**Date and Time:**

**Chief complaint:**

- [ ] Current inpatient at UHC:
- [ ] Consultation per service
- [ ] Admitted through ED (see also below)
- [ ] Transferred from another acute care hospital

**History of acute illness:**

- [ ] Admit from chronic care/SNF/rehab facility
- [ ] Admit from home
- [ ] Other

**Time course:**

- [ ] Onset of symptoms:
  - Witnessed
  - Self-reported
  - Awoke with sx
  - Sx while awake

- [ ] Is time of onset when pt last known normal?
  - Yes
  - No

**Arrival mode:**

- [ ] EMS from scene to ED
- [ ] Private/walk-in to ED
- [ ] EMS hosp trfr to ED
- [ ] Did not present via ED

**Time arrived at other ED:**

**Time arrived at UH ED:**

**Time first seen by ED MD:**

**Functional status prior to current presentation**

*(modified Rankin scale):*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms</td>
</tr>
<tr>
<td>1</td>
<td>No significant disability</td>
</tr>
<tr>
<td>2</td>
<td>Slight disability</td>
</tr>
<tr>
<td>3</td>
<td>Moderate disability</td>
</tr>
<tr>
<td>4</td>
<td>Moderately severe disability</td>
</tr>
<tr>
<td>5</td>
<td>Severe disability</td>
</tr>
</tbody>
</table>
### Past medical history:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td><strong>no</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Prior TIA or stroke</td>
<td>☐ Carotid stenosis</td>
<td>☐ CAD/prior MI/angina</td>
</tr>
<tr>
<td>☐ Atrial fibrillation</td>
<td>☐ Valvular heart disease</td>
<td>☐ Prosthetic heart valve</td>
</tr>
<tr>
<td>☐ CHF</td>
<td>☐ Peripheral vascular disease</td>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>☐ Hypertension</td>
<td>☐ Hyperlipidemia</td>
<td>☐ Renal insufficiency</td>
</tr>
<tr>
<td>☐ CHF</td>
<td>☐ Sedentary lifestyle</td>
<td>☐ Obesity</td>
</tr>
<tr>
<td>☐ GI bleeding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Allergies:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>☐</td>
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</table>

### Medications at home:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<td>☐</td>
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<p>| | |</p>
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<tbody>
<tr>
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</tbody>
</table>

### Review of systems:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>pos</strong></td>
<td><strong>neg</strong></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Constitutional</td>
<td>Psychiatric</td>
<td>Eyes</td>
</tr>
<tr>
<td>ENT</td>
<td>Cardiovasc</td>
<td>Respiratory</td>
</tr>
<tr>
<td>GI</td>
<td>GU</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Integument</td>
<td>Heme/Lymphatic</td>
<td>Allergic/Immunologic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Endocrine</td>
</tr>
</tbody>
</table>

### Family history:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>yes</strong></td>
<td><strong>no</strong></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Stroke at young age</td>
<td>Coronary artery disease</td>
<td>Other</td>
</tr>
</tbody>
</table>

### Social History:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>yes</strong></td>
<td><strong>no</strong></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Smoking in past year</td>
<td>Alcohol – occasional</td>
<td>Alcohol – regularly</td>
</tr>
<tr>
<td>Drug abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### General Physical Examination:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td></td>
</tr>
<tr>
<td>Resp</td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td></td>
</tr>
<tr>
<td>Wt</td>
<td></td>
</tr>
<tr>
<td>Ht</td>
<td></td>
</tr>
<tr>
<td>Temp</td>
<td></td>
</tr>
<tr>
<td>O₂ sat</td>
<td></td>
</tr>
<tr>
<td>% on</td>
<td></td>
</tr>
</tbody>
</table>

### Neurologic Exam:

#### Level of Consciousness:

- Alert: 0
- Drowsy: 1
- Stuporous: 2
- Comatose: 3

#### LOC Question:

- Both correct: 0
- One correct: 1
- Neither correct: 2

#### LOC Commands:

- Obey both: 0
- Obey one: 1
- Obey neither: 2

#### Best Language:

- No aphasia: 0
- Mild-moderate aphasia: 1
- Severe aphasia: 2
- Mute: 3

#### Dysarthria:

- Normal: 0
- Mild-moderate: 1
- Unintelligible: 2

#### Best Gaze:

- Normal: 0
- Partial gaze palsy: 1
- Forced deviation: 2

#### Visual Field:

- No visual loss: 0
- Partial HH: 1
- Complete HH: 2
- Bilateral: 3

#### Facial Paresis:

- Normal: 0
- Minor paresis: 1
- Complete UMN: 2
- Complete LMN: 3

#### Left Upper Extremity:

- No drift (10 sec): 0
- Drift: 1
- Effort vs gravity: 2
- No effort vs gravity: 3
- No movement: 4

#### Right Upper Extremity:

- No drift (10 sec): 0
- Drift: 1
- Effort vs gravity: 2
- No effort vs gravity: 3
- No movement: 4

#### Left Lower Extremity:

- No drift (5 sec): 0
- Drift: 1
- Effort vs gravity: 2
- No effort vs gravity: 3
- No movement: 4

#### Right Lower Extremity:

- No drift (5 sec): 0
- Drift: 1
- Effort vs gravity: 2
- No effort vs gravity: 3
- No movement: 4

#### Limb Ataxia:

- Absent: 0
- Present 1 limb: 1
- Present 2 limbs: 2

#### Sensory:

- Absent: 0
- Partial loss: 1
- Dense loss: 2

---

**Total NIHSS Score:**
## Imaging studies:

<table>
<thead>
<tr>
<th>CT scan … time done</th>
<th>@ OSH</th>
<th>@ UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>initial CT old disease:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>initial CT new disease:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MRI scan … time done</th>
<th>@ OSH</th>
<th>@ UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI result:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| circulation territory: |       |       |

## Labs:

- **PT**
- **PTT**
- **INR**

<table>
<thead>
<tr>
<th>Total cholesterol:</th>
<th>Hgb A1C:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triglycerides:</td>
<td>Ca</td>
</tr>
<tr>
<td>HDL:</td>
<td>CPK:</td>
</tr>
<tr>
<td>LDL:</td>
<td>Troponin:</td>
</tr>
<tr>
<td></td>
<td>PO₄</td>
</tr>
</tbody>
</table>

## EKG:

## CXR:

## Thrombolytic Therapy Decision:

<table>
<thead>
<tr>
<th>None</th>
<th>IV</th>
<th>IA</th>
</tr>
</thead>
</table>

If not, why not:

- Delay in patient arrival (>3 hrs after onset of stroke symptoms)
- Other time delay
- Uncontrolled hypertension
- Rapid improvement
- CT findings
- Stroke severity – too mild
- Stroke severity – too severe
- Seizure at onset
- Recent surgery/trauma (<15 days)
- Recent intracranial surgery, head trauma, or stroke (3 months)
- Patient/family refused (eg DNR/CMO)
- Consent not obtainable

- Hx of ICH, brain aneurysm, vasc malformation, or brain tumor
- Active internal bleeding (<22 days)
- Platelet count < 100,000
- Abnormal PTT or PT
- Glucose <50mg/dL or >400mg/dL
- No IV access
- Life expectancy <1 yr or severe co-morbid illness
- IV t-PA given at outside hospital prior to transfer
- Investigational protocol instead of IV t-PA
- Other reason
- Not documented

Therapy, if not tPA:
<table>
<thead>
<tr>
<th>IV Thrombolysis:</th>
<th>Time started:</th>
<th>Last BP prior to (IV) tPA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Where started:*

Narrative of clinical course …

<table>
<thead>
<tr>
<th>Immediately apparent complications:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IA Thrombolysis:</th>
<th>Angio time:</th>
<th>Last BP prior to (IA) tPA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Initial findings:*

<table>
<thead>
<tr>
<th>Carotid stenosis</th>
<th>Yes</th>
<th>No</th>
<th>If yes, is intervention considered/performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Narrative of IA thrombolysis …

<table>
<thead>
<tr>
<th>Time</th>
<th>Quantity</th>
<th>Location</th>
<th>BP@infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total amt rtPA:</th>
<th>Recanalization:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immediately apparent complications:</th>
<th></th>
</tr>
</thead>
</table>

|                                    |  |
|                                    |  |
## Assessment:

- Check here if *not* acute ischemic stroke

## Co-morbid conditions:

- Hypertension
- Diabetes
- Hyperlipidemia
- Other (list) …

## Plan (check relevant items and specify):

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiplatelet agent</td>
<td></td>
</tr>
<tr>
<td>Anticoagulation</td>
<td>Screening for dysphagia prior to oral intake</td>
</tr>
<tr>
<td>Neuroprotective measures</td>
<td>DVT prophylaxis</td>
</tr>
<tr>
<td>BP</td>
<td>GI prophylaxis</td>
</tr>
<tr>
<td>Glucose</td>
<td>Aspiration precautions</td>
</tr>
<tr>
<td>Temperature</td>
<td>PT/OT/ST</td>
</tr>
<tr>
<td>Goal LDL &lt; 100</td>
<td></td>
</tr>
<tr>
<td>Further studies (specify)</td>
<td>Counseling re risk factor modification</td>
</tr>
<tr>
<td>Information sheet given to patient</td>
<td></td>
</tr>
</tbody>
</table>

ER resident: ____________________________
Ward resident: _________________________
Senior resident: _____________________

Brain attack attending: _______________________
Ward or consult attending: ___________________

MD Signature: ____________________________

*if BAT … fax to 4-7443*
### Summary of hospital course and follow-up:

<table>
<thead>
<tr>
<th>Admit date:</th>
<th>NIHSS @ admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge date:</td>
<td>NIHSS @ 24hrs:</td>
</tr>
<tr>
<td>NIHSS @ discharge:</td>
<td></td>
</tr>
</tbody>
</table>

### Final diagnosis:

- [ ] Ischemic stroke
- [ ] TIA
- [ ] SAH
- [ ] ICH
- [ ] Uncertain type

If ischemic:
- [ ] cardioembolism
- [ ] Small vessel dz
- [ ] Large artery atherosclerosis

### Narrative summary:

- 
- 
- 

### Complications during hospital course:

- [ ] Intracranial hemorrhage
- [ ] GI bleeding
- [ ] GU bleeding
- [ ] Pneumonia (treated? Yes/No)

### Discharge functional status:

- [ ] Able to ambulate alone (with or without device)
- [ ] Ambulate with assist from other person(s)
- [ ] Not able to ambulate

### Discharge destination:

- [ ] 01: discharged to home or self care (routine)
- [ ] 02: to another short term general hospital for inpatient care
- [ ] 03: to skilled nursing facility (SNF) with medicare certification
- [ ] 04: to an intermediate care facility (ICF)
- [ ] 05: to another type of institution for inpatient care
- [ ] 06: to home under care of home health service organization
- [ ] 07: left against medical advice or discontinued care
- [ ] 08: to home under care of home IV drug therapy provider
- [ ] 20: expired (or did not recover – Christian Science pt)
- [ ] 41: expired in medical facility (eg hospital, SNF, ICF, hospice)
- [ ] 50: hospice - home
- [ ] 51: hospice - medical facility
- [ ] 61: within this institution to medicare approved swing bed
- [ ] 62: to inpatient rehab facility (IRF)
- [ ] 63: to medicare certified long term care hospital (LCTH)
- [ ] 64: to nursing facility Medicaid not medicare
### DVT prophylaxis:

Patient ambulating without assistance from another person on 2nd day?  
- Yes  
- No  
- Not applicable – patient ambulating

If patient not ambulating, was DVT prophylaxis (heparin, heparinoids, other anticoagulants, TEDs, SCDS) initiated by 2nd hospital day?  
- Yes  
- No  
- Not applicable – patient ambulating

### Antiplatelet/anticoagulation given within...

<table>
<thead>
<tr>
<th>FIRST 24 hrs</th>
<th>FIRST 48 hrs</th>
<th>AFTER 48 hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes / no</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
</tbody>
</table>

If yes, check all appropriate:

- **Coumadin**  
- **Unfractionated heparin SQ**  
- **Unfractionated heparin IV**  
- **LMW heparin**  
- **Lovenox**  
- **ASA (75-325mg)**  
- **Ticlid (ticlopidine)**  
- **Plavix (clopidogrel)**  
- **Persantine (dipyridamole)**  
- **Other (specify)**

If not, why not:

- Hemorrhagic stroke  
- Current peptic ulcer disease  
- Intracranial surgery or biopsy  
- Refused treatment  
- Terminal comfort care  
- Other (specify)

### Treatment for atrial fibrillation:

If a-fib documented, was pt discharged on anticoag?  
- Yes  
- No

If not, give reason …

- Risk for bleeding  
- Risk for falls  
- Mental status  
- Liver disease  
- Terminal illness  
- Patient refused, did not want risk  
- Patient refused, reason not specified  
- Discontinued due to bleeding  
- On ASA as regular medication  
- Arthritis requiring NSAIDs or ASA  
- Other

### Antithrombotic treatment at discharge:

If yes, check all appropriate:

- **Coumadin**  
- **Unfractionated heparin SQ**  
- **Unfractionated heparin IV**  
- **LMW heparin**  
- **Lovenox**  
- **ASA (75-325mg)**  
- **Ticlid (ticlopidine)**  
- **Plavix (clopidogrel)**  
- **Persantine (dipyridamole)**  
- **Other (specify)**

### Treatment for hypertension

- None prescribed  
- None – contraindicated  
- ACE inhibitors  
- ARB  
- Beta blockers  
- Ca++ blockers  
- Diuretics  
- Other anti-hypertensives  
- Anti-hypertensive diet

### Cholesterol reducing treatment

- None prescribed  
- None – contraindicated  
- Statin  
- Fibrate  
- Low cholesterol diet (eg, TLC)  
- Other

### Treatment for diabetes

- None prescribed  
- None – contraindicated  
- Insulin  
- Oral agents  
- ADA diet

### Other lifestyle interventions:

- Smoking – no intervention  
- Smoking – counseling  
- Smoking – medication  
- Weight loss – no intervention  
- Weight loss recommended  
- Increased activity recommended  
- Not applicable

---

**MD Signature:** _______________________________