COOPERATIVE STUDY OF SICKLE CELL DISEASE

NEUROLOGICAL EVALUATION

1. Person completing form (Name): _____ (Initials): [ ][ ][ ]
2. CSSCD Code number of person completing form (if known): [ ][ ][ ]
3. Date form completed (Month, Day, Year): ____/____/____

EVALUATION

4. **INTELLECTUAL FUNCTION – FOR PATIENTS 10 YEARS OF AGE OR OLDER**

Describe the patient's intellectual function:

- 1. Normal
- 2. Disoriented with respect to person, place and time
- 3. Inappropriate behavior, unable to care for self in spite of motor ability
- 4. NOT TESTED

5. **LANGUAGE FUNCTION**

A. **10 YEARS OF AGE AND OLDER:**

Describe the patient's language function:

- 1. No deficits noted
- 2. Normal conversation possible but definite errors in comprehension or expression present
- 3. Normal conversation difficult to maintain because of frequent errors
- 4. Some verbal communication possible
- 5. No verbal communication possible
- 6. Dysarthria

B. **UNDER 10 YEARS OF AGE:**

Were deficits noted? 1. NO 2. YES → 5.B.1 SPECIFY: _____

C. **COMPLETE FOR ALL AGES ONLY IF REPEAT EXAM:**

Was there a change from previous function? 1. NO – SAME 2. YES – WORSENED 3. YES – IMPROVED

[ ] Mail Log [ ] Data Entry

6. CRANIAL NERVES

FILL IN THE BOXES OF 6.1 AND 6.2, A-H, USING THE FOLLOWING CODES:

CODES
1 = NORMAL
2 = ABNORMAL
3 = NOT TESTED

	6.1 RIGHT	6.2 LEFT
A. Visual acuity	☐	☐
	6.3 If Abnormal, is patient blind? 1. NO 2. YES	6.4 If Abnormal, is patient blind? 1. NO 2. YES
B. Pupillary reflexes	☐	☐
C. Extraocular movement (exclude nystagmus)	☐	☐
D. Corneal reflex	☐	☐
E. Facial sensation	☐	☐
F. Facial power	☐	☐
G. Palatal reflex	☐	☐
H. Tongue movements	☐	☐

CHECK PRESENT OR ABSENT FOR EACH OF 6.1 AND 6.2 I-K

I. Nystagmus on gaze toward	1. PRESENT 2. ABSENT	1. PRESENT 2. ABSENT
J. Nystagmus on vertical gaze	1. PRESENT 2. ABSENT	1. PRESENT 2. ABSENT
K. Horner's syndrome	1. PRESENT 2. ABSENT	1. PRESENT 2. ABSENT

7. MOTOR

A. Muscle Tone

A.1 Right	a. Upper	1. NORMAL	2. INCREASED	3. DECREASED
	b. Lower	1. NORMAL	2. INCREASED	3. DECREASED
A.2 Left	a. Upper	1. NORMAL	2. INCREASED	3. DECREASED
	b. Lower	1. NORMAL	2. INCREASED	3. DECREASED

B. Motor Power

B.1 Right a. Upper: 1. NORMAL | 2. ABNORMAL → B.3: 1. PROXIMAL | 2. DISTAL | 3. BOTH

b. Lower: 1. NORMAL | 2. ABNORMAL → B.4: 1. PROXIMAL | 2. DISTAL | 3. BOTH

B.2 Left a. Upper: 1. NORMAL | 2. ABNORMAL → B.5: 1. PROXIMAL | 2. DISTAL | 3. BOTH

b. Lower: 1. NORMAL | 2. ABNORMAL → B.6: 1. PROXIMAL | 2. DISTAL | 3. BOTH

C. Involuntary Movement

	C.1 Right		C.2 Left	
a. Upper	1. NO	2. YES	1. NO	2. YES
b. Lower	1. NO	2. YES	1. NO	2. YES

D. Romberg: 1. POSITIVE | 2. NEGATIVE

E. Gait and Coordination

Describe the patient's coordination and gait:

1. Normal
2. Unable to walk
3. Broad based
4. Limp → E.1: 1. RIGHT | 2. LEFT
5. Ataxic
6. Not tested

8. CEREBELLAR FUNCTION

	8.1 Right		8.2 Left	
a. Upper finger-nose	1. NORMAL	2. ABNORMAL	1. NORMAL	2. ABNORMAL
b. Lower heel-shin	1. NORMAL	2. ABNORMAL	1. NORMAL	2. ABNORMAL
c. Rapid alternating movements	1. NORMAL	2. ABNORMAL	1. NORMAL	2. ABNORMAL

9. REFLEXES

A. Deep Reflexes

A.1 Right	a. Biceps	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	b. Triceps	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	c. Ulnar	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	d. Radial	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	e. Knee	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	f. Ankle	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
A.2 Left	a. Biceps	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	b. Triceps	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	c. Ulnar	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	d. Radial	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	e. Knee	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE
	f. Ankle	1. NORMAL	2. HYPERACTIVE	3. ABSENT/HYPOACTIVE

B. Plantar Reflexes

B.1 Right	1. NORMAL	2. ABNORMAL	3. CLONUS
B.2 Left	1. NORMAL	2. ABNORMAL	3. CLONUS

10. **SENSORY**

For each of the parts of the patient's body listed below, indicate whether the patient's ability to sense the following is NORMAL, ABNORMAL or NOT TESTED, using the codes in the box below the table. COMPLETE EVERY BOX IN THE TABLE.

Sensations to be tested:
- 10.1 Pain
- 10.2 Tactile
- 10.3 Vibration
- 10.4 Position

CODES
- 1 = NORMAL
- 2 = ABNORMAL
- 3 = NOT TESTED

Part of the Body	10.1 Pain	10.2 Tactile	10.3 Vibration	10.4 Position
A. Left arm/hand	☐	☐	☐	☐
B. Right arm/hand	☐	☐	☐	☐
C. Left leg/foot	☐	☐	☐	☐
D. Right leg/foot	☐	☐	☐	☐
E. Left trunk	☐	☐	☐	☐
F. Right trunk	☐	☐	☐	☐
G. Left saddle	☐	☐	☐	☐
H. Right saddle	☐	☐	☐	☐

Name of Data Coordinator: _____

Signature: _____

Date (Month, Day, Year): _____ / _____ / _____