION: <input type="checkbox"/> NL <input type="checkbox"/> Abnl ♦ GAIT: <input type="checkbox"/> NL <input type="checkbox"/> Abnl			

Attending Physician Key Findings	<p style="text-align: right;">VCU Health Systems Neurology Intensive Care Note Page 2 of 2</p>
	Patient Identification TESTS:
	LABS:  ABG: / / / / LFT'S: ALB TP AST ALT ALP
	A/P: Neurological: CVS: Resp.: Renal: GI/nutrition: Code Status:
	Teaching Physician Note:

RESIDENT SIGNATURE: _____ BEEPER: _____ DATE: _____

I have interviewed & examined the patient & confirm/revised the history, exam, assessment & plan as noted above. Please see resident's notes for details.

ATTENDING SIGNATURE: _____ DATE: _____