

## Telestroke Referral Worksheet

### General Questions

1. Does this patient have a presumed acute ischemic stroke and would potentially benefit from thrombolytic therapy or endovascular therapy (EVT)? (see selection criteria below)
2. Has the patient been sent for a Non-contrast CT Head and CT Angiogram (CTA)?
3. What information will I need to provide to the Telestroke Consultant? (see below)

### Selection Criteria

1	Patient is presenting with a sudden onset of focal neurological deficits suggestive of an acute stroke	<input type="checkbox"/>
2	The patient does <b>NOT</b> have <b>severe</b> pre-stroke impairments, co-morbidities, or is not already palliative with end of life care <i>(Patients who cannot be left unattended for hours, who are bed bound, or who have severe cognitive impairment to degree that they cannot communicate or recognize family members are not candidates)</i>	<input type="checkbox"/>
3	The patient has significant <b>persisting</b> neurological deficits. <i>(Patients with very mild deficits – e.g. isolated facial droop, isolated sensory loss, isolated dizziness, minimal hand clumsiness, are <b>not</b> candidates.)</i>	<input type="checkbox"/>
4	The patient was last known to be well $\leq$ 6 hours ago; or for patients 6 – 24 hours, if there is evidence of a Large Vessel Occlusion (LVO). <i>(Based on a CTA or clinical criteria - a positive ACT-FAST Screen or severe motor weakness, and/or aphasia and/or neglect)</i>	<input type="checkbox"/>
5.	The CT (if already completed) does not show evidence of acute intracranial hemorrhage	<input type="checkbox"/>

### Patient Information Required

Age / Sex	Times: ED arrival ___/___ Last Seen Well: ___/___	
History of Bleeding <input type="checkbox"/>	Recent surgery / trauma, biopsy <input type="checkbox"/>	Prior Stroke <input type="checkbox"/> History of AF <input type="checkbox"/>
Medications:	Antiplatelet Agent <input type="checkbox"/> Warfarin <input type="checkbox"/> NOAC <input type="checkbox"/>	
EXAMINATION	BP ____/____ HR ____	AF on ECG <input type="checkbox"/>
Deficits and severity: describe visual, speech, motor deficits (completed NIHSS not required)		NIHSS ____ (if known)
Referring physician's OHIP Billing Number: _____		

***If your patient does not meet the above selection criteria, please do not call CritiCall for a Telestroke Consultation. Consult your local neurologist or medical stroke specialist for advice.***

***If your patient meets the selection criteria, please call CritiCall as soon as the patient is on the way to the CT scanner. For patients in the 6 – 24 hours window, If there is a delay in obtaining a CTA, DO NOT call CritiCall until the CTA is in progress.***