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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 | |