

Region One EMS

Fibrinolytic Therapy Checklist for Ischemic Stroke

Patient Name:

Date:

Time:

All of the “**YES**” boxes and all of the “**NO**” boxes must be checked before a patient should be transported to an “Acute Stroke Care Facility.” If there is not one within 30 minutes, then go to the nearest hospital.

Inclusion Criteria

(All of the “**YES**” boxes must be checked)

YES

- ☐ Age greater than or equal to 15 years
- ☐ Signs and symptoms of stroke with neurologic deficit (abnormal Cincinnati Stroke Scale)
- ☐ Time of symptom onset less than 120 minutes prior to EMS arrival

Exclusion Criteria

(All of the “**NO**” boxes must be checked)

NO

- ☐ Active internal bleeding (e.g., gastrointestinal bleeding or urinary bleeding within the last 21 days)
- ☐ Known bleeding disorder
- ☐ Within 3 months of intracranial surgery, serious head trauma, or previous stroke
- ☐ Within 14 days of major surgery or serious trauma
- ☐ History of intracranial hemorrhage
- ☐ Witness of seizure at stroke onset
- ☐ History of cancer of the brain

County Incident Number:

ALS Provider Name

Date:

Signature: