STROKE/NEURO ALERT CHECKLIST

PATIENT NAME: ________________________________ RUN # ______________ DOB __________

BASELINE VITALS: B/P __________ P __________ R __________ Oxygen SAT __________

911 CALL TIME: _______ DATE OF ONSET: _______ LAST KNOWN WELL TIME: _______

TIME AT PT: _______ LEAVE SCENE TIME: _______ ER ARRIVAL: _______

Completed

1. PATIENT WITH SUSPECTED STROKE SYMPTOMS----------------------------------------------------------------- □
   WITHIN 4.5 HOURS OF LAST KNOWN WELL TIME!!

   OR (OBTAIN WITNESS NAME & PHONE NUMBER)
   (DETERMINE IF PT HAS CONTRAINDICATIONS FOR THROMBOLYTICS- HEAD TRAUMA,
   SEIZURE AT ONSET, TAKING ANTICOAGULATION, HX OF BLEEDING PROBLEMS,
   POSSIBLE BRAIN HEMORRHAGE)

2. PATIENT WITH SUSPECTED STROKE SYMPTOMS----------------------------------------------------------------- □
   GREATER THAN 4.5 HOURS LAST KNOWN WELL TIME!!
   □

3. A CINCINNATI STROKE SCALE AND GCS HAS BEEN DONE!! ------------------------------------------------- □
   □

4. A BLOOD SUGAR IS DONE AND GREATER THAN 60!! -------------------------------------------------------- □
   □

5. INITIATED SUSPECTED CVA PROTOCOL AND MEDS---------------------------------------------------------- □
   □IV □Oxygen □MONITOR □EKG □BLOOD SUGAR □OTHER______________________________________________

ALL OF THE ABOVE CRITERIA MUST BE CHECKED IN ORDER TO ACTIVATE A "STROKE ALERT" FROM THE FIELD. IF ANY OF THE ABOVE CRITERIA CAN NOT BE CHECKED OFF, THEN A "STROKE ALERT" CAN NOT BE CALLED IN FROM THE FIELD!!