

AUTONOMIC STANDARDS ASSESSMENT FORM

Patient Name: _____

Anatomic Diagnosis: (Supraconal , Conal , Cauda Equina)

General Autonomic Function

System/Organ	Findings	Abnormal conditions	Check mark
Autonomic control of the heart	Normal		
	Abnormal	Bradycardia	
		Tachycardia	
		Other dysrhythmias	
	Unknown		
Unable to assess			
Autonomic control of blood pressure	Normal		
	Abnormal	Resting systolic blood pressure below 90 mmHg	
		Orthostatic hypotension	
		Autonomic dysreflexia	
	Unknown		
Unable to assess			
Autonomic control of sweating	Normal		
	Abnormal	Hyperhidrosis above lesion	
		Hyperhidrosis below lesion	
		Hypohidrosis below lesion	
	Unknown		
Unable to assess			
Temperature regulation	Normal		
	Abnormal	Hyperthermia	
		Hypothermia	
	Unknown		
Unable to assess			
Autonomic and Somatic Control of Broncho-pulmonary System	Normal		
	Abnormal	Unable to voluntarily breathe requiring full ventilatory support	
		Impaired voluntary breathing requiring partial vent support	
		Voluntary respiration impaired does not require vent support	
Unknown			

Lower Urinary Tract, Bowel and Sexual Function

System/Organ	Score
Lower Urinary Tract	
Awareness of the need to empty the bladder	
Ability to prevent leakage (continence)	
Bladder emptying method _____ (specify)	
Bowel	
Sensation of need for a bowel movement	
Ability to Prevent Stool Leakage (Continence)	
Voluntary sphincter contraction	
Sexual Function	
Genital arousal (erection or lubrication)	Psychogenic
	Reflex
Orgasm	
Ejaculation (male only)	
Sensation of Menses (female only)	

2 = Normal function, 1=Reduced or Altered Neurological Function
0=Complete loss of control NT=Unable to assess due to preexisting or concomitant problems

Urodynamic Evaluation

System/Organ	Findings	Check mark
Sensation during filling	Normal	
	Increased	
	Reduced	
	Absent	
Detrusor Activity	Non-specific	
	Normal	
	Overactive	
	Underactive	
Sphincter	Acontractile	
	Normal urethral closure mechanism	
	Normal urethral function during voiding	
	Incompetent	
	Detrusor sphincter dyssynergia	
	Non-relaxing sphincter	

Date of Injury _____

Date of Assessment _____

Examiner _____