

Acute Stroke Transfer Guidelines



1. Patient name: _____
Last First

Date: _____

EMT performing field assessment _____ Time: _____

2. Information / history from:

Patient

Family member \ _____ Phone: _____
(authorized to give consent) Name (Phone en-route)

3. Last known time patient was at baseline or deficit free and awake:

Time: _____ Date: _____

TIME OF SYMPTOM ONSET: _____ AM PM

CODE STROKE CRITERIA:	YES	UNKNOWN	NO
4. Symptom duration less than 4.5 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Blood glucose between 80 and 400:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. OBVIOUS ASYMMETRY

	Normal	Right	Left
Facial: smile/grimace	<input type="checkbox"/>	<input type="checkbox"/> Absent/lax	<input type="checkbox"/> Absent/lax
Grip	<input type="checkbox"/>	<input type="checkbox"/> Weak <input type="checkbox"/> No grip	<input type="checkbox"/> Weak <input type="checkbox"/> No grip
Arm drift	<input type="checkbox"/>	<input type="checkbox"/> Drifts down <input type="checkbox"/> Falls rapidly	<input type="checkbox"/> Drifts down <input type="checkbox"/> Falls rapidly

Based on exam, patient has **only unilateral** (not bilateral) weakness: Yes No

In no circumstances should acquisition of these items delay the transfer of the patient. Urgent transfer minimizing time to presentation is an absolute priority.

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7. LANGUAGE:	Appropriate	Inappropriate
LOC Questions (alert/verbal/painful/unresponsive)	[]	[]
LOC Commands (close eyes, make fist)	[]	[]
Language (repeat sentence, name objects)	[]	[]
Speech clarity (evaluate for slurring)	[]	[]

Based on assessment, patient has new onset language/orientation deficit: Yes [] No []

8. Items 4-7 all Yes (or unknown) CODE STROKE CRITERIA MET	Yes []	No []
Onset of symptoms plus transport time < 4.5 hours	Yes []	No []

If criteria are met, call receiving hospital with a "Stroke Alert."