Pre-hospital Stroke Screening Scale

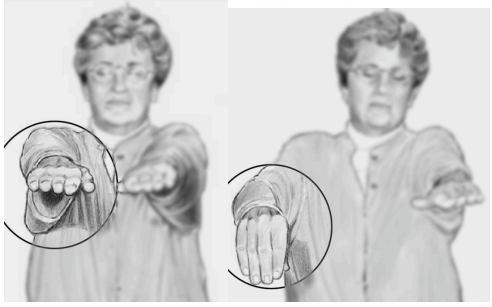
1. **Patient Name:** _____

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 **absent**			
6.	Symptom duration < 24 hours			
7.	Patient **not** 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"