Appendix 3- Neonatal Encephalopathy Examination Scoring Sheet

Date	Exam 1	Exam 2	Exam 3	Exam 4			
1- Observe	0	0	0	0	Normal		
spontaneous	2	2	2	2	Decreased = decreased frequency or amplitude of spontaneous facial and extremity movements		
activity	3	3	3	3	Absent		
2- Observe for	0	0	0	0	Normal		
Heart rate	1	1	1	1	Tachycardia = resting HR 160-180. Only occasionally decreased to 120		
	2	2	2	2	Bradycardia = resting HR 80-90. Only occasionally increases to 120		
	3	3	3	3	Variable = resting HR varies considerably without a consistent baseline		
3- Observe for	0	0	0	0	Normal		
respiration	2	2	2	2	Periodic Breathing = 3 or more respiratory pauses ≥ 3 sec separated by normal breathing and < 20 sec. Often associated with shallow breathing		
	3	3	3	3	Apnea = no breathing for ≥ 20 sec or < 20sec with HR changes or O2 desaturation		
4- Observe for	0	0	0	0	Normal		
posture	1	1	1	1	Mild Distal Flexion = fingers, toes in mild flexion, incomplete extension of fingers when stroked on dorsal surfaces. Thumbs flexed, adducted, opposed across palms "cortical thumb"		
	2	2	2	2	Strong Distal Flexion = f ingers and toes in strong flexion, incomplete extension of fingers when stroked on dorsal surfaces. Thumbs flexed, adducted, opposed across palms "cortical thumb"		
	3	3	3	3	Decerebrate = Head, neck and back are arched in extension (opithotonus), elbows are extended, wrists are pronated and hips are abducted.		
5- Observe for					Use Auditory stimulation, Visual stimulation and Tactile stimulation to assess level of consciousness		
level of	0	0	0	0	Normal		
consciousness	1	1	1	1	Hyperalert = full wakefulness with eyes open/staring but decreased frequency of blinking/tracking. Spontaneous motor activity normal or decreased with lowered threshold to all stimulus types		
					Irritable = lowered threshold with excessive responses to all stimulus types. Can be seen with varied states including hyperalert, lethargy or obtundations		
	2	2	2	2	Lethargic = slightly delayed but complete response to stimuli with slightly increased threshold for eliciting responses and decreased spontaneous activity		
					Obtunded = delayed and incomplete response with marked increased threshold to all sensory stimuli and little or no motor activity.		
	3	3	3	3	Stupor = no spontaneous eye opening to tactile stimulation elicits poorly sustained eye opening. Responds only to strong noxious stimuli. Absent gag and cornel reflex Coma = no eye opening with vigorous tactile stimulation		
6- Tone	0	0	0	0	Normal		
o ione	J	U	U	U	Normal		

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Assessment	2	2	2	2 Hypotonic = focal or generalized decreased resistance to passive movement. Associated with greater extension of extremities than normal								
	3	3	3	3	Flaccid"Flat on the mat" appearance. Maybe associated with frog-leg posturing with arm and hips/legs lying in abduction							
	Arm Recoi	I: Quickly e	extend (str	aighten) b	oth arms; put next to body.	Leg Recoil: Take both ankles, bend hips+ knee. Quickly extend when infant						
	Count to t	wo. Let go.	Repeat 3	times.	·	not pushing. Let go. Repeat 3 times.						
	Normal- A	Arms flexes	and	Hypotoni	a	Normal: Complete Fast Flexion	Hypotonia:					
	remains fl	exed (a)					⊙->- ⊙>					
		spension: back, arm	•		l under the belly. Look at	Head Lag: Pull baby to sit by the wrists and support head slightly.						
	Normal:	Back straig	ht, head	Hypotoni	a:	Normal: Lifts head in line with body	Hypotonia:					
	Ģ	72		(1) P	\$ (D) (Q)	Q	04,04, 0K					
	Vertical Suspension: Hold baby upright by placing hands under axillae Normal: No Slip through Hypotonia: Slip Through											
7- Reflexes												
Sucking reflex	0	0	0	0	Normal							
	1	1	1	1	Weak							
	2	2	2	2	Weak/Incoordinated							
	3	3	3	3	Absent							
Moro Reflex	0	0	0	0	Normal							
	1	1	1	1	Exaggerated							
	2	2	2	2	Weak/Incomplete							
	3	3	3	3	Absent							
Light Reflex	0	0	0	0	Normal							
	1	1	1	1	Dilated							
	2	2	2	2	Constricted							
	3	3	3	3	Unequal/ Fixed dilated							
Total NE Score												