

# Childhood Stroke Clerking Checklist

# SOCS

Study of Outcome of  
Childhood Stroke



[www.childstroke.org.uk](http://www.childstroke.org.uk)

The aim of this clerking checklist is to supplement the conventional process of history taking and examination by providing prompts for clinical factors that are potentially relevant to a child presenting with acute stroke. This clerking checklist must not be considered to be comprehensive but should complement the normal clerking process. It is important to record if it was not possible to record any of these parameters and give the reasons why not (e.g. test was developmentally inappropriate or the child was uncooperative).

## History

- |  |   |
|--|---|
| <input type="checkbox"/> Time of onset of symptoms                     | <input type="checkbox"/> Head or neck pain?                                     |
| <input type="checkbox"/> Prior events e.g. TIA                         | <input type="checkbox"/> Past medical history (including history of thrombosis) |
| <input type="checkbox"/> Seizures                                      | <input type="checkbox"/> Family history (including thrombosis, miscarriage)     |
| <input type="checkbox"/> Prior trauma to the head or neck (even minor) | <input type="checkbox"/> Medication (and recreational drugs)                    |
| <input type="checkbox"/> Chickenpox? If so, when?                      | <input type="checkbox"/> Development  |
| <input type="checkbox"/> History of recent infection                   |   |

## General Examination

- |  |   |
|--|---|
| <input type="checkbox"/> Cardiovascular examination                        | <input type="checkbox"/> Oxygen saturation    |
| <input type="checkbox"/> Peripheral pulses (check for radio-femoral delay) | <input type="checkbox"/> Temperature          |
| <input type="checkbox"/> Blood pressure (4 limbs)                          | <input type="checkbox"/> Neurocutaneous signs |

## Neurological examination to include evaluation for:

- |  |   |
|--|---|
| <input type="checkbox"/> Conscious level (use GCS or modified GCS)   | <input type="checkbox"/> Motor deficit (if present specify location and severity using MRC 0-5 scale) |
| <input type="checkbox"/> Cranial nerve function including: <ul style="list-style-type: none"><li><input type="checkbox"/> Eye movements (?gaze palsy)</li><li><input type="checkbox"/> Visual fields</li><li><input type="checkbox"/> Fundoscopy</li><li><input type="checkbox"/> Facial palsy</li><li><input type="checkbox"/> ?Horner's syndrome</li></ul> | <input type="checkbox"/> Ataxia (if present specify location e.g. truncal or limb)                    |
| <input type="checkbox"/> Neglect (if present specify location)   | <input type="checkbox"/> Sensory dysfunction (if present specify location)                            |
|  | <input type="checkbox"/> Communication (including expressive & receptive language & articulation)     |
|  | <input type="checkbox"/> Swallowing   |