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| **STROKE ALERT ORDERS - EMERGENCY DEPARTMENT** (Initiate on patients who meet criteria for stroke activation) |
| ***Provider to check appropriate boxes and cross out pre-checked order if not desired.  These orders are not implemented until signed by provider.*****BEFORE CT:****☒** Blood Glucose Point of Care STAT, notify for glucose < 60 mg/dL or > 180 mg/dL**☒** BEFAST Stroke identification assessment: Notify provider if positive**☒**  Large Vessel Occlusion Screen (LAMS or VAN): Notify provider if positive**☒** Vital Signs: every 15 minutes until treatment decision is made**☒** Notify provider for BP greater than 185/110 or systolic less than 100mmHg**☒** O2 to keep SpO2 >94%-98% or as ordered: \_\_\_\_\_\_**☒**  Assure 2 patent large bore peripheral IVs **AFTER CT:****☒** Obtain weight **☒** Nursing swallow screen for dysphagia prior to any oral intake**☒**  Acetaminophen 650 mg PO/PR for temperature > 100.4 °F (38.0 °C)**☒** Cardiac monitoring, continuous**☒** Full NIHSS (before thrombolytic [Alteplase or Tenecteplase] or transfer)**☒** Neuro checks: every 15 minutes until treatment decision is made**LABORATORY (STAT):** Only blood glucose results are needed prior to thrombolytic administration.**☒** CBC**☒** CMP**☒** PT/INR**☒** PTT**☒** Troponin**☐** HCG Qualitative Serum for women less than 55 years of age **☐** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DIAGNOSTIC:****☒** Non-contrast head CT (goal is done within 20 minutes of arrival and read within 45 minutes of arrival)**☐** CTA head and neck (if available- consider for positive Large Vessel Occlusion Screen)**☒ 12** LeadEKG after CT**OTHER:****☐**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **NOTE:** Only marked orders will be initiated. Provider must cross-out pre-checked orders if not desired. |
| **Verbal order from**  (Provider) Nursing signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **Patient Identification** |
| Revised 11/21 |