

## THROMBOLYTIC CHECKLIST

This checklist is intended as a tool for the pre-hospital identification of patients who may benefit from the administration of thrombolytics for acute stroke.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Unit: \_\_\_\_\_ PSS: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Est. Wt: \_\_\_\_\_ lbs/kg

Time last seen at baseline: \_\_\_\_\_

Time of symptom onset: \_\_\_\_\_

Onset Witnessed or reported by: \_\_\_\_\_

Symptoms from BOSS Scale (circle abnormal findings)

***ANY ONE FINDING = POSSIBLE STROKE***

FACIAL DROOP:                R                L

ARM DRIFT:                R                L

SPEECH:                slurred                wrong words                mute

Possible Contraindications (check all that apply)

Current use of anticoagulants (e.g., warfarin sodium)	Yes	No	?
Has blood pressure consistently over 180/110 mm Hg	Yes	No	?
Witnessed seizure at symptom onset	Yes	No	?
History of intracranial hemorrhage	Yes	No	?
History of GI or GU bleeding, ulcer, varices	Yes	No	?
Is within 3 months of prior stroke	Yes	No	?
Is within 3 months of serious head trauma	Yes	No	?
Is within 21 days of acute myocardial infarction	Yes	No	?
Is within 21 days of lumbar puncture	Yes	No	?
Is within 14 days of major surgery or serious trauma	Yes	No	?
Is pregnant	Yes	No	?
Abnormal blood glucose level (<50 or >400): FSBS (if done): _____	Yes	No	?

Have you identified any contraindications to thrombolytic therapy?    ? YES    ? NO

Receiving Site/Physician: \_\_\_\_\_ Time \_\_\_\_\_

EMT # \_\_\_\_\_ Signature \_\_\_\_\_