

## Pre-hospital Stroke Screening Scale

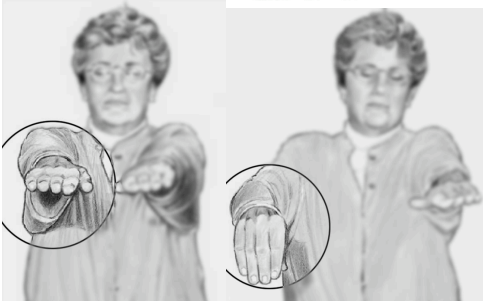
1. Patient Name: \_\_\_\_\_

2. Information/History from \_\_\_\_\_  
 Patient  Family  Other

3. Time last seen normal/baseline and awake \_\_\_\_:\_\_\_\_ \_\_/\_\_/\_\_\_\_

Screening Criteria		Yes	Unknown	No
4.	Age >45			
5.	History of seizures or epilepsy <b>absent</b>			
6.	Symptom duration < 24 hours			
7.	Patient <b>not</b> wheelchair bound or bedridden at baseline			
8.	Glucose between 60 and 400			
9.	Unilateral weakness only (droop or drift)			

Facial Droop



Arm drift

↓

**All Yes?**

↓

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