Stroke EMS Feedback Form

Date of Service: _____ **Level of Service Provided:** _____

Hospital Name:	**Patient initials:**
EMS Agency Name:	**EMS Run Number:**
Pre-Hospital Diagnosis:	**ED Disposition Diagnosis:**

Pre-Hospital Care Quality	
Pre-hospital stroke screen performed and communicated	○ **YES** ○ **NO**
If YES , Indicate type	☐CPSS ☐LAPSS ☐MASS ☐FASTER ☐NIHSS ☐ Other _____
Last Known Well Documented by EMS	○ **YES** ○ **NO** **Date/Time:**
Advanced Pre-Notification to Hospital of Possible Stroke Patient	○ **YES** ○ **NO**
Pre-Activation of Hospital Stroke Team	○ **YES** ○ **NO**

In-Hospital Care Quality	
Last Known Well Documented by Hospital	○ **YES** ○ **NO** **Date/Time:**
Brain Image Completed **Date/Time:** **Interpretation of First Brain Image** (Indication of Hemorrhage?)_____ _____	○ **YES** ○ **NO**
IV-tPA administered? **IF NO-WHY**:_____ _____	○ **YES** ○ **NO** **Date/Time:**

System Goals	**Time**	**Goal**
1. Door to Stroke Team (Physician)		**Goal = < 15 minutes**
2. Door to CT/MRI		**Goal = < 25 minutes**
3. Door to IV-tPA		**Goal = < 60 minutes**

Parties Involved & Contact Information
Emergency Physician:
Neurologist:

Outcome/Discharge Disposition: _____

Comments: _____

_____

NEUROIMAGING (OPTIONAL)

PRE-INTERVENTION	POST-INTERVENTION

**All Patient Identifiers Should Be Removed*