

McLaren Print System Order

Order No: 81803
Order Date: 2023-12-20
User: Catherin Carrier
Phone: 586-493-8879

Ship Location: McLaren Macomb Interventional Neurology Office attn Catherine
1030 Harrington Blvd suite 304
Mt Clemens, MI 48043

Forms

Quantity: 1
Paragon Dept No: 25240
Dept Name: Interventional Neurology
Company Number: 260

Order Total Price: 58.00

Item Number: 17841-B
Item Description: STROKE t-PA ASSESSMENT FLOW SHEET
Revision Date: 12/2023
Print:
Paper:
Size:
Fold:
Finish:
Drill:
Poster:
Misc Info: 100 per package Finish size: 11 x 25 1/2 inches; color; DS

Thrombolytic Time Out Date: _____ Time: _____ Thrombolytic: _____ Bolus _____ mg Time: _____ 0.3 NaCl Flush 10 cc Time: _____ Assess BP, HR, & NIHSS Q 15 in x 2 hours, Q 30 min x 6 hours, Q 1 hour x 16 hours Complete Bedside Swallow Screen Document in Stroke Quality Documentation Band		Baseline at Start of Thrombolytic	w/in 15 min	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	15 MIN	
		Time																	
		BP																	
		HR																	
LOC Level of consciousness	0 = alert, keenly responsive 1 = not alert, arousable by minor stimulation 2 = not alert, arousable by pain 3 = reflex response, unresponsive, coma																		
LOC Orientation	0 = answers month, age correctly 1 = answers only 1 question correctly 2 = answers neither correctly, coma																		
LOC Commands	0 = performs 2 commands correctly 1 = performs 1 command correctly 2 = performs neither command correctly, coma																		
Horizontal Gaze patient eyes to follow your finger or face	0 = normal eye movement all way to right & left 1 = gaze deviation but pupil crosses midline 2 = gaze deviation but pupil does not cross midline	Deviates LT RT																	
Visual Fields test 4 quadrants, may use visual threat if pt. aphasic	0 = no visual field loss 1 = visual field loss in 1 quadrant 2 = visual field loss upper and lower quadrant 3 = bilateral visual field loss or blindness	Vision Loss LT RT Upper Lower																	
Facial Weakness smile, showing teeth, raise eyebrows, frown	0 = equal smile 1 = unequal smile, flattened nasal labial fold 2 = paralysis of lower face 3 = paralysis of upper and lower face																		
Motor Arm arm raised by patient or examiner lifts up arm	0 = no drift at end of 10 seconds 1 = drifts down, does not hit bed by end of 10 seconds 2 = drifts & hits bed before 10 seconds 3 = arm moves on bed, no anti-gravity effort 4 = no movement x = untestable, amputation or fusion	LT RT																	
Motor Leg leg raised by patient or examiner	Test for 5 seconds Score same as motor arm	LT RT																	
Limb Ataxia finger to nose, heel down shin (score only if out of proportion to weakness)	0 = normal smooth movement or coma or unable to understand your command 1 = present in 1 extremity, upper or lower 2 = present in both upper & lower extremity	Ataxia LT RT Arm Leg																	
Sensory pin prick to face, arm and legs	0 = normal sensation 1 = mild loss but aware of touch 2 = severe loss, unaware of touch, coma	Sensory Loss LT RT Face Arm Leg																	
Best Language identify objects, read sentences, explain picture	0 = normal 1 = mild impairment 2 = severe, fragmented speech 3 = mute, no usable speech, coma																		
Dysarthria repeat tip top, 50/50, huckleberry, baseball player, mama	0 = normal, no slurring 1 = mild to moderate slurring but some words understandable 2 = severe, unintelligible, mute or coma																		
Extinction / Neglect test double stimulation to info and touch.	0 = no abnormality, coma, or aphasic 1 = present with touch or vision 2 = present with both touch & vision	Neglect LT RT Touch Vision																	
Thrombolytic Complications: if suspected, alert ordering provider or Med Control if in ambulance. Angioedema: swelling of tongue, lips, mouth or throat, difficulty breathing. Intracranial Hemorrhage (ICH): decrease level of consciousness, N&V, change in NIHSS 4 or greater, abrupt rise in BP, new headache, pupillary changes		TOTAL																	
		Dizziness	Y (yes) or N (no)																
		Double Vision	Y (yes) or N (no)																
		Nausea / vomiting	Y (yes) or N (no)																
		Headache	Rate pain in box 0-10																
		Sx Intracranial Hemorrhage	Y (yes) or N (no)																
		Sx Angioedema	Y (yes) or N (no)																
		Pupil Size Left/Right																	
		Pupil Reaction Left/Right																	
		INITIALS																	
Signature _____		Signature _____	Signature _____																

Spec

