STROKE CHECKLIST 10.2

Date: _____ PCR#: _____Time: _____
AM PM

Destination_____

Patient
Name:_____D.O.B._____

Stroke Scale Score_____ Stroke Scale used :__SOS __Cincinnati __LA

Last time seen normal: _____Exact time __3 hours or less __3-6 hours __> than 6 hours

Patient Signs and Symptoms (mark all that apply):	**YES**	**NO**		**YES**	**NO**
1. Patient is alert	__	__	6. Active internal bleeding.	__	__
2. Arm/Leg movement normal	__	__	7. History of past: stroke, intracranial neoplasm, arteriovenous malformations or aneurysm.	__	__
3. Speech is understandable	__	__			
4. Current glucometer reading _____			8. Recent (within 2 months) intracranial or intraspinal surgery or trauma.	__	__
5. Coumadin (if taken):					
Prescribed dose_____			9. Past or present bleeding disorder.	__	__
Last taken_____			10. Pregnant	__	__

	YES	**NO**
11. Recent (within 10 days) major surgery at <u>non-compressible</u> site (eg. CABG)	___	___
12. Recent (within 7 days) gastrointestinal or genitourinary bleeding	___	___
13. Previous thrombolytic therapy?	___	___
14. Trauma to the head in the last two weeks?	___	___
15. Surgery in the last two weeks?	___	___

- ✓ **TO BE COMPLETED ON ALL PATIENTS TREATED WITH THE STROKE PROTOCOL**
- ✓ **A COPY SHOULD BE LEFT WITH PCR AT THE RECEIVING HOSPITAL**