EMERGENCY DEPARTMENT- HNE HEALTH

STROKE/ TIA

Emergency Department Form

Rural Hunter

Draft March 2005 Trial Project

Surname:	MRN
Other Names:	
Address:	
Date of Birth:	MO

This form is to be used in conjunction with usual Emergency Department documentation.

Arrival Date: __/__/__ Time: ____Hrs Allergies:_____

TIME OF ONSET (Circle Option A, B, C, or D): ***Assessor Initials***: _____

	DATE		TIME: HH	MM	HH	MM
A. ACCURATE						
B. APPROXIMATE		BETWEEN FOLLOWING TIMES:				
C. SLEEP		RETIRED TO BED:				

SCANDINAVIAN STROKE SCALE

Please place the relevant score in the box

	Nurse	Dr
Assessor Initials:	_____	_____
Time of assessment 24 hr time:	___:___	___:___

Consciousness
- **6** Fully conscious
- **4** Somnolent but can be awakened fully
- **2** Reacts to verbal command
- **0** Comatose

Eye Movement
- **4** No gaze palsy
- **2** Gaze palsy present
- **0** Conjugate eye deviation

Arm, Motor Power
- **6** Raises arm with normal strength
- **5** Raises arm with reduced strength
- **4** Raises arm with flexion in elbow
- **2** Can move but not against gravity
- **0** Paralysis

Hand, Motor Power
- 6 Normal strength
- 4 Reduced strength in full range
- 2 Some movement, fingertips do not reach palm
- 0 Paralysis

Leg, Motor Power
- 6 Normal strength
- 3 Raises straight leg with reduced strength
- 4 Raises leg with flexion in knee
- 2 Can move, but not against gravity
- 0 Paralysis

Orientation (Nurse / Dr)
- **6** Correct time, place and person
- **4** Two of these
- **2** One of these
- **0** Completely disoriented

Speech (Nurse / Dr)
- **10** No aphasia
- **6** Incoherent speech
- **3** More than yes/no but no longer sentences
- **0** Only yes/no or less

Facial Palsy (Nurse / Dr)
- **2** None/dubious
- **0** Present

Gait (Nurse / Dr)
- **12** Walks 5m without aids
- **9** Walks with aids
- **6** Walks with the help of another person
- **3** Sits without support
- **0** Bedridden/wheelchair

TOTAL SCORE

Mild >39 **Moderate 10-39** **Severe <10**

Pilot Project

DRUG THERAPY (TPA) ELIGIBILITY ***Assessor Initials:*** _____

	YES	
Onset time clearly defined and < 3 Hours		If patient has onset time of less than 6 hours and a SSS between 10-40 they may be eligible for acute drug treatment – this is **urgent** as time is critical.
Onset time < 6 Hours (clearly defined)		
Scandinavian Stroke Score between 10-40		

*If potentially therapy eligible then an urgent CT should be performed (Level 1 Priority). G.P. to page Acute Stroke Team, John Hunter Hospital. **Pager 5655**

PAST HISTORY ***Assessor Initials***: _____

- ☐ stroke
- ☐ TIA
- ☐ IHD
- ☐ PVD
- ☐ Smoker
- ☐ Recent head injury
- ☐ Hypertension
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Atrial Fibrillation

*** If recent head injury and altered level of consciousness, consider subdural haemorrhage and CT priority 1.**

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CT PRIORITY GUIDELINES ***Assessor Initials***: _____

It is recommended that non-contrast CT brain scanning be performed as early as is practical after the patient arrives in hospital with a stroke syndrome. **Tick appropriate box below**

☐ **Level 1 = "Immediate" = CT needed within 1 hour**
- possibility of associated head trauma
- impaired or deteriorating level of consciousness
- clinical suspicion of an expanding posterior fossa lesion (cerebellar signs, lower cranial nerve palsy, coning)
- clinical suspicion of subarachnoid haemorrhage

☐ **Level 2 = "Urgent" = CT needed within 4 hours**
- full anticoagulant therapy considered appropriate by senior medical staff
- expanding intracranial aneurysm suspected
- moderate to severe acute stroke syndrome
- Scandinavian Stroke Scale of < 40

☐ **Level 3 = "Semi-urgent" = CT within same day**
- minor stroke syndromes
- transient ischaemic attacks
- stable acute deficit for 24 hours or longer
- Scandinavian Stroke Scale of > 40

☐ **CT Scan not currently indicated**
Reason:……
…… .....

☐ CT to be arranged as an outpatient

SWALLOWING ASSESSMENT ***Assessor Initials***: _____

Swallowing assessment: Completed by Medical Office or Speech Pathologist ☐ Yes ☐ No

If no assessment is conducted patient is to **remain NBM**. Address fluid requirements.

CURRENT MEDICATIONS

_____

_____

_____

_____

EXAMINATIONS:

Results of ECG indicate Atrial Fibrillation ☐ Yes ☐ No Action:

STROKE SYNDROME USING OXFORDSHIRE CLASSIFICATION SCALE

Please tick the following boxes as applicable ***Assessor Initials:*** _____

☐ **TACS – Total Anterior Circulatory Syndrome**

Combination of:
1. hemiparesis +/- hemisensory loss
2. homonymous hemianopia
3. global aphasia (dominant hemisphere) OR visuo – spatial deficit / neglect (non-dominant hemisphere

☐ **PACS – Partial Anterior Circulation Syndrome**
1. Two of the three components of TACS
2. Dysphasia typically related to either expressive or receptive
3. Typically no drowsiness

☐ **LACS – Lacunar Circulation Syndrome**
1. pure motor stroke
2. sensory-motor stroke
3. pure sensory stroke
4. ataxic hemiparesis
5. dysarthria clumsy-hand syndrome

☐ **POCS – Posterior Circulation Syndrome**
1. ipsilateral cranial nerve palsy with contralateral motor and/or sensory deficit / neglect
2. conjugate gaze disorder
3. cerebellar dysfunction without ipsilateral long tract signs
4. isolated homonymous hemianopia

☐ **UNCERTAIN**

☐ **TIA**

Name	Initials	Signature	Designation