

SAN JUAN COUNTY EMS BRAIN ATTACK ALERT FORM

Pt. Name: _____ Incident #: _____
Date: _____ BAT Alert Time: _____ Age: _____ Gender: M F
Responding ALS Unit(s): _____
Hospital Destination: _____ Arrival Time: _____

FAST-G EXAM

Facial droop Yes No
Arm drift Yes No
Speech NL ABNL/None

Time last seen or known normal*: _____ Date: _____
**If interval > 4 hours, see note*
Glucose: _____ (Treat if less than 50 mg/dl)

FIBRINOLYTIC SCREENING (Check if present)

Head trauma at onset <input type="checkbox"/>	On Coumadin (Warfarin) <input type="checkbox"/>
Seizure at onset <input type="checkbox"/>	Bleeding/clotting disorder <input type="checkbox"/>
Sx of cerebral bleed (severe HA, stiff neck, focal sx with altered LOC, nausea/vomiting) <input type="checkbox"/>	Previous hemorrhagic stroke <input type="checkbox"/>
	Current pregnancy <input type="checkbox"/>
	Surgery or significant hemorrhage w/in 3 mos. <input type="checkbox"/>

PAST HISTORY (Check if present)

Dysrhythmia <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Nontraumatic cerebral bleed <input type="checkbox"/>	Current pregnancy <input type="checkbox"/>
	Sickle cell disease <input type="checkbox"/>

**Valid Prehospital DNR, see note*

HPI (Check if present)

Extremity weakness <input type="checkbox"/>	Syncope/Near-syncope <input type="checkbox"/>
General weakness <input type="checkbox"/>	Dizziness/Vertigo <input type="checkbox"/>
Vision change <input type="checkbox"/>	Altered sensation <input type="checkbox"/>
Slurred speech/Aphasia <input type="checkbox"/>	Severe headache <input type="checkbox"/>
Nausea/Vomiting <input type="checkbox"/>	Stiff/painful neck <input type="checkbox"/>

**Symptoms resolved prior to transport, see note*

WITNESS/FAMILY INFO

Witness Name: _____ Phone #1: _____ Phone #2: _____
Closest Relative/Caregiver Name: _____ Phone: _____

VITAL SIGNS

Time: _____ BP: _____/_____ HR: _____ Rhythm: _____ RR: _____ SpO2: _____ (Rm. air)
Time: _____ BP: _____/_____ HR: _____ Rhythm: _____ RR: _____ SpO2: _____

MEND EXAM (Repeats some FAST elements)

Mental Status

- Level of consciousness A V P U
- Speech Not clear/no speech Clear
("You can't teach an old dog new tricks")
- Questions (age and month) NL ABNL
- Commands (open/close eyes) NL ABNL

Cranial Nerves

Facial droop	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Visual field abnl	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Horizontal gaze abnl	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>

Limbs

Arm drift	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Leg drift	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Abnl sensation arms	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Abnl sensation legs	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Finger to nose abnl	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>
Heel to shin abnl	RT <input type="checkbox"/>	LT <input type="checkbox"/>	None <input type="checkbox"/>

SUSPECTED STROKE SYNDROME

Right hemisphere <input type="checkbox"/>	Left hemisphere <input type="checkbox"/>
Cerebellar <input type="checkbox"/>	Brainstem <input type="checkbox"/>

Hemorrhagic, see note

- If interval since last normal is > 4.5 hours, symptoms have resolved prior to transport, or patient has a DNR, transport to closest or choice facility*
- If suspected hemorrhagic stroke, contact OLMC for destination*
- Otherwise, transport stroke patients to closest Stroke Center unless otherwise authorized by OLMC**