BROWARD STROKE NETWORK

FAX THE COMPLETED FORM TO THE BROWARD EMS COUNCIL'S EMRC (954) 357-9002

EMS - FILL OUT THIS SECTION: FILL IN ALL DATA FIELDS

EMS Agency:				
☐ American	☐ Davie	☐ Lighthouse Point	☐ Oakland Park	☐ Seminole Tribe
☐ AMR	☐ Ft. Lauderdale	☐ Margate	☐ Pembroke Pines	☐ Sunrise
☐ BSO	☐ Hallandale Beach	☐ Medics	☐ Plantation	☐ Tamarac
☐ Coral Springs	☐ Hollywood	☐ Miramar	☐ Pompano Beach	☐
	☐ Lauderhill	☐ N. Lauderdale		

Date of Service:		**Alarm Number:**	
Dispatched Time:		**Time Arrived on Scene:**	
Time Last Seen Normal		**Time of Onset of Symptoms**	
LA Motor Scale (EMS): (0-5)		**Was This a Wake Up Stroke?**	Yes / No
Time Stroke Alert Called (EMS)		**Time of Arrival at Destination Facility:**	

Closest Hospital to Incident (Check Box under "C" Column) *AND* Destination Hospital (Check Box under "D" Column)

C D	C D	C D	C D
☐ ☐ Aventura	☐ ☐ Broward Imperial Point	☐ ☐ Broward Health North	☐ ☐ Broward Health Medical Center
☐ ☐ Cleveland Clinic	☐ ☐ Florida Medical Center	☐ ☐ Holy Cross	☐ ☐ Broward Health Coral Springs
☐ ☐ Memorial West	☐ ☐ Memorial Regional	☐ ☐ Memorial Pembroke	☐ ☐ Northwest Medical Center
☐ ☐ Plantation Gen	☐ ☐ Westside Regional	☐ ☐ University Med Center	☐ ☐ Other

Was a Primary Stroke Center Bypassed?	Yes / No	**Bypass Reason:**	☐ EMS Agency Protocol ☐ Pt/Family Request ☐ PCP Request ☐ Other

HOSPITAL - FILL OUT THIS SECTION: FILL IN ALL DATA FIELDS

Did Patient Require Transfer		**If Transferred, Receiving Hospital Name**	
Name of Transferring Agency			
Was Patient Transferred to a CSC?	Yes / No	**Date**	**Time**
NIHSS (First Hospital)		**NIHSS (Second Hospital, if Transferred)**	
Was IV rTPA given?		**Time IV rTPA given**	

If IV rTPA was not given – Check appropriate box below

☐ Evidence of Intracranial hemorrhage	☐ AVM or Aneurysm
☐ Suspicion of subarachnoid hemorrhage	☐ Known bleeding diathesis
☐ Recent Intracranial surgery	☐ PT over 15 / INR > 1.7
☐ Recent serious head trauma	☐ Use of Heparin past 24hrs./Elevated PTT
☐ Recent Stroke	☐ Use of new anticoagulants
☐ History of Intracranial hemorrhage	☐ Stroke symptoms onset over 4.5hrs
☐ Uncontrolled hypertension	☐ Severe neurological deficit (NIHSS >22)
☐ Seizure at stroke onset	☐ Active internal bleeding
☐ Major early infarct signs on CT or midline shift	☐ Intracranial neoplasm
☐ Minor deficit	☐ Resolving deficit
☐ Other	

Door to Drug Time (minutes):					
Was a Procedure Performed at the CSC?	Yes / No	**[Input procedure information on the line below]**			
Procedure(s)		**Date**		**Time**	
Primary Discharge Diagnosis		**ICD Code**			
Date of Hospital Discharge		**Discharge Disposition**	☐ Home ☐ Rehabilitation ☐ ALF ☐ SNF		
Rankin Score at Discharge			☐ Long Term Care ☐ Hospice ☐ Expired		

{ Attention - Stroke Coordinator }

Place Patient Label or Write Pt. Name and MR Number Here

**** NOT A PART OF THE PERMANENT RECORD ****