

# VERMONT EMS STROKE SCREENING TOOL

## DATE & TIMES

EMS Agency:		EMS person completing this form:		
Date :	Dispatch Time:	EMS Arrival Time:	EMS Departure Time:	ED Arrival Time:

## BASIC DATA

Patient name:	Age or DOB:	Gender:
Last time without symptoms: <i>(If patient awoke with symptoms, last time known to be at baseline)</i>		
Witness/family name:		Best contact number for witness:
New Onset Complaint (check all that apply): <input type="checkbox"/> Weakness R / L <input type="checkbox"/> Confusion, difficulty speaking or understanding		
<input type="checkbox"/> Numbness R / L <input type="checkbox"/> Balance/coordination difficulty <input type="checkbox"/> Acute visual disturbance <input type="checkbox"/> Severe headache		
<input type="checkbox"/> Other		

## EXAMINATION

<u>CINCINNATI STROKE SCALE</u>	Abnormal	Normal
<b>FACIAL DROOP:</b> Have patient smile or show teeth: look for asymmetry. <u>Normal:</u> Both sides of the face move equally <u>Abnormal:</u> One side of the patient's face droops.	<input type="checkbox"/>	<input type="checkbox"/>
<b>MOTOR WEAKNESS:</b> Have patient close eyes, extend arms, palms up for 10 seconds. <u>Normal:</u> Arms remain extended equally, or drift equally. <u>Abnormal:</u> One arm drifts down compared to the other, or unable to lift one arm.	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPEECH:</b> Have patient repeat after you: "You can't teach an old dog new tricks" <u>Normal:</u> Phrase is repeated clearly and correctly. <u>Abnormal:</u> New onset of slurred speech (dysarthria), abnormal (aphasia) or none.	<input type="checkbox"/>	<input type="checkbox"/>
<b>BLOOD GLUCOSE (if possible):</b>		

## INTERVENTIONS PER EMS CERTIFICATION LEVEL (check boxes):

<input type="radio"/> Establish STROKE ALERT CRITERIA	YES
Time from onset of symptoms known to be less than 6 hours?	<input type="checkbox"/>
Blood glucose is or has been corrected to greater than 50? (if fingerstick possible)	<input type="checkbox"/>
Any abnormal finding on Cincinnati Stroke Scale examination?	<input type="checkbox"/>
Deficit unlikely due to head trauma or other identifiable cause?	<input type="checkbox"/>
<b>* IF <u>YES TO ALL STROKE ALERT CRITERIA</u>: CONTACT RECEIVING HOSPITAL AND REPORT "STROKE ALERT"</b>	

- Administer oxygen to maintain saturation  $\geq 94$
- Head of stretcher at 30°
- Minimize on-scene time
- 18g AC IV access
- Correct glucose if  $< 80$  mg/dl
- 250 cc NS bolus IV (preferred) or other isotonic fluid specified by EMS District Medical Advisor
- 12 lead EKG (or other single lead EKG view) transmitted to receiving hospital if possible

<b>HOSPITAL DESTINATION:</b>	<b>HOSPITAL CONTACT NAME:</b>
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