

Order set: IN-PATIENT EVALUATION POSSIBLE ACUTE STROKE Saskatchewan Acute Stroke Pathway Protocols	Addressograph
Site:	


PATIENT INFORMATION

Last seen normal __ __ : __ __ Date _____ Seen by (witness name): History provided by: <input type="checkbox"/> Patient <input type="checkbox"/> Family member <input type="checkbox"/> Other _____	Past medical history: <input type="checkbox"/> Diabetic <input type="checkbox"/> Recent Trauma <input type="checkbox"/> Bleeding <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Antiplatelet	Sending unit contact number: Next of kin contact number:
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PHYSICAL EXAMINATION

Time of initial assessment __ __ : __ __		
Vital Signs: BP: HR: T: /4 /5 /6 RR: Sat%: <input type="checkbox"/> RA <input type="checkbox"/> O2@____ L/min Airway Clear? BGM: Yes <input type="checkbox"/> No <input type="checkbox"/>	GCS: /4 /5 /6 Airway Clear? Yes <input type="checkbox"/> No <input type="checkbox"/>	Pupils: (L) _____ (R) _____

****Consider Brain stem stroke: Sudden onset coma/impaired LOC with no other cause****



FAST Screen

F

Right droop
 Left droop

 Normal

→

A

Right weak
 Left weak

 Normal

→

S

Slurred

 Normal

→

T

< 4.5 hr
 4.5 – 12 hr

 > 12 hr

FAS+ = At least one abnormal finding for Face, Arm or Speech (suggestive of stroke)
 If < 12 hours since LSN = within time window for stroke intervention

NOTIFICATIONS

<input type="checkbox"/> Call ambulance service for STROKE ALERT transport <input type="checkbox"/> MRP notified of stroke alert and pending transfer <input type="checkbox"/> Next of kin notified of stroke alert and pending transfer ** Notification of physician/family should not delay emergency transport of stroke patient.**
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INTERVENTIONS

Intravenous X2 above the wrist <input type="checkbox"/> Site _____ <input type="checkbox"/> Site _____	Provide most recent lab reports to ambulance personnel: <input type="checkbox"/> CBC, NA, K, CL, Creatinine, BUN, Bicarb, Glucose <input type="checkbox"/> PTT/INR <input type="checkbox"/> Trop, CK <input type="checkbox"/> ALT, AST, ALP <input type="checkbox"/> 12 Lead ECG <input type="checkbox"/> B-HGC <input type="checkbox"/> Bicarb <input type="checkbox"/> Other _____
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