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** ☐ **NO** ☐
If YES , Indicate type	CPSS ☐ LAPSS ☐ MASS ☐ FASTER ☐ NIHSS ☐ Other ☐ _____
Last Known Well Documented by EMS	**YES** ☐ **NO** ☐ **Date/Time:**
Advanced Pre-Notification to Hospital of Possible Stroke Patient	**YES** ☐ **NO** ☐
Pre-Activation of Hospital Stroke Team	**YES** ☐ **NO** ☐

In-Hospital Care Quality	
Last Known Well Documented by Hospital	**YES** ☐ **NO** ☐ **Date/Time:**
Brain Image Completed	**YES** ☐ **NO** ☐ **Date/Time:**
Interpretation of First Brain Image (Indication of Hemorrhage?)_____ _____	
IV-tPA administered?	**YES** ☐ **NO** ☐ **Date/Time:**
IF NO-WHY:_____ _____	

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*

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)