



## Nursing Home to EMS Report Sheet for Potential Stroke Patient

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

<b>Nursing Home Information</b>	<b>PATIENT/FAMILY EMERGENCY CONTACT</b>					
	Name:			Circle what applies:		
	Phone Number:			HCP	Emergency Contact	
	Code Status (CIRCLE)	DNR	DNI	Full Code	Comfort Measures	eMolst
	Nursing Home Contact	Name: _____		Phone: _____		
	<b>STROKE SIGNS &amp; SYMPTOMS (CIRCLE ANY THAT APPLY)</b>					
	Slurred speech [ yes / some / no ]	Ataxia [ body ] [ right / left ] [ arm / leg/ both ]				
	Aphasia [ mute / garbled / confused ]	Vision impairment [ one eye / both eyes ] [ right / left ]				
	Weakness [ right / left ] [ arm / leg / both ]	Increased and/or New Confusion [yes] / [no]				
	Facial droop [ right / left ]	Other: _____				
<b>DATE &amp; TIME</b>						
Last Known Well Time:	AM / PM		Current Alert & Orientation:			
Symptom Discovery Time:	AM / PM		Current VS:			
<b>PATIENT HISTORY</b>						
Recent surgery or bleeding episodes	NO	YES	Details: _____			
Previous brain hemorrhage	NO	YES	Details: _____			
Brain cancer	NO	YES	Details: _____			
Recent head trauma /Unwitnessed fall	NO	YES	Details: _____			
Previous stroke/TIA (Hx of/if so when)	NO	YES	Details: _____			
Migraines	NO	YES	Details: _____			
Seizures	NO	YES	Details: _____			
Diabetic	NO	YES	Details: _____ Blood Sugar: (Oral Meds) (Insulin)			
Blood thinning medications	NO	YES	[e.g., (warfarin (Coumadin), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa))]			
Allergies	NO	YES	Details: _____			
<b>PATIENT BASELINE</b>						
Level of Assist (amb) (SPT) (sit to stand) (hoyer)	Weakness [ yes / no ]		Details: _____			
Difficulty Swallowing [ yes / no ]	Alert and Oriented [ yes / no ]		Details: _____			
Speech difficult [ yes / no ]	Other: _____					
<b>ASSESSMENT</b>						
Glucose:		Cardiac Rhythm: [Sinus / Atrial Fibrillation / Other]				
Blood Pressure:						
<b>STROKE SPECIFIC REPORT EMS TO EMERGENCY DEPARTMENT</b>						
<b>EMS</b>	Basic Data <ul style="list-style-type: none"><li>• Age</li><li>• Gender</li><li>• Chief Compliant</li></ul>	Symptoms <ul style="list-style-type: none"><li>• Last normal</li><li>• Trauma</li><li>• Seizure</li></ul>	History <ul style="list-style-type: none"><li>• Recent surgery</li><li>• Recent illness</li><li>• Medications</li></ul>	Exam <ul style="list-style-type: none"><li>• GCS</li><li>• FASTED Scale</li><li>• VS &amp; glucose</li></ul>		