



Neurological Assessment										
Glasgow Coma Scale				Pupil Reaction						
Spontaneous		= 4		B = Brisk S = Sluggish F = Fixed		8 7 6 5 4 3 2 1				
To voice		= 3								
To pain		= 2								
None		= 1								
Best Verbal Response				MMAASS: Modified Motor Activity Assessment Scale						
Age > 2 yrs		Age < 2 yrs		If chemically paralyzed or developmentally dysmature	Score		Description	Definition		
Oriented		5	Smiles, Listens, Follows		+ = under sedated:	+3	Dangerously agitated, uncooperative	Moves w/o external stimuli, thrashes head side to side. Pulls at tubes, tries to climb from bed, strikes at others.		
Confused Conversation		4	Cries, Consolable		Autonomic response (> 20 increase in HR, BP) to noxious stimuli*	+ 2	Agitated	Moves w/o external stimuli. Tries to sit up or get up. Requires restraint. Inconsolable.		
Inappropriate Words		3	Inappropriate, persistent cry			+ 1	Restless, but Cooperative	Moves w/o external stimuli, picks at tubes. Consolable.		
Incomprehensible sounds		2	Agitated, Restless			0	Calm and cooperative	Calms, awakens easily, and follows commands. Moves w/o external stimuli.		
None		1	No response			- 1	Responsive to touch or to name	Opens eyes, raises eyebrows, turns head or moves limbs with touch or when name spoken. Drifts off after stimulation.		
Obey commands		= 6				- 2	Responsive only to noxious stimuli	Opens eyes, raises eyebrows, or turns head toward stimulus. Moves limbs with noxious stimuli. May move spontaneously but does not communicate.		
Localizes pain		= 5				- 3	Unresponsive	Minimal to no response to noxious stimuli. Does not communicate or follow commands.		
Flexor withdrawal		= 4				* Noxious stimuli = suctioning or 5 seconds of nailbed pressure				
Abnormal flexion		= 3				Total Scores:				
Extension		= 2			GSC =					
None, flaccid		= 1			Verbal =					
Best Motor Response					Pediatric Pain Assessment Tools					
Extremity Strength					FLACC Pain Scale (< 3 yrs & Non verbal)					
Normal power		= 5								
Minimal weakness		= 4								
Lifts/holds against resistance		= 3								
Lifts/holds against gravity		= 2								



Strength =				Category	Score = 0	Score = 1	Score = 2	
No movement		= 0		Face	No particular expression or smile	Occasional grimace/frown. Withdrawn/disinterested	Quivering chin (frequent or constant). Clenched jaw.	
				Legs	Relaxed. Normal Position	Uneasy, restless or tense.	Kicking or legs drawn up	
Faces Pain Scale								
No Pain	Little Pain	Medium Pain	Large Pain	Worst possible Pain	Activity	Lying quietly, normal position.	Squirming, tense, shifting back & forth	Arched, rigid, or jerking.
					Cry	No cry (awake or asleep)	Occasional complaint, moans, or whimpers	Frequent complaints. Crying steadily, screams or sobs
Vital Signs References				Consolability	Content, relaxed			
Age	Pulse	Blood Pressure	Respirations					
< 1 yr	80 - 180	60 - 90 / 40 - 60	Asleep 2 - 31; Awake 58 - 75					
1 - 3 yrs	70 - 160	70 - 100 / 45 - 70	Asleep 17 - 24; Awake 30 - 41					
3 - 6 yrs	60 - 140	75 - 120 / 50 - 75	Asleep 14 - 24; Awake 19 - 39					
6 - 12 yrs	50 - 140	80 - 130 / 50 - 80	13 - 30					
12 - 18 yrs	50 - 120	80 - 135 / 50 - 80	14 - 22					

Cardiovascular Function											
Capillary refill		Peripheral pulses				Edema			Murmur		
Brisk	0	Bounding	0	Palpable, weak	3	Absent	0	Severe, deep depression	3	Absent	0
3 - 4 seconds	1	Palpable, strong	1	Absent	4	Mild Pitting	1	Anasarca	4	Present	1
Delayed	2	Palpable	2	Present only by doppler	5	Moderate Pitting	2	Generalized All over	5		

				by doppler		Pitting		All over			
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