

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	YES NO
Date/Time: _____	
Interpretation of First Brain Image (Indication of Hemorrhage?) _____	
IV-tPA administered?	YES NO Date/Time: _____
IF NO-WHY: _____	

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: _____

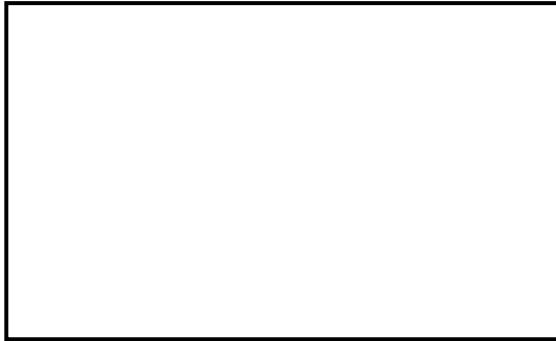
Outcome/Discharge Disposition: _____

Comments: _____

**NEUROIMAGING
(OPTIONAL)**

PRE-INTERVENTION

POST-INTERVENTION



**All Patient Identifiers Should Be Removed*