STROKE THROMBOLYTIC CHECKLIST

This checklist is intended as a tool for the pre-hospital identification of patients who may benefit from the administration of thrombolytics for acute stroke.

Date:_____ Time:_____Unit: _____ PSS:_____

Patient Name:_____ Age:_____ Est.Wt:_____lbs/kg

Time last seen at baseline: _____
Time of symptom onset: _____
Onset Witnessed or reported by: _____

Symptoms (circle abnormal findings)

ANY ONE FINDING = POSSIBLE STROKE

FACIAL DROOP: R L

ARM DRIFT: R L

SPEECH: slurred wrong words mute

Possible Contraindications (check all that apply)

Current use of anticoagulants (e.g., warfarin sodium)	Yes	No	?
Has blood pressure consistently over 180/110 mm Hg	Yes	No	?
Witnessed seizure at symptom onset	Yes	No	?
History of intracranial hemorrhage	Yes	No	?
History of GI or GU bleeding, ulcer, varices	Yes	No	?
Is within 3 months of prior stroke	Yes	No	?
Is within 3 months of serious head trauma	Yes	No	?
Is within 21 days of acute myocardial infarction	Yes	No	?
Is within 21 days of lumbar puncture	Yes	No	?
Is within 14 days of major surgery or serious trauma	Yes	No	?
Is pregnant	Yes	No	?
Abnormal blood glucose level (<50 or >400): FSBS (if done): _____	Yes	No	?

Have you identified any contraindications to thrombolytic therapy? □ YES □ NO

Receiving Site/Physician: _____Time_____
EMT #_____Signature_____