Spinal Cord Injury Patient Assessment

History	Physical Exam	Action
Level of lesion	brief confirmatory exam	
Problems with skin? Sore areas on skin?	decubitus ulcer/heterotopic ossification areas of warmth/redness/pain	Consider referral
Respiratory problems? If on vent, last visit to pulmonary? Changes in management?	lung exam	Consider referral
Episodes autonomic dysreflexia Caused by?	look for ingrown toenails or any stimulation that could cause AD	Check UA, KUB?
Bladder management Continence? S/S infection?	check bladder volumes, PVR amounts	Consider UA/culture Meds for neurogenic bladder
Bowel management Continence? S/S pain, distention, n/v Constipation/diarrhea?	ask about consistency, amount, timing	Change program Consider UA/culture Diet changes Laxative,clean out?
New contractures or spasticity?	exam for DTRs,clonus, spasticity, contractures	Consider rehab/ortho
Depression? Caregivers doing okay?		Referral social work, psych Respite care Family support groups
School?/Recreation 504, IEP?, school health plan? Access to school? Included?		
Stander? Wheelchair – fitting? Any problems?		
Fractures, bone pain?		Consider dexa-scan
Sexuality/reproductive issues		Consider referral