

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert DOB]

**Patient ID:** [Insert ID Number]

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**To:** [Referring Physician Name]

**From:** [Your Name/Department]

**Subject:** Neurological Clinical Observation Notes

## 1. Chief Complaint

[Brief description of the reason for the encounter and current symptoms.]

## 2. Mental Status and Cognition

- **Level of Consciousness:** [e.g., Alert, Lethargic, Obtunded]
- **Orientation:** [Person, Place, Time, Situation]
- **Speech/Language:** [e.g., Fluent, Dysarthric, Aphasic signs]

## 3. Cranial Nerves

[Note findings for CN I through XII, focusing on pupillary response, extraocular movements, facial symmetry, and swallow/gag reflex.]

## 4. Motor System

- **Muscle Tone:** [e.g., Normal, Spastic, Flaccid]
- **Muscle Strength:** [Rated 0/5 to 5/5 for Upper and Lower Extremities]
- **Bulk/Atrophy:** [Observations of muscle wasting or fasciculations]

## 5. Sensory System

[Response to light touch, pain/pinprick, vibration, and proprioception.]

## 6. Reflexes

- **Deep Tendon Reflexes:** [Biceps, Triceps, Patellar, Achilles - Grade 0-4+]
- **Plantar Response:** [Flexor/Normal or Extensor/Babinski sign]

## **7. Coordination and Gait**

- **Cerebellar Signs:** [Finger-to-nose, Heel-to-shin, Rapid alternating movements]
- **Gait:** [Steady, Ataxic, Antalgic, or Narrow/Wide based]

## **8. Clinical Impression and Assessment**

[Summary of neurological findings and suspected localization of the lesion/issue.]

## **9. Plan and Recommendations**

[Proposed diagnostic imaging, laboratory tests, medication changes, or follow-up schedule.]

**Signature:** \_\_\_\_\_

[Your Name and Credentials]