**Table 3.**
Disorders of Consciousness Scale (DOCS) baseline observations protocol. L = left, R = right, UE = upper extremity, LE = lower extremity ICU = intensive care unit, ICP = intracranial pressure, SLP = speech pathologist, PT = physical therapist, and OT = occupational therapist.

**Instructions:** Prior to providing stimulation, the evaluator should place the “Do Not Disturb” sign on the door and unobtrusively approach the subject (i.e., do not speak, do not touch the subject, do not close the door, do not disturb the subject) and document the subject’s spontaneous behaviors at rest. The following checklist should be systematically completed:

**General Information:**
Is the DOCS being coadministered: Yes or No (if yes remember to score separately)
Disciplines completing this evaluation (circle all that apply): SLP  PT  OT  Psychology  Nursing  Research  Respiratory
Date of evaluation: _____________ Time of evaluation: _____________ a.m. or p.m.
Location of Baseline Observation (specify): _________________________________________________
If in the ICU: Previous day’s highest ICP: _____ Today’s highest ICP: _____ Highest ICP during evaluation: _____
Time of and nature of previous activity: ____________________________________________________
Evaluation was broken into 2 sessions: Yes or No If yes, is this the 1st session or 2nd session?
Noise Level of Environment (Circle):  Noisy  Quiet  Intermittent Noise  Interruptions
Weight: _________ Blood oxygen level (via pulse oximetry): Lowest reading: _________ Highest reading: _________
Heart Rate: Lowest reading: _________ Highest Reading: _________

**Position of Patient** (check one):
___ in bed lying on back  ___ in bed sitting up between 45° & 90°  ___ side-lying in bed  ___ upright in chair  ___ reclined in chair

**Spontaneous/Random Movements** (check all that are observed):
___ eyebrow movement (circle one: right left both)  ___ frown or grimace  ___ smiling  ___ biting or grinding of teeth  ___ mouth twitching or tremors  ___ tongue movement (describe: _________________________)
___ lip movement (describe: ______________________________________)  ___ head movement  ___ LLE movement  ___ RLE movement  ___ LUE movement  ___ RUE movement  ___ none

**Respiration** (check the appropriate boxes):
__quiet __shallow __striderous __fast __other (describe:___________________)

**Swallowing:**
Check the amount of drooling:  ___constant ___occasional ___not observed ___none
Check location of drooling: ___right corner ___left corner ___midline ___all of these locations ___none
Number of spontaneous swallows observed: ________

**Posture:**
Describe the following as tense, relaxed, spastic, flexed, extended, or describe other posturing:
Facial Posture: _______________________________________________________________________________
Neck Posture: _______________________________________________________________________________
LUE Posture: _________________________________________________________________________________
RUE Posture: _________________________________________________________________________________
LLE Posture: _________________________________________________________________________________
RLE Posture: _________________________________________________________________________________
Whole Body Posture: ___________________________________________________________________________

**Visual:** Does subject wear eye glasses? Yes or No  If yes, were they worn during this observation? Yes or No
Level of illumination in room (check only one):  ___dark ___dim ___bright
Duration and Frequency of Eye Opening: (check only one)
___eyes closed; no spontaneous eye opening
___eyes closed initially; spontaneous eye opening for less than 1 minute (_____ # of occurrences)
___eyes closed initially; spontaneous eye opening for greater than 1 minute (_____ # of occurrences)
___eyes open; spontaneously close after ___ seconds and remain closed
___eyes open initially; spontaneously close after ___ seconds, but reopened for ___ seconds
___eyes spontaneously open and remain open throughout the observation period
___partially open (circle amount that the eyes are open:  1/4  1/2  3/4)
___eyes remain open all the time without any blinking
___one eye open Right___ or Left_____
Other: _____________________________________________________________________________________
Eye Positioning and Movement (check all that are appropriate):

___ could not observe eyes throughout baseline observation
___ both eyes deviated right  ___ both eyes deviated left  ___ left eye deviated  ___ right eye deviated

Notes: _______________________________________________________________________

___ nystagmus (i.e., rhythmical oscillation of the eyeballs—either pendular or jerky)
___ ptosis (i.e., drooping of the upper eyelid) (circle one): left eye  right eye  bilateral
___ other: ___________________________________________________________________

right pupil: ___ dilated  ___ constricted
left pupil: ___ dilated  ___ constricted