# NEUROLOGICAL ASSESSMENT RECORD

**Name:** **HCRN:**

## *Paediatric Glasgow Coma Scale*

**DOB:** **Ward:**

| | | | DATE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | TIME | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Eyes Opening** | Spontaneously | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | To verbal stimuli | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | To pain | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | No response | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Best Verbal/Grimace** | **4+ yrs** Oriented and converses as norm **0-4 years**. Vocalises or coos/ smiles/cries appropriately | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **4+ years** Disoriented **0-4** Spontaneous irritable cry | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Cries/Screams to pain | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Grunts/Moans to pain | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | No Response | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Best Motor Response** | Usual mobility/obeys command | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Localises pain | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Withdraws from pain | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Abnormal flexion | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Extension to pain | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | No Reaction to pain | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Total GCS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

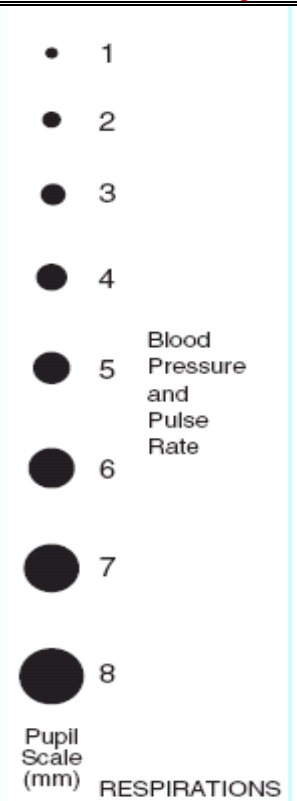
**Eyes closed by swelling - C**

**Endotracheal tube/ tracheostomy - T**

**Record best arm response**

**A total GCS of ≤ 13 needs Medical review,**
**A total GCS of ≤ 9 needs Urgent Anaesthetic review/PICU.**

***Any individual score in the (orange) section needs medical review.***
***Any individual score in the red section requires urgent anaesthetic review.***




230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

40 39 38 37 36 35 34 33 32 31 30

Temperature °C
Record in Red

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PUPILS** | Right | Size (mm) Reaction | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Left | Size (mm) Reaction | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LIMB MOVEMENT** | Arms | Normal Power | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Mild Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Moderate Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Severe Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | No response | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Legs | Normal Power | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Mild Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Moderate Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Severe Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | No response | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Initials** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(+)Reacting
(SL) Sluggish
(-) Not reaction

Record Right [R] and Left [L] separately if there is a difference between two sides
(P)-paralysed

# NEUROLOGICAL ASSESSMENT RECORD

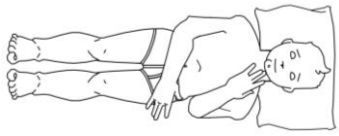
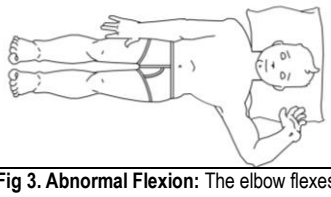
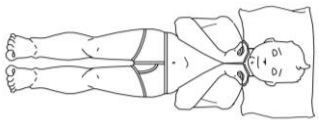
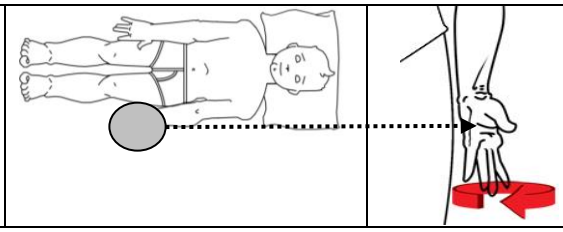
***Paediatric Glasgow Coma Scale***

**Name:** **HCRN:**

**DOB:** **Ward:**

**Guide to using Neurological Observation Chart for all infants/Children**

***Involve carers in assessment to establish normal response***

| **EYE OPENING** | **EXPECTED RESPONSE** | **PROMPT** Waken a sleeping infant/child |
|---|---|---|
| **4** = Spontaneously<br>**3** = To verbal stimuli<br>**2** = To pain<br>**1** = No response | Eyes open without stimulation<br>Eyes open to sound or verbal stimuli.<br>Eyes open to painful stimulus only.<br>No response to painful stimuli | Prior to assessment, touch to waken.<br>Use appropriate language and familiar names.<br>Involve the family.<br>***Painful Stimulus***: Use Trapezius squeeze.<br>Apply gentle stimulus, gradually increasing for 10 seconds or less, or until eye opening is seen. |
| **BEST VERBAL RESPONSE** | **EXPECTED RESPONSE**<br>**Assess patient with Intellectual disability in 0-4years age group** | **PROMPT** |
| **5** = 4+ years Orientated and converses as normal | Vocalises ***to usual ability***<br>**Young child-**answers simple questions, gives name on request, can name toys, parents etc.<br>**Infant-** smiles, coos or cries appropriately | Ask age appropriate questions.<br>Involve carers to establish what's normal. |
| 0-4 years Vocalises normally or coos/smiles/ cries/screeches appropriately | **Intellectual disability / Non-verbal Infant/child:** communicates to usual ability. | Screeching/shouting or grunting may be appropriate in an infant/child with intellectual disability. Involve carer in assessment (where possible). |
| **4** =Spontaneous irritable cry/disoriented | Cry is high pitched and inconsolable<br>Cry is irritable and infant is difficult to pacify | The infant/child with Intellectual disability or who is non verbal has a change in normal vocalisation pattern or ability |
| **3** = Cries/screams to pain | Cry is in response to pain **only**. | ***Painful Stimulus:*** As above |
| **2** = Grunt/Moans to pain | Grunts or moans in response to pain. | ***Painful Stimulus:*** As above |
| **1** =No Response | No response to painful stimuli | ***Painful Stimulus:*** As above |
| **BEST MOTOR RESPONSE** | **EXPECTED RESPONSE – *Please assess best response*** | **PROMPT (Visual or Verbal)** |
| **6** = Usual mobility/ Obeys commands | The child will perform a task correctly.<br>***Intellectual disability / Non-verbal child:*** task performed to usual ability | Ask carers if mobility is normal<br>Offer child a toy/ bottle |
| **5** = Localises pain | **Fig1. Localises Pain-**<br>***Note:*** Infants 0-6 months will not localise pain but should demonstrate normal flexion in response to pain.<br>Infants > 6 months should bring hand to source of pain and may try to push it away(Purposeful).<br>  | ***Painful Stimulus:***<br>Infants/ children with physical disability may have abnormal posture. Flexion may be a normal position for these infants/children. |
| **4** = Withdraws from pain | **Fig 2. Withdraws from Pain:** The child moves limb away from painful stimulus<br>  | ***Painful Stimulus:*** As above |
| **3** = Abnormal flexion | **Fig 3. Abnormal Flexion:** The elbow flexes and the wrist rotates in response to a central painful stimulus<br>  | ***Painful Stimulus:*** As above<br>Flexion may be the normal position for a child. This does not indicate a low score. |
| **2** = Extension to pain | **Fig 4. Extension:** Arm straightens at the elbow and there may be internal rotation of the lower arm<br>  | ***Painful Stimulus:*** As above |
| **1** = No Response | | ***Painful Stimulus:*** As above |