



**Stroke/TIA Consult
History and Physical Assessment**

Demographics																																	
Location: <input type="checkbox"/> Emergency Department <input type="checkbox"/> In patient Unit	Type: <input type="checkbox"/> Code stroke <input type="checkbox"/> Consult																																
Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Arrival: <input type="checkbox"/> EMS <input type="checkbox"/> Walk-in <input type="checkbox"/> In-patient <input type="checkbox"/> Transfer from other hospital																																
Baseline modified Rankin Score: please circle below 0 - No symptoms. 1 - No significant disability. Able to carry out all usual activities, despite some symptoms. 2 - Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities. 3 - Moderate disability. Not able to live independently, but able to walk unassisted (can use walking aids such as walker or cane). 4 - Moderately severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted. 5 - Severe disability. Requires constant nursing care and attention, bedridden, incontinent.	Living situation: <input type="checkbox"/> Home <input type="checkbox"/> Retirement home <input type="checkbox"/> Nursing home <input type="checkbox"/> Rehab <input type="checkbox"/> Other hospital																																
Past Medical History	Medications																																
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Migraine <input type="checkbox"/> Epilepsy <input type="checkbox"/> Dementia <input type="checkbox"/> TIA _____ (yyyy/mm/dd) <input type="checkbox"/> Ischemic stroke _____ (yyyy/mm/dd) <input type="checkbox"/> Hemorrhagic stroke _____ (yyyy/mm/dd) <input type="checkbox"/> Atrial fibrillation / Atrial flutter <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> CABG <input type="checkbox"/> Cardiac stent <input type="checkbox"/> Mechanical valve <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Pacemaker / Defibrillator / Loop	<input type="checkbox"/> Antiplatelet: _____ <input type="checkbox"/> Anticoagulant: _____ <input type="checkbox"/> Others: _____ _____ _____ _____																																
<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP <input type="checkbox"/> COPD <input type="checkbox"/> Renal disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Peripheral arterial disease <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Other: _____ _____ _____																																	
Smoking: <input type="checkbox"/> Nonsmoker <input type="checkbox"/> Ex-Smoker, quit ____ <input type="checkbox"/> Current smoker: __ Pk/yr: __ Alcohol: <input type="checkbox"/> Low risk <input type="checkbox"/> Moderate to high risk <small>Low risk :Male < 3/d or 15/wk ; Female < 2/d or <10/wk</small> Substance use: <input type="checkbox"/> Marijuana <input type="checkbox"/> Others:	Adverse reactions / Allergies:																																
History & Physical Examination	NIHSS																																
Symptom onset/Last known well :(yyyy/mm/dd) (hhmm):	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>1a. Level of Consciousness(0-3)</td><td></td></tr> <tr><td>1b. LOC Questions (0-2)</td><td></td></tr> <tr><td>1c. LOC Commands (0-2)</td><td></td></tr> <tr><td>2. Best Gaze (0-2)</td><td></td></tr> <tr><td>3. Visual Fields (0-3)</td><td></td></tr> <tr><td>4. Facial Palsy (0-3)</td><td></td></tr> <tr><td>5a. Motor Left Arm (0-4)</td><td></td></tr> <tr><td>5b. Motor Right Arm (0-4)</td><td></td></tr> <tr><td>6a. Motor Left Leg (0-4)</td><td></td></tr> <tr><td>6b. Motor Right Leg (0-4)</td><td></td></tr> <tr><td>7. Limb Ataxia (0-2)</td><td></td></tr> <tr><td>8. Sensory (0-2)</td><td></td></tr> <tr><td>9. Best Language (0-3)</td><td></td></tr> <tr><td>10. Dysarthria (0-2)</td><td></td></tr> <tr><td>11. Extinction & Inattention (0-2)</td><td></td></tr> <tr><td>Total Score (1-42)</td><td></td></tr> </table>	1a. Level of Consciousness(0-3)		1b. LOC Questions (0-2)		1c. LOC Commands (0-2)		2. Best Gaze (0-2)		3. Visual Fields (0-3)		4. Facial Palsy (0-3)		5a. Motor Left Arm (0-4)		5b. Motor Right Arm (0-4)		6a. Motor Left Leg (0-4)		6b. Motor Right Leg (0-4)		7. Limb Ataxia (0-2)		8. Sensory (0-2)		9. Best Language (0-3)		10. Dysarthria (0-2)		11. Extinction & Inattention (0-2)		Total Score (1-42)	
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HR (bpm): BP (mmHg): Glucose (mmol/L): RR (rpm): SpO2: Temp (°C):																																	
Neurological Examination	Systemic Examination																																



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Imaging / Labs:				
<input type="checkbox"/> CT Head <i>ASPECTS</i> score: ___/10 <input type="checkbox"/> CTP: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Core: ___ Penumbra: ___ <input type="checkbox"/> MRI:	<input type="checkbox"/> CTA <input type="checkbox"/> No occlusion seen <input type="checkbox"/> Large vessel occlusion: <input type="checkbox"/> ICA <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> ACA <input type="checkbox"/> Vertebral <input type="checkbox"/> Basilar <input type="checkbox"/> PCA <input type="checkbox"/> Carotid stenosis: <input type="checkbox"/> < 50% <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> > 50 % <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> High risk plaque: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arch disease <input type="checkbox"/> Intracranial Atherosclerosis	Creat: eGFR: Na: K:	Hb: WBC: Platelets: PT: INR:	ECG:
Resident Impression:				
Print Name	Designation	Signature	Date (yyyy/mm/dd)	Time (hhmm)
Staff Impression:				
<input type="checkbox"/> Ischemic stroke <input type="checkbox"/> Transient ischemic attack <input type="checkbox"/> Hemorrhagic stroke Location: <input type="checkbox"/> Lobar <input type="checkbox"/> Deep Etiology: <input type="checkbox"/> HTN <input type="checkbox"/> CAA <input type="checkbox"/> Anti-coagulation <input type="checkbox"/> Other <input type="checkbox"/> Stroke mimic: <input type="checkbox"/> Migraine <input type="checkbox"/> Seizure <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Peripheral vertigo <input type="checkbox"/> Others:				
Plan:				
<input type="checkbox"/> Thrombolysis Bolus given at (hhmm) _____ by _____ <input type="checkbox"/> Endovascular thrombectomy (Staff to complete EVT worksheet) <input type="checkbox"/> Medical treatment:				
Note:				
Disposition: <input type="checkbox"/> Admit <input type="checkbox"/> Discharge <input type="checkbox"/> Repatriate <input type="checkbox"/> Consult other Service <input type="checkbox"/> Will follow (inpatient consult)				
Investigations : <input type="checkbox"/> Echo <input type="checkbox"/> Holter <input type="checkbox"/> MRI <input type="checkbox"/> Other:				
Print Name	Designation	Signature	Date (yyyy/mm/dd)	Time (hhmm)