OSCE Checklist - Paediatric Neurological Examination

NB - This mark scheme will need to be adapted to each child, depending on their age. You would not be expected to perform all of the below points in a single examination and many of these items would be omitted for most children.

INTRODUCTION		
1	Wash hands	
2	Introduce yourself to both the parents & child	
3	Confirm patient details	
4	Explain what the examination will involve in appropriate language	
5	Gain consent	
GENERAL INSPECTION		
6	Observe the child during play (attention span, gross/fine motor coordination, problem-solving)	
7	Observe for age-appropriate milestones	
CRANIAL NERVES		
8	**Olfactory** nerve assessment (not appropriate in small children or infants)	
9	**Optic nerve** assessment (visual acuity, visual fields, pupillary reflexes, fundoscopy)	
10	**Oculomotor**, **Trochlear** & **Abducens** nerve assessment (inspect for ptosis, assess eye movements)	
11	**Trigeminal** nerve assessment (assess facial sensation, mouth opening against resistance)	
12	**Facial** nerve assessment (inspect face for asymmetry, observe facial expressions)	
13	**Vestibulocochlear** nerve assessment (assess gross hearing, Rinne's/Weber's if older, inspect for evidence of vestibular nerve dysfunction)	
14	**Glossopharyngeal** and **Vagus** nerve assessment (observe child drinking/eating and observe soft palate)	
15	**Accessory** nerve assessment (assess shoulder elevation and turning against resistance if appropriate)	
16	**Hypoglossal** nerve assessment (inspect the tongue for fasciculations and ask child to stick out tongue)	
UPPER & LOWER LIMB NEUROLOGICAL EXAMINATION		
17	**Inspect** upper and lower limbs (asymmetry, wasting, abnormal movements)	
18	Assess upper and lower limb muscle **tone** (spasticity, rigidity, clonus)	
19	Assess upper and lower limb muscle **power** (shoulders, elbow, wrist, fingers, hip, knee, ankle, big toe)	
20	Assess upper and lower limb **reflexes** (biceps, triceps, supinator, knee jerk, ankle jerk, plantar)	
21	Assess upper and lower limb **sensation** (light touch, pin-prick, vibration, proprioception)	

22	Assess upper and lower limb **co-ordination** (finger to nose, reaching for toys etc)	
23	Observe child's **gait** (posture, arm swing, stride length, speed, symmetry, balance)	
TO COMPLETE THE EXAMINATION		
24	Re-dress the child (or ask the parents to do so if appropriate)	
25	Thank the child and/or parents	
26	Explain your findings to the parents and/or child	
27	Ask if the parents and/or child have any questions	
28	Wash your hands	
29	Suggest further clinical assessments (skin assessment, spine assessment, cardiovascular examination, abdominal examination)	
30	Suggest further investigations (i.e. vital signs, height/weight on growth chart, blood tests including autoantibodies, lumbar puncture, neuro-imaging, EEG, nerve conduction studies)	