


Date of Arrival: ___/___/___	MRN: _____	Please write legibly:
ED Provider:	Patient Name:	RN Signature:
Neurologist MD:	DOB: ___/___/___ Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	ICU Charge Nurse Signature:
Delay Notes:	Allergies:	*Additional notes can be documented on reverse side. This IS PART OF PERMANENT MEDICAL RECORD

EMS Pre Stroke Alert Time	ED Arrival time/or time of bedded patient presenting with stroke	Time of last Known Well or time symptom onset	ED provider/MD assessment goal of <10 min in ED and <15 min for the bedded patient	Time of RRT stroke 6111 with <15 min response time	EKG time	Labs time	CT Scan time with a goal of <25 min	Time of Dysphagia screening by nurse	CT Scan result time Goal is <45 min	Time of Thrombolytics for patients meeting inclusion guidelines with goal <60 min from arrival
Time	Time	Time	Time	Paged	Arrived	Time	Time	Time	Time	Time

<p>Patient History</p> <p>If patient is on anticoagulation, the last dose must have been taken >48 hours prior to receiving tPA. Patient must also have normal renal function. Common anticoagulation medications:</p> <ul style="list-style-type: none"> Xarelto (rivaroxaban) Pradaxa (dabigatran) Eliquis (apixaban) Savaysa (edoxaban) Coumadin (warfarin) Lovenox (enoxaparin) Fragmin (dalteparin) Heparin <ul style="list-style-type: none"> <input type="checkbox"/> Anticoagulation Therapy <input type="checkbox"/> Previous MI within 3 months <input type="checkbox"/> CVA/TIA <input type="checkbox"/> COPD <input type="checkbox"/> Diabetic <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> HTN <input type="checkbox"/> PVD <input type="checkbox"/> CHF <input type="checkbox"/> Illicit Drug Use <input type="checkbox"/> Smoker (last year) <input type="checkbox"/> Recent surgery <input type="checkbox"/> Bleeding Disorder 	<p>LABS/Diagnostic Test Required</p> <ul style="list-style-type: none"> <input type="checkbox"/> PT/PTT/INR <input type="checkbox"/> CBC with PLT <input type="checkbox"/> CMP <input type="checkbox"/> Troponin <input type="checkbox"/> Lipid profile within 24 hours of arrival <input type="checkbox"/> Blood Glucose <input type="checkbox"/> CXR <input type="checkbox"/> EKG <input type="checkbox"/> CT Scan <p>*All the above test should be ordered STAT and results within 45 minutes from arrival</p>  <p>ND0910 rev 02.2016</p>	<p>Stroke Checklist</p> <ul style="list-style-type: none"> <input type="checkbox"/> O2 supp for O2 sat <92% <input type="checkbox"/> Monitors Cardiac, Oxygen saturation, and BP monitoring applied <input type="checkbox"/> Height _____ WT _____ <input type="checkbox"/> Pharmacy notified with patients weight <input type="checkbox"/> Clothing off/gown on <input type="checkbox"/> 2 IV starts <input type="checkbox"/> NIHSS completed / Score _____ <input type="checkbox"/> Inclusion/Exclusion completed for Thrombolytics <input type="checkbox"/> Consent Signed for Thrombolytic Therapy/Pharmacy Notified <input type="checkbox"/> Dysphagia Screening completed prior to oral intake 	<p>Exclusions for Thrombolytic Therapy</p> <p>Exclusion Criteria/Mark only if yes for the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms suggestive of subarachnoid hemorrhage <input type="checkbox"/> Definite seizure at onset of Stroke symptoms <input type="checkbox"/> Minor or rapid improving deficits <p>Exclusion – History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous History of Intracranial hemorrhage <input type="checkbox"/> Female patient known or suspected to be pregnant <input type="checkbox"/> History of GI/GU bleed in past 21 days <input type="checkbox"/> History of MI in last 3 months <input type="checkbox"/> History of Stroke or head trauma in preceding 3 mo. <input type="checkbox"/> History of major surgery or serious trauma in 14 days <input type="checkbox"/> History of serious illness that could interfere with/benefit of tPA <input type="checkbox"/> Arterial puncture at non-compressible site in previous 7 days <input type="checkbox"/> Patient received heparin in past 48 hours with elevated PTT <input type="checkbox"/> Patient taking Warfarin and elevated INR > 1.7 <input type="checkbox"/> Consistent refractory severe hypertension >185/110 <input type="checkbox"/> Significant disability before current Stroke <p>Exclusion Lab</p> <ul style="list-style-type: none"> <input type="checkbox"/> PT >15 sec <input type="checkbox"/> PLT <100,000 <input type="checkbox"/> Glucose < or += to 50mg/dl or >400mg/dl <input type="checkbox"/> Heme positive stools or hematuria
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Additional Notes:

STROKE is an Emergency.
Every minute counts.
ACT F.A.S.T!

F **FACE** Does one side of the face droop? Ask the person to smile.

A **ARMS** Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?

S **SPEECH** Is speech slurred? Ask the person to repeat a simple sentence. Is the sentence repeated correctly?

T **TIME** If the person shows any of these symptoms, **Call 911** or get to the hospital immediately.

Does one side of the face droop? Yes _____ No _____

Is one arm weak or numb?
 Yes _____ No _____

Does one arm drift downward?
 Yes _____ No _____

Is speech slurred?
 Yes _____ No _____

Signature _____ Date _____ Time _____



ND0910 rev 02.2016

NIH STROKE SCALE

___ 1A Level of Consciousness

0=alert 1=drowsy
 2=Stuporous 3=coma

___ 1B LOC Questions – ask pt month & age

0=both correct 1=one correct 2=none

___ 1C LOC Commands - (Ask pt to open/close eyes & then grip/release nonparetic hand)

0=both correct 1=one correct 2=none

___ 2 Best Gaze - (horizontal movement tested. Oculocephalic reflex is OK, but not calorics. Eyes open – patient follows finger or face)

0=normal 1=partial gaze 2=forced deviation

___ 3 Visual - (Test by confrontation. Introduce visual stimulus to patient's upper and lower field quadrants)

0=no loss 1=partial hemianopia
 2=complete 3=bilateral

___ 4 Facial Palsy - (Ask patient to show teeth / smile, raise eyebrows and squeeze eyes shut)

0=Normal 1=Minor 2=Partial 3=Complete

___ 5A&B Motor Arms - (Extend left arm, palm down, to 90 degrees if sitting or 45 degrees if supine)

Left arm 0=no drift 3=no effort
 Right arm 1=drift 4=no movement
 2=cant resist gravity UN=Amputation, joint

fusion

___ 6A&B Motor Legs - (Elevate left leg to 30 degrees and flex at hip, always supine)

Left arm 0=no drift 3=no effort
 Right arm 1=drift 4=no movement
 2=cant resist gravity UN=Amputation, joint fusion

___ 7 Limb Ataxia - (Finger-nose, heel-shin tests done on both sides)

0=Absent 2=Present, two limbs
 1=Present, one limb UN=amputation

___ 8 Sensory - (Use a pinprick to face, arm, trunk, and leg-compare side to side. Assess patient's awareness of being touched)

0=Normal 1=Partial loss 2=Severe loss

___ 9 Best Language - (Ask patients to name items, describe a picture, read a sentence; intubated patients should write responses)

0 - No aphasia 1=Mild to mod aphasia 2=Near to unintelligible 3=Mute

___ 10 Dysarthria - (Evaluate speech clarity by asking patient to repeat listed words)

0=Normal articulation 1=Mild - mod dysarthria
 2=Near to unintelligible UN=intubated or other

___ 11 Extinction – Inattention (Use information from prior testing to identify neglect of double simultaneous stimuli testing).

0=no neglect 1=partial 2=complete

Total: _____ Date _____

Time _____

Signature _____

Dysphagia Screen

Not valid for clinical use without appropriate training and competency.

PART ONE:

Patient Demonstrates:

Awake Upright Stable Breathing Clean Oral Cavity

PASS – If ALL FOUR are present, proceed to PART TWO

FAIL – If ANY ITEM is absent, STOP. Maintain NPO. Re-screen when able

PART TWO:

Patient Demonstrates:

Present	Absent	Score	Clinical Features	Target
<input type="checkbox"/>	<input type="checkbox"/>	1	Tongue movement	<i>Stick tongue straight out and lick all the way around lips fully touching both sides</i>
<input type="checkbox"/>	<input type="checkbox"/>	1	Cough	<i>Produce a strong, sharp cough</i>
<input type="checkbox"/>	<input type="checkbox"/>	1	Voice Quality	<i>Phonate loudly and clearly; without hoarse, breathy or wet quality</i>
<input type="checkbox"/>	<input type="checkbox"/>	1	Pharyngeal Sensation	<i>Identify when each side of pharynx is touched with the cotton-tipped swab</i>
<input type="checkbox"/>	<input type="checkbox"/>	2	Water Drinking	<i>Drink 3 single teaspoons of water without cough, throat clearing, or change in voice. If none present, drink ½ cup of water without cough, throat clearing or change in voice/breathing</i>

_____ **SCORE (6 MAXIMUM)**

RESULTS

PASS (5 OR 6) Initiate diet appropriate to dietician; thin liquids, observe meal

FAIL (<=4) NPO/Nothing by mouth; consult SLP for swallow evaluation

FAIL (clinical judgment) NPO/Nothing by mouth; consult SLP for swallow evaluation

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Signature: _____ Date: _____ Time: _____

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