



Montana Stroke Initiative Pre-hospital Stroke Screening Scale

1. Patient Name: _____

2. Informant/History from _____ Phone# () ____ - ____
 Patient Family Other

3. Time last seen normal/baseline and awake ____:____ ____/____/____

Screening Criteria		No	Yes
F acial Droop – ask patient to show teeth and smile			
A rm Drift – ask patient to extend arms, palms down, with eyes closed			
S peech Abnormal– ask patient to say “You can’t teach an old dog new tricks”			
T est			

All Yes?



**Call receiving hospital with
“Code Stroke”**