

Porter Adventist Hospital
Stroke Alert/Rapid Response
Record

Critical Times for Stroke Alert	Time (24 hr clock)
Bio Phone Stroke Alert call received	:
Time Stroke Alert/Rapid Response Called	:
Triage Time/Time of onset of symptoms	:
Patient presents to ED	:
ED/Attending/Intensivist Physician in to see pt.	:
Neurologist paged (Name: _____)	:
Neurologist call back time	:
Neurologist decision time	:
CT called	:
Patient to CT (Goal 25 minutes from Door)	:
Results from CT called to physician(Goal 45 min)	:
Admin. Coordinator paged	:
Admin. Coordinator response to page	:
Labs ordered	:
Labs drawn	:
Lab results received (Goal 45 min. from order)	:
Thrombolytic started	:
Patient admitted / Transferred (Total ED Time)	:
	:

EMS Agency	From Field	From PAH
<input type="checkbox"/> Action Care Ambulance	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Columbine Ambulance Service	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cunningham Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Denver Health Paramedics	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elk Creek Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Englewood Fire/Rescue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flight for Life	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Littleton Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Parker Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sheridan Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> South Metro Fire Rescue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> West Metro Fire Department	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

To Be Completed by Pre-Hospital		
EMS follow-up completed by:		
Date/Time:		
Report to:		
Stroke Alert – Critique		
EMS "Stroke Alert"?	Yes	No
Did patient fit Stroke Alert criteria?	Yes	No
Was EMS Stroke Alert accurate?	Yes	No

CONFIDENTIAL
Not Part of the Patient's Medical Record
 Version 2

READ FIRST

- Initiate form in ED or at Rapid Response location
- Please complete for all Stroke Patients regardless of time of day
- When complete, please return to Stroke Coordinator

Barriers to Thrombolytic Therapy
Complete if Time to Thrombolytic > 3 Hours
<input type="checkbox"/> Unknown time of onset of Symptoms <input type="checkbox"/> Symptoms of Stroke not recognized <input type="checkbox"/> Delay in Patient seeking Medical Treatment <input type="checkbox"/> Delay in Neurologist Call Back <input type="checkbox"/> Prolonged Decision Time <input type="checkbox"/> Equipment Failure <input type="checkbox"/> CT in Use <input type="checkbox"/> CT Stroke Protocol not utilized <input type="checkbox"/> Other – Explain: _____ _____ _____ _____

Patient Disposition		
Admitted to the floor Room # _____		
Admitted/Transferred to ICU Room # _____		
Transferred to another Facility, Facility Name: _____		
CT Stroke Protocol	Yes	No
CT without contrast	Yes	No
CT with contrast	Yes	No
MRI	Yes	No
CTA Brain and Neck	Yes	No
Carotid NIVEA	Yes	No
Expired	Yes	No
Emerg. Dept. MD: _____		
Neurologist: _____		
Admitting MD: _____		
Dx: _____		

Place Zebra Label Here

Source: Porter Adventist Hospital, Denver.