

# MIAMI EMERGENCY NEUROLOGIC DEFICIT (MEND) PREHOSPITAL CHECKLIST

Date:	Name:	Age:	Sex:
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## BASIC DATA

WITNESS NAME: ★	WITNESS PHONE: ★
Dispatch time:	EMS arrival time:
Departure to ED time:	ED arrival time:

## EXAMINATION

BP: L \_\_\_\_\_ / \_\_\_\_\_ R \_\_\_\_\_ / \_\_\_\_\_ Pulse: Rate & Rhythm: \_\_\_\_\_ Resp \_\_\_\_\_

## MEND EXAM

*On scene: Perform LOC & basic exam (Cincinnati Prehospital Stroke Scale in shaded boxes) En route: If time allows, perform the complete MEND exam.*

## HISTORY

LAST TIME PATIENT WITHOUT SYMPTOMS ★ DATE: \_\_\_\_\_ TIME \_\_\_\_\_

YES	NO	T-PA EXCLUSIONS	ADDITIONAL HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	Head trauma at onset ★	Symptoms _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure (shaking or staring) at onset ★	Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Taking warfarin (Coumadin)	Medications _____
<input type="checkbox"/>	<input type="checkbox"/>	History of bleeding problems	Past History _____
<input type="checkbox"/>	<input type="checkbox"/>	Possible brain hemorrhage (severe headache, stiff neck, ↓LOC)	Last Meal _____
			Events Prior _____

### MENTAL STATUS

CHECK IF ABNORMAL

ON SCENE    EN ROUTE

<ul style="list-style-type: none"> <li>■ Level of Consciousness (AVPU) ★</li> <li>■ Speech "You can't teach an old dog new tricks." ★ Abnormal = wrong words, slurred speech, no speech</li> <li>■ Questions (age, month)</li> <li>■ Commands (close, open eyes)</li> </ul>	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    
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### CRANIAL NERVES

R    L    R    L

<ul style="list-style-type: none"> <li>■ Facial Droop (show teeth or smile) Abnormal — one side does not move as well as other</li> <li>■ Visual Fields (four quadrants) ★</li> <li>■ Horizontal Gaze (side to side)</li> </ul>	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    
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### LIMBS

R    L    R    L

<ul style="list-style-type: none"> <li>■ Motor — Arm Drift (close eyes and hold out both arms) ★ Abnormal — arm can't move or drifts down</li> <li>■ Leg Drift (open eyes and lift each leg separately) ★</li> <li>■ Sensory — Arm and Leg (close eyes and touch, pinch)</li> <li>■ Coordination — Arm and Leg (finger to nose, heel to shin)</li> </ul>	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    	<input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    <input type="checkbox"/>    
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## MANAGEMENT

<input type="checkbox"/> Do <u>NOT</u> treat hypertension	
<input type="checkbox"/> Do <u>NOT</u> allow aspiration	→ Keep NPO, head up, O <sub>2</sub> 2-4 L
<input type="checkbox"/> Do <u>NOT</u> give glucose (unless glucose <50)	→ IV NS; check fingerstick: _____
<input type="checkbox"/> ECG rhythm _____	→ If AMI, 12-lead time: _____

## STROKE-SPECIFIC ED REPORT (see starred items on checklist)

SYMPTOM ONSET	NEUROLOGIC EXAM	WITNESS
★ TIME (last time w/o sx)	★ Level of consciousness	★ Name
★ Trauma (history)	★ Speech/language	★ Contact info
★ Seizure (staring, shaking)	★ Visual fields	
	★ Moto strength	