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| **NEURO** | **CALL** | **Form B: Stroke Team**  *Place patient sticker here* |
| **Section 1: Stroke Team checklist before CT scan** | | |
| **History** | | |
| □ **Stroke onset time, or time last seen well:** | | |
| □ **Relevant medical history**   * Atrial fibrillation? * Renal impairment? * Recent surgery? * History of bleeding? | | |
| □ **Advanced care directives?** | | |
| □ **Medications**   * Anti-coagulants? *(Time last dose taken?)* * Anti-platelet agents? * Nephrotoxins? * Other: | | |
| □ **Pre-morbid function** | | |
| **Examination** | | |
| □ **Vital signs**   * Blood glucose level * Blood pressure * GCS | | |
| □ **NIH Stroke Scale** *(Document on separate form from ‘NEURO CALL’ BOX)* | | |
| □ **Stroke mimics?** | | |
| □ **Potential sources of bleeding?** | | |
| **Doctor responsible for this assessment:**  □Neurology□Medical□Registrar□Consultant | | |

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| **NEURO** | **CALL** | **Form B: Stroke Team** |
| **Section 1: Stroke Team checklist before CT scan (continued)** | | |
| **Investigations** | | |
| □ **Renal function**   * Creatinine: * eGFR:   *Creatinine and eGFR can be taken from most recent blood results.*  *If none available, take screening creatinine from venous blood gas.*  *Must transcribe onto CT request form (use pre-printed form from ‘NEURO CALL’ BOX).* | | |
| □ **Request urgent bloods, and notify haematology lab (phone 28014)**  *Liaise with Emergency Nurse (use pre-printed form from ‘NEURO CALL’ BOX).*   * INR: * Platelets: | | |

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| **Section 2: CT scan** | | | |
| □ **Arrange urgent transfer to CT-scanner at Darwin Private Hospital (phone 8928 9821)** | | | |
| □ **Ensure patient is stable and has two working IV cannulas (at least one 18G)** | | | |
| □ **Accompany patient with ED nurse and Stroke Team to CT-scanner** | | | |
| □ **Notify Stroke Consultant once imaging is complete for decision** | | | |
| □ **Return to ED with patient** *(Resus bay if likely decision to give thrombolysis)* | | | |
| □ **CT report:**  Time report received:  Reporting radiologist: | | | |
| **NEURO** | **CALL** | **Form B: Stroke Team** | |
| **Section 3: Inclusion & exclusion criteria** | | | |
| **Inclusion criteria** | | | |
| * Onset of symptoms consistent with ischaemic stroke   within preceding 4.5 hours *(at time of commencing thrombolytics)* | | | □ **YES** □ **NO** |
| * Potentially disabling neurological deficit | | | □ **YES** □ **NO** |
| * CT rules out haemorrhage or non-vascular cause of stroke | | | □ **YES** □ **NO** |
| **Exclusion criteria − absolute** *(do not administer thrombolytics)* | | | |
| * Uncertainty about time of stroke onset   *(including last seen well >4.5 hours ago)* | | | □ **YES** □ **NO** |
| * Hereditary or acquired coagulopathy   + INR >1.7   + Platelet count <100 ×109/l   + On heparin with aPTT elevated   + LMWH or other oral anticoagulant within last 12 hours | | | □ **YES** □ **NO** |
| * Clinical and radiological suspicion of subarachnoid haemorrhage | | | □ **YES** □ **NO** |
| * Suspected septic embolus | | | □ **YES** □ **NO** |
| * Hypertension *(systolic BP >185 mmHg, OR diastolic BP >110 mmHg)* | | | □ **YES** □ **NO** |
| * Seizure at symptom onset without vessel occlusion | | | □ **YES** □ **NO** |
| * CT evidence of extensive MCA territory infarction *(>⅓ of MCA territory)* | | | □ **YES** □ **NO** |
| **Exclusion criteria − relative** *(administer thrombolytics with caution and appropriate consent)* | | | |
| * Age < 18 years | | | □ **YES** □ **NO** |
| * Pregnancy | | | □ **YES** □ **NO** |
| * Abnormal BGL *(<3.6 mmol/l, or >22.2 mmol/l; treat and re-evaluate)* | | | □ **YES** □ **NO** |
| * CT-perfusion shows an infarct core (CBF/CBV) >70 ml with minimal penumbral mismatch | | | □ **YES** □ **NO** |
| * Stroke or serious head trauma in the past 3 months   *(Risks of bleeding considered to outweigh benefits of thrombolysis)* | | | □ **YES** □ **NO** |
| * Known history of intracranial haemorrhage, subarachnoid haemorrhage, arteriovenous malformation, or intracranial neoplasm   *(Risks of bleeding considered to outweigh benefits of thrombolysis)* | | | □ **YES** □ **NO** |
| * Suspected recent myocardial infarction *(within last 30 days)* | | | □ **YES** □ **NO** |
| **NEURO** | **CALL** | **Form B: Stroke Team** | |
| **Section 3: Inclusion & exclusion criteria (continued)** | | | |
| * Recent *(within 30 days)* parenchymal organ biopsy or surgery, trauma with internal injuries, partuition, gastrointestinal or urinary tract haemorrhage, that would increase the risk of unmanageable *(e.g. by local pressure)* bleeding | | | □ **YES** □ **NO** |
| * Cardiopulmonary resuscitation, or arterial puncture at non-compressible site within the last 7 days | | | □ **YES** □ **NO** |
| * Severe co-morbidities *(limiting life expectancy or posing treatment risk)* | | | □ **YES** □ **NO** |
| * Pre-existing dementia or severe dependency | | | □ **YES** □ **NO** |
| * Minor, or rapidly improving non-disabling neurological deficit *(if CT-angiogram is normal)* | | | □ **YES** □ **NO** |
| * Dose of oral anti-coagulant *(e.g. apixaban, dabigatran, rivaroxaban)* last administered within last 12 hours | | | □ **YES** □ **NO** |
| **Doctor responsible for this assessment:**  □Neurology□Medical□Registrar□Consultant | | | |

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| **Section 4: Decision to thrombolyse and post-thrombolysis management** | |
| **Informed consent** *(Document on Consent Form from ‘NEURO CALL’ BOX)* | □ **YES** □ **NO** |
| □ Informed consent obtained from patient *(if the patient is able to make and communicate decision)*  □ Informed consent obtained from proxy  □ Unable to obtain informed consent | |
| **Stroke Consultant responsible for final decision to administer thrombolytics:**  □Neurology Consultant□MedicalConsultant | |
| □ **Write dose of thrombolytics on medication chart**  □ **Write maintenance saline infusion on medication chart**  □ **Institute post-thrombolysis plan** *(see Stroke Thrombolysis protocol for details)*  □ **Arrange patient transfer to ICU** | |