

Pre-hospital Stroke Screening Scale

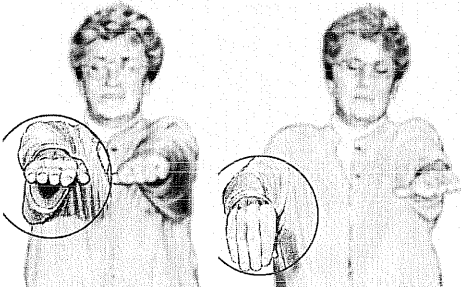
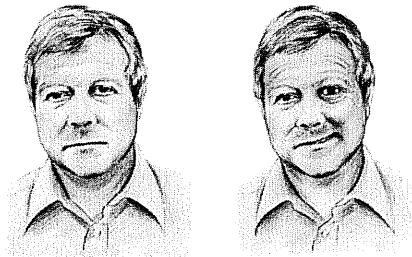
1. Patient Name: _____

2. Information/History from _____
 Patient Family Other

3. Time last seen normal/baseline and awake ____:____ __/__/____

Screening Criteria		Yes	Unknown	No
4.	Age >45			
5.	History of seizures or epilepsy absent			
6.	Symptom duration < 24 hours			
7.	Patient not wheelchair bound or bedridden at baseline			
8.	Glucose between 60 and 400			
9.	Unilateral weakness only (droop or drift)			

Facial Droop



Arm drift

↓

All Yes?

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Call receiving hospital with
"Code Stroke"