Upper Extremity Sensory Test for Stereognosis

Complete all patient information here and in the addressograph area.

Patient name: _____ **Date:** _____

Hand dominance: o **Left** o **Right** o **Ambidextrous**

Therapist: _____

For each of the 12 objects, record whether the patient's responses were intact (IN), impaired (IMP), or absent (AB). Record comments next to impaired or absent scores. Record total correct responses of the 12 items.

LEFT			RIGHT	
Grade	Comment	ITEM	Grade	Comment
		Cube		
		Key		
		Pencil		
		Penny		
		Marble		
		String		
		Button		
		Safety pin		
		Pill		
		Glove		
		Spoon		
		Paper clip		
		Total Correct		

GRADING SYSTEM	
INTACT (IN):	**Responses are quick and accurate**
IMPAIRED (IMP):	**Responses are inaccurate and/or delayed**
ABSENT (AB):	**No response**