

# Modified Finnegan Scoring System

**Table 2**  
NAS Scoring and treatment form\*

NAME: \_\_\_\_\_ MR#: \_\_\_\_\_

SIGNS AND SYMPTOMS	SCORE	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
		/time	/time	/time	/time	/time	/time	/time	/time	/time	/time	/time	/time
Excessive Cry	2 - 3												
Sleeps < 1 hour after feeding	3												
Sleeps < 2 hours after feeding	2												
Sleeps < 3 hours after feeding	1												
Hyperactive Moro Reflex	1												
Markedly Hyperactive Moro Reflex	2												
Mild Tremors: Disturbed	1												
Moderate-Severe Tremors: Disturbed	2												
Mild Tremors: Undisturbed	1												
Moderate-Severe Tremors: Undisturbed	2												
Increased Muscle Tone	1-2												
Excoriation (specific area)	1 - 2												
Generalized Seizure	8												
Fever > 37.2 C	1												
Frequent Yawning	1												
Sweating	1												
Nasal Stuffiness	1												
Sneezing	1												
Tachypnea (Respiratory Rate > 60/min)	2												
Poor Feeding	2												
Vomiting	2												
Loose Stools	2												
Failure to Thrive (weight gain $\geq$ 10% below birth weight)	2												
Excessive Irritability	1 - 3												
<b>TOTAL SCORE / CATEGORY</b>													
<b>INITIALS</b>													

Source: Jansson L, Velez M, Harrow C. The Opioid Exposed Newborn: Assessment and Pharmacologic Management. J Opioid Manag. 2009; 5(1): 54

## Continued: Modified Finnegan Scoring Tool Guideline

The following guide is an example of how the Modified Finnegan Scoring Tool should be used.

### Guide to assessment and scoring

Score Neonates twice per shift. The neonatal abstinence syndrome scoring tool was designed for term babies on 4 hourly feeds and may therefore need modification for preterm infants. In a term infant, scoring should be performed 30 minutes to one hour after a feed, before the infant falls asleep. Do not wake infant to score.

Finnegan, L.P. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Nelson, N. editor. Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990 © Western Australian Centre for Evidence based Nursing and Midwifery, January 2007 (RHSET 01660A) All guidelines should be read in conjunction with the Disclaimer.

<b>High pitched cry:</b>	Score 2 if cry is excessive high pitched when infant has: intermittent or continuous cry for up to 5 minutes despite care giver interventions or infant is unable to self-console / unable to decrease crying within a 15 second period. Score 3 if infant has a continuous high pitched cry greater than 5 minutes despite care giver intervention.
<b>Sleep:</b>	This is a scale of increasing severity and a term infant should receive only 1 score from the 3 levels of severity. A premature infant on 3 hourly feeds can sleep for 2 1/2 hour at most. Scoring should be 1 if the infant sleeps less than 2 hours, 2, if less than 1 hour and 3 if the infant does not sleep between feeds.
<b>Moro reflex:</b>	The moro or startle reflex is a normal reflex of infants and occurs when a sudden loud noise causes the infant to stretch out the arms and flex the legs. Score 2 if the infant exhibits pronounced jitteriness (rhythmic tremors that are symmetrical and involuntary) of the hands during or at the end of a moro reflex. Score 3 if jitteriness and clonus (repetitive involuntary jerks) of the hands and/or arms present during or after the initiation of the reflex.
<b>Tremors:</b>	Infant only receives 1 score from the four levels. <b>Mild Tremors: Disturbed (1)</b> - Observable tremors of the hands or feet when the infant is asleep, drowsy awake, active, or alert - while being handled <b>Moderate-Severe Tremors: Disturbed (2)</b> - Observable tremors of the arms (one or both) or legs (one or both) with or without observable tremors of the hands or feet, when the infant is asleep, drowsy, awake, active, or alert - while being handled. <b>Mild Tremors: Undisturbed (3)</b> - Observable tremors of the hands or feet when the infant is asleep, drowsy, awake, or alert - but not being handled by a care giver. (Allow at least two one-minute undisturbed period during the exam). <b>Moderate-Severe Tremors: Undisturbed (4)</b> - Observable tremors of the arms (one or both) or legs (one or both) with or without observable tremors of the hands or feet, when the infant is asleep, drowsy, awake, active, or alert - but not being handled.
<b>Increased muscle tone:</b>	Score if excessive or above normal muscle tone or tension is observed—muscles become “stiff” or rigid and the infant shows marked resistance to passive movements, e.g. if the infant does not experience any head lag when being pulled to the sitting position; or if there is tight flexion of the infants arms and legs (unable to slightly extend these when an attempt is made to extend and release the supine infants arms and legs).
<b>Excoriation:</b>	Score only when excoriation’s first appear, on chin, knees, cheeks, elbows, nose, or toes. Red diaper area is not to be scored here
<b>Myoclonic jerks:</b>	Score if involuntary muscular contractions which are irregular and exceedingly abrupt (usually involving a single group of muscles) are observed.
<b>Convulsions:</b>	Generalized seizure activity
<b>Sweating:</b>	Score if sweating is spontaneous and is not due to excessive clothing or high room temperature.
<b>Hyperthermia:</b>	Measure temperature by axilla.
<b>Mottling:</b>	Score if mottling (marbled appearance of pink and pale or white areas) is present on infant’s chest, trunk, arms or legs.
<b>Generalized convulsions:</b>	In the newborn infant, generalized convulsions or seizures are often referred to as tonic seizures. They are most commonly seen as generalized activity involving tonic extension of all limbs, but are sometimes limited to one or both limbs on one side. Unusual limb movement may accompany a seizure. In the upper limbs, these often resemble “swimming” or “rowing”. In the lower limbs, “bicycling”. Other subtle signs may include eye staring, rapid involuntary movements of the eyes, chewing, back arching and fist clenching.
<b>Yawning:</b>	Score if more than 3 yawns observed within a scoring interval.
<b>Nasal stuffiness:</b>	Score if infant sounds congested; mucous may be visible.
<b>Sneezing:</b>	Score if more than 3 sneezes observed in a scoring interval.
<b>Nasal flaring:</b>	Score only if repeated dilation of the nostrils is observed without other evidence of lung or airways disease.
<b>Respiratory rate:</b>	Score only if greater than 60/min without other evidence of lung or airways disease. Score 2 if respiration involves drawing in of the intercostal muscles (retractions).
<b>Excessive sucking:</b>	Score if hyperactive/disorganized sucking, increased rooting reflex, or attempts to suck fists or thumbs (more than that of an average hungry infant) are observed.
<b>Poor feeding:</b>	Score if the infant demonstrates excessive sucking prior to feeding yet sucks infrequently during a feeding taking in a small amount of breast milk or formula, and/or demonstrates an uncoordinated sucking reflex (difficulty sucking and swallowing). Prematures may require tube feeding and should not score for poor feeding if tube feeding is expected at their gestation.
<b>Regurgitation:</b>	Score if at least 1 episode of regurgitation is observed.
<b>Loose / watery stools:</b>	Score if loose (curds/seedy appearance) or watery stools (water ring on nappy around stool) are observed. Check the diaper after the examination is complete if not apparent during the examination.

Source: St. Joseph’s Health Care, Hamilton, ON