Hudson Valley Regional
Medical Advisory Committee
Pre-Hospital Stroke Evaluation Form

Patient Stamper

Directions:
DO NOT DELAY TRANSPORT to complete this form. Use the 24 hour clock (Military Time) to complete all times. This form is to be completed by **ALS PROVIDERS ONLY**.

Leave Form with the Receiving Hospital when completed

PATIENT / CALL INFORMATION:

Patient Name:	Age:	Sex: ☐ Male ☐ Female	DOB:	Date of Event:	Time of Call:

HISTORY OF PRESENT ILLNESS:

	Date	Time			
Time of onset of symptoms			Is patient bleeding?	☐NO	☐YES
Last known time patient was without deficits (symptom free)			Any seizure activity noted at symptom onset?	☐NO	☐YES
Did patient complain of severe headache at symptom onset?	☐NO	☐YES	Does the patient currently take Coumadin or other blood thinners	☐NO	☐YES

CINCINNATI PRE-HOSPITAL STROKE SCALE:

Facial Droop	☐Normal	Droop noted to: ☐ Left side of face ☐ Right side of face
Arm Lift	☐Normal	Drift noted to: ☐ Left arm ☐ Right arm
Speech	☐Normal	Slurred speech, inappropriate words, or aphasia noted: ☐ YES ☐ NO

PAST MEDICAL HISTORY:

Reported active internal or GI/GU bleeding within 2 days?	☐ NO	☐ YES
Reported CVA / TIA, head trauma or CNS surgery within the past 3 months?	☐ NO	☐ YES
Reported General surgery or trauma with in the past 2 weeks?	☐ NO	☐ YES

TPA Exclusions:

Head Trauma at onset	☐ NO	☐ YES
Taking Coumadin (Warfarin)	☐ NO	☐ YES
Seizure at onset	☐ NO	☐ YES
History of bleeding problems	☐ NO	☐ YES
Possible brain hemorrhage (severe headache, stiff neck, ↓ LOC)	☐ NO	☐ YES
Symptomatic upon awakening	☐ NO	☐ YES

Vital Signs

Time	B/P	Blood Sugar	Glasgow Coma Scale			
	/		Eye	Motor	Verbal	Total
	/		Eye	Motor	Verbal	Total
	/		Eye	Motor	Verbal	Total
	/		Eye	Motor	Verbal	Total

Current Medications

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Name(Print) **Cert #**	**Signature:**	**Date:**
Agency Name	**Agency Code:**	**PCR# :**