

Assessor's name: \_\_\_\_\_

Job Title: \_\_\_\_\_

## Neurobehavioral Pre-Assessment Checklist

Name Preferred name/Nickname Date of Birth Hand Dominance Native Language Cultural/Religious considerations																																									
<b>Medical Condition and Assistive Devices</b>																																									
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 70%;">Comments/Concerns</th> </tr> </thead> <tbody> <tr> <td>Hearing Devices</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Glasses</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Orally Intubated</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Tracheostomy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>If tracheostomy, use of speaking valve</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Supplemental Oxygen</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Ventilatory support</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Metabolic disorders</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Please list any relevant premorbid medical history</td> <td colspan="3"></td> </tr> </tbody> </table>		Yes	No	Comments/Concerns	Hearing Devices	<input type="checkbox"/>	<input type="checkbox"/>		Glasses	<input type="checkbox"/>	<input type="checkbox"/>		Orally Intubated	<input type="checkbox"/>	<input type="checkbox"/>		Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>		If tracheostomy, use of speaking valve	<input type="checkbox"/>	<input type="checkbox"/>		Supplemental Oxygen	<input type="checkbox"/>	<input type="checkbox"/>		Ventilatory support	<input type="checkbox"/>	<input type="checkbox"/>		Metabolic disorders	<input type="checkbox"/>	<input type="checkbox"/>		Please list any relevant premorbid medical history			
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<b>Motor</b>	<b>Cognitive</b>	<b>Sensorial</b>	<b>Neurological/ Neurosurgical</b>	<b>Behaviour</b>																																					
<ul style="list-style-type: none"> <li>Spinal cord injury</li> <li>Neuropathy/myopathy</li> <li>Tremor/Myoclonus</li> <li>Spasticity/retractions</li> <li>Fractures</li> <li>Others:</li> </ul>	<ul style="list-style-type: none"> <li>Aphasia</li> <li>Apraxia</li> <li>Agnosia</li> <li>Others:</li> </ul>	<ul style="list-style-type: none"> <li>Blindness</li> <li>Deafness</li> <li>Others:</li> </ul>	<ul style="list-style-type: none"> <li>Uncontrolled seizures</li> <li>Active hydrocephalus</li> <li>Craniectomy</li> <li>Ptosis*</li> <li>Others:</li> </ul> <p style="font-size: small; margin-top: 10px;">*If suspected ptosis, consider manual eye opening</p>	<ul style="list-style-type: none"> <li>Agitation/aggressivity</li> <li>Paroxysmal sympathetic hyperactivity</li> <li>Suspected pain or discomfort</li> <li>Others:</li> </ul>																																					

Note: this checklist can be applied prior to any assessment scale

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Assessment				
Date				AM / PM
Assessment scale used				
Hospital ward or Home (please specify)				
Prior to starting assessment, please consider:				
	Yes	No	N/A	Comments
Best time for patient's responsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rest period prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family involvement/input/presence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Familiar stimuli identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Location of assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
"Do not disturb" sign up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minimize noise ( <i>music/tv off</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Door closed/close curtains if not single room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Tracheal suctioning needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sedative meds administered prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acute illness/fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient's wakefulness ( <i>i.e., eye opening; needed prompts to wake up</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Remove splints/casts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Remove sheets from covering body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At least 1 min observation prior to session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documented affective responses ( <i>e.g. smile, grimace, etc</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Patient Testing Position</b>				
(Reposition as needed to maintain optimal positioning, avoid discomfort, and avoid fatigue)				
<input type="checkbox"/> Supine	<input type="checkbox"/> Supine with head of bed elevated (please specify degree of incline____)			
<input type="checkbox"/> Sitting in wheelchair	<input type="checkbox"/> Sitting on the mat			
<input type="checkbox"/> Supported standing	<input type="checkbox"/> Other: _____			

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