SCORING SHEET FOR PSOM-SNE

SUMARY OF IMPRESSIONS

After completing the PSOM-NE or equivalent detailed neurologic examination, summarize and grade your impressions in the following categories:

A. Sensorimotor Deficit (ANY motor or sensory abnormality including Cranial Nerve Deficits, Visual, and Hearing deficits)

	R side	L side
Not Done	n/t	n/t
None	0	0
Mild but no impact on function	0.5	0.5
Moderate with some functional limitations	1	1
Severe or Profound with missing function	2	2
Not Tested	n/t	n/t

Select the Sensorimotor Deficits You Observed (select all that apply)

☐ Global developmental delay ☐ Global hypotonia or hypertonia

☐ Hemiparesis ☐ Hemifacial weakness ☐ Hemiataxia ☐ Dysarthria ☐ Other Motor deficit

☐ Hemisensory deficit ☐ Other Sensory deficit

☐ Difficulty with vision

☐ Difficulty with drinking, chewing or swallowing

☐ Other, describe: _____

B. Language Deficit – Production (exclude dysarthria)

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some functional limitations	1
Severe or Profound with missing function	2
Not Tested	n/t

Describe the Language Production Deficits You Observed Here: _____

_____

C. Language Deficit - Comprehension

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some functional limitations	1
Severe or Profound with missing function	2
Not Tested	n/t

Describe The Language Comprehension You Observed Here: _____

_____

D. Cognitive or Behavioural Deficit (specify which) ☐ **Cognitive** ☐ **Behavioural**

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some functional limitations	1
Severe or Profound with missing function	2
Not Tested	n/t

Describe the Cognitive or Behavioural Deficits You Observed Here: _____

_____

TOTAL SCORING: _____/10

PICTURES TO ASSESS 'NAMING' (see Language on Page 1) (adapted from STOP study: E. S. Roach)

1. Have you/your child recovered completely from the stroke? o Yes o No
2. Does your child need extra help with day-to-day activities compared to other children their age? o Yes o No
3. a) Has the stroke affected you/your child's emotional state, behavior and feelings about his/herself? o Yes o No
   b) Does your child show any signs of depression? o Yes o No
4. Does the child use aids or assistive devices (e.g. splints, braces)? o Yes o No Specify:_____