



**CONSULT NOTE
FAX COVER**

Date: _____
DD-MMM-YYYY

SENDER

Name: _____

Title: _____

Org. : _____

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RECIPIENT

Name: _____

Title: _____

Org. : _____

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This fax contains ____ pages total including the cover page.

Notes (optional):

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CONSULT NOTE FORM

Patient: _____

OHIP #: _____

DOB: _____ Age: _____ Sex (M/F): _____

Hospital: _____

MRN: _____

Ref MD: _____

Contact #: _____

Billing Code: _____

Date of Stroke: _____

Stroke Onset: _____ Time (HHMM) + day

Last seen normal: _____

Symptoms first recognized: _____

EMS Evaluation: _____

ER Arrival: _____

CT Scan: _____

Consultant paged: _____

Consult initiated: _____

Consult completed: _____

HISTORY

RISK FACTORS

<input type="checkbox"/> Hypertension	<input type="checkbox"/> DM	<input type="checkbox"/> ↑Lipids	<input type="checkbox"/> Smoking	<input type="checkbox"/> Neck Trauma
<input type="checkbox"/> CAD	<input type="checkbox"/> Valve Disease	<input type="checkbox"/> AF	<input type="checkbox"/> PVD	<input type="checkbox"/> Prior Stroke

Other Relevant Illnesses:

Current Medications:

 Pre-stroke patient was on antiplatelet agent, specify: _____
 anticoagulant, specify: _____

Patient: _____

Date: _____

MRN: _____

EXAMINATION

BP: _____ / _____	Pulse: _____	<input type="radio"/> Reg <input type="radio"/> Irreg	RR: _____	Temp: _____
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GCS: _____

Any evidence of recent bruising, trauma?

Other relevant features?

Neurological Exam (other):

NIH STROKE SCORE

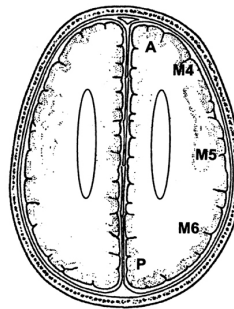
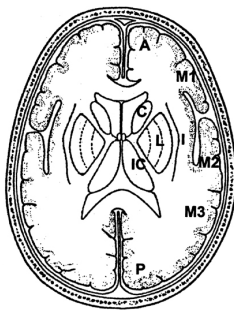
Item		Score
1 a.	Level of Consciousness	
1 b.	LOC Questions	
1 c.	LOC Commands	
2.	Best Gaze	
3.	Visual	
4.	Facial Palsy	
5 a.	Motor Arm - Left	
5 b.	Motor Arm - Right	
6 a.	Motor Leg - Left	
6 b.	Motor Leg - Right	
7.	Limb Ataxia	
8.	Sensory	
9.	Language	
10.	Dysarthria	
11.	Extinction and Inattention	
TOTAL		

LAB RESULTS

Glucose: _____	Platelets: _____	INR: _____	PTT: _____	Creat: _____
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CT Scan: CTA Multiphase Perfusion

- Hemorrhage
- Hyperdense vessel
- LVO
 - Carotid T
 - Carotid L
 - M1
 - M2
 - M3



ASPECT Score

- Caudate _____
- Lentiform _____
- Insula _____
- IC _____
- MCA 1 _____
- MCA 2 _____
- MCA 3 _____
- MCA 4 _____
- MCA 5 _____
- MCA 6 _____
- TOTAL _____

Consultant's interpretation CT imaging:

Patient: _____

Date: _____

MRN: _____

CONSULTANTS OPINION:

Recommendation to treat with tPA: <input type="radio"/> Yes <input type="radio"/> No	If tPA not given, specify reason: _____	Document needle time: _____
Recommendation to send for EVT: <input type="radio"/> Yes <input type="radio"/> No	Name of hospital where patient was transferred for EVT: _____	

Time: _____

Date: _____

Signature: _____

Contact Information

Name: _____

Fax: _____

Title: _____

Telephone: _____

Org. : _____

[Download](#) Hospital Telephone & Fax

DATA COLLECTION FORM

DO NOT send to referring hospital

FAX to 416-603-5768 or
EMAIL to frank.silver@uhn.ca

Date of Consult: _____

Age of Patient: _____

Referring Hospital: _____

Date of Stroke: _____

Telestroke MD: _____

Time (HHMM) + day

CT Scan: CTA Multiphase Perfusion

Stroke Onset:

Hemorrhage

Time: _____

Last seen normal: _____

Hyperdense vessel

ASPECT: _____

Symptoms first recognized: _____

LVO

Carotid T

NIHSS: _____

Carotid L

M1

GCS: _____

M2

M3

EMS Evaluation: _____

ER Arrival: _____

antiplatelet agent,
specify: _____

CT Scan: _____

anticoagulant,
specify: _____

Consultant paged: _____

IV tPA:

Yes No Needle time: _____

Consult initiated: _____

If not given, why: _____

Consult completed: _____

EVT:

Yes No

Hospital: _____

Services Provided:

Comments (technical problems, concerns, feedback):

Telestroke Consult Sent