

Stroke EMS Feedback Form

Date of Service: _____ Level of Service Provided: _____

Hospital Name:	Patient initials:
EMS Agency Name:	EMS Run Number:
Pre-Hospital Diagnosis:	ED Disposition Diagnosis:

Pre-Hospital Care Quality	
Pre-hospital stroke screen performed and communicated	YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES , Indicate type	CPSS <input type="checkbox"/> LAPSS <input type="checkbox"/> MASS <input type="checkbox"/> FASTER <input type="checkbox"/> NIHSS <input type="checkbox"/> Other <input type="checkbox"/> _____
Last Known Well Documented by EMS	YES <input type="checkbox"/> NO <input type="checkbox"/> Date/Time: _____
Advanced Pre-Notification to Hospital of Possible Stroke Patient	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pre-Activation of Hospital Stroke Team	YES <input type="checkbox"/> NO <input type="checkbox"/>

In-Hospital Care Quality	
Last Known Well Documented by Hospital	YES <input type="checkbox"/> NO <input type="checkbox"/> Date/Time: _____
Brain Image Completed Interpretation of First Brain Image (Indication of Hemorrhage?) _____	YES <input type="checkbox"/> NO <input type="checkbox"/> Date/Time: _____
IV-tPA administered? IF NO-WHY: _____	YES <input type="checkbox"/> NO <input type="checkbox"/> Date/Time: _____

System Goals	Time	Goal
1. Door to Stroke Team (Physician)		Goal = < 15 minutes
2. Door to CT/MRI		Goal = < 25 minutes
3. Door to IV-tPA		Goal = < 60 minutes

Parties Involved & Contact Information
Emergency Physician:
Neurologist:

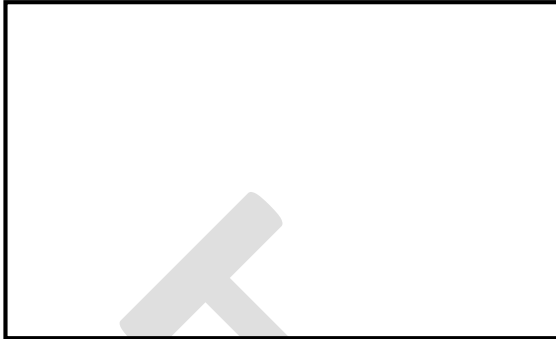
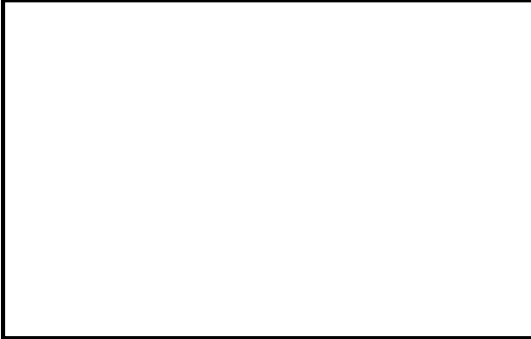
Outcome/Discharge Disposition: _____

Comments: _____

**NEUROIMAGING
(OPTIONAL)**

PRE-INTERVENTION

POST-INTERVENTION



**All Patient Identifiers Should Be Removed*

DRAFT

Definition of Data Elements:

(For data elements denoted with * symbol, please see GWTG-Stroke coding instructions for more details)

Level of Service Provided- Indicate whether ALS or BLS service provided by the EMS agency

EMS Agency Name- Enter the formal name of the EMS agency

EMS Run Number- Enter the unique number assigned by EMS for identification of transport

† Pre-hospital Diagnosis (Optional Field 8)- Please select the most appropriate diagnosis from the list below that was communicated and/or documented by the EMS provider:

- Alcohol
- Altered Mental Status
- Hypoglycemia
- Infection
- Neuromuscular Diseases
- Seizure
- Syncope
- Other: Please Specify:

† ED Disposition Diagnosis (Optional Field 9)- Please select the most appropriate diagnosis from the list below that was documented by the Emergency Department:

- Infection
- Metabolic
- Neuromuscular Disease
- Non-Neurological Sepsis
- Seizure
- Syncope
- Other: Please Specify
- Stroke: Please Specify location of Stroke; Left or Right sided

Pre-Hospital Care Quality

*** Pre-Hospital stroke screen performed-** Indicate if there is documentation of a pre-hospital stroke screen performed by the EMS agency. Indicate which stroke screen was performed from the list below.

*** Last Known Well Documented by EMS-** Enter the date and time that the patient was last known to be without stroke symptoms documented and/or communicated by the EMS agency

*** Advanced Pre-Notification to Hospital of Possible Stroke Patient-** Enter date and time that the EMS agency notified the hospital of transport of possible stroke patient.

† Pre-Activation of Stroke Team (Optional Field 10, if non-NYS Hospital) - If advanced notification by EMS, indicate if the stroke team was activated prior to the arrival of the patient. Pre-activation of the stroke team is defined as notification or activation of the stroke team via the hospitals stroke alert or stroke code policy/protocol prior to patient arrival at the hospital. Check “No” if activation of stroke team was not done prior to arrival.

In-Hospital Care Quality

*** Last Known Well Documented by Hospital-** Enter the date and time that the patient was last known to be without stroke symptoms documented by Hospital staff

*** Brain Image Completed-** Enter the date and time the initial brain image was completed

*** IV-tPA Administered-** Enter the date and time IV-tPA was administered (if applicable)

* **Door to Stroke Team-** Calculate the time from patient arrival to patient seen by stroke team physician who is in charge of the treatment decision-making

* **Door to CT/MRI-** Calculate the time from patient arrival to time of initial imaging

* **Door to IV-tPA-** Calculate the time from patient arrival to time of IV-tPA administration (If applicable)

* **Patient Diagnosis-** Indicate the patient's primary reason for being admitted to the hospital

* **Outcome/Discharge Disposition-** Document the patient's final place or setting to which they were discharged on the day of discharge from the hospital

Potential sources of EMS Information:

1. EMS Provider calling-in the information to the ED
2. Call log provided tracking information in the Emergency Department
3. ePCR, Paper PCR, EMS Run Sheet

* Data elements that are currently collected in the GWTG-Stroke Standard Tool and the EMS Form. Please refer to the GWTG-Stroke Coding Instructions for additional information

† Data elements that are collected in the "Optional" Tab (Fields 8, 9 and 10)