

Brain Attack – Clinical Facility Transfer Checklist

Kansas Stroke Coalition – KDHE/KSU – KFMC – AHA/ASA

1. Patient name: _____ Date: _____
Last First

EMT performing field assessment _____ Time: _____ AM _____ PM

2. Information / history from:

Patient
 Family member \ _____ Phone: _____
 (authorized to give consent) Name (Phone en-route) _____

3. Last known time patient was at baseline or deficit free and awake: Time: _____ Date: _____

TIME OF SYMPTOM ONSET: _____ AM
 _____ PM

CODE STROKE CRITERIA:	Yes	Unknown	No
4. Symptom duration less than 3 hours	[]	[]	[]
5. Blood glucose between 80 and 400:	[]		[]

6. OBVIOUS ASYMMETRY

	Normal	Right	Left
Facial: smile/grimace	[]	[] Absent/Lax	[] Absent/Lax
Grip	[]	[] Weak [] No grip	[] Weak [] No grip
Arm drift	[]	[] Drifts down [] Falls rapidly	[] Drifts down [] Falls rapidly

Based on exam, patient has **only unilateral** (not bilateral) weakness Yes [] No []

7. LANGUAGE:	Appropriate	Inappropriate
LOC Questions (alert/verbal/painful/unresponsive)	[]	[]
LOC Commands (close eyes, make fist)	[]	[]
Language (repeat sentence, name objects)	[]	[]
Speech clarity (evaluate for slurring)	[]	[]

Based on assessment, patient has **new onset** language / orientation deficit Yes [] No []

8. Items 4-7 all **Yes** (or unknown) **CODE STROKE CRITERIA MET** Yes [] No []
Onset of symptoms plus transport time <3 hours Yes [] No []

If criteria are met, call receiving hospital with a “code stroke.” Document ALERT HOSPITAL information:

ALERT RECEIVING HOSPITAL:

HOSPITAL NOTIFIED Time called _____ ETA _____ Person receiving notification _____
CT IMMEDIATELY AVAILABLE _____ If not, how long _____ CT technician called in _____
Radiology interp available _____ If not, how long _____ Neurologist avail _____ If not, how long _____
TPA available _____ (Pharmacy _____ Nursing _____ ICU _____)

DOCUMENT MEASURES TAKEN IV _____ O₂ _____ Glucose ck. _____ EKG _____ Other _____

Kansas Rural Stroke Prevention Project, 2000

Note: This is designed to be a BASIS for a local clinical facility transfer protocol. Protocols must be agreed to by all parties involved in Acute Ischemic Stroke Treatment: Emergency Department and medical advisor, sending facility/provider, receiving facility/physician, etc.

Clinical Facility Transfer Agreement

_____ to _____

To facilitate continuity of care and timely transfer of patients who require medical facilities and/or expertise not available at the site of transfer, _____ and _____ agree to:

1. RECEIVING FACILITY, _____, agrees to admit the patient as promptly as possible, as long as the receiving facility has available space and qualified personnel for the treatment of the patient.
2. TRANSFERRING FACILITY, _____, agrees to use qualified personnel and equipment, as required, including use of medically appropriate life support measures during transfer.
3. All transfers will be done according to federal and state laws and regulations.
4. TRANSFERRING FACILITY agrees to provide appropriate documentation of clinical care in order to ensure continuity of care and information.
5. Charges for services performed at either facility, and/or emergency medical services, shall be collected by the party rendering the services directly from the patient, third party payor, or other sources normally billed by the party. Neither facility shall be liable to the other for charges.
6. This agreement does not limit the rights of either institution to contract with any other facility.
7. RECEIVING FACILITY agrees to refer the patient back to local health care providers for further care.
8. This agreement may be terminated by either facility upon notice.

Receiving facility

date

Transferring facility

date

Effective date _____