CONFIDENTIAL

otn.telestroke®

CONSULT NOTE FAX COVER

Date: _____

DD-MMM-YYYY

SENDER

Name: _____

Title: _____

Org. : _____

Fax: _____

Telephone: _____

RECIPIENT

Name: _____

Title: _____

Org. : Niagara Health System Greater Niagara G

Fax: 905-358-3066

Telephone: 905-378-4647 x53456

This fax contains 4 pages total including the cover page.

Notes (optional):

Otn.telestroke®

Date: _____

CONSULT NOTE FORM

Patient: _____

OHIP #: _____

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

Hospital: Niagara Health System Greater Niagara G

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

☐ Hypertension	☐ DM	☐ ↑Lipids	☐ Smoking	☐ Neck Trauma
☐ CAD	☐ Valve Disease	☐ AF	☐ PVD	☐ Prior Stroke

Other Relevant Illnesses:

Current Medications:

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

☐ anticoagulant, specify: _____

Patient: _____ Date: _____

MRN: _____

EXAMINATION

BP: _____ / _____	Pulse: _____ ○ Reg ○ Irreg	RR: _____	Temp: _____

GCS: _____

Any evidence of recent bruising, trauma?

Other relevant features?

Neurological Exam (other):

NIH STROKE SCORE

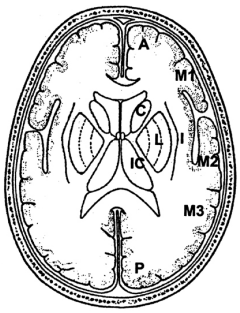
Item		Score
1 a.	Level of Consciousness	
1 b.	LOC Questions	
1 c.	LOC Commands	
2.	Best Gaze	
3.	Visual	
4.	Facial Palsy	
5 a.	Motor Arm - Left	
5 b.	Motor Arm - Right	
6 a.	Motor Leg - Left	
6 b.	Motor Leg - Right	
7.	Limb Ataxia	
8.	Sensory	
9.	Language	
10.	Dysarthria	
11.	Extinction and Inattention	
TOTAL		0

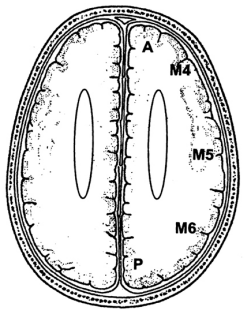
LAB RESULTS

Glucose: _____	Platelets: _____	INR: _____	PTT: _____	Creat: _____

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 0

Consultant's interpretation CT imaging:

Patient: _____ Date: _____

MRN: _____

CONSULTANTS OPINION:

Recommendation to treat with tPA: O Yes O No	If tPA not given, specify reason: _____	Document needle time: _____
Recommendation to send for EVT: O Yes O 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: _____

Referring Hospital: Niagara Health System Greater Niagara G

Telestroke MD: _____

CT Scan: ☐CTA ☐Multiphase ☐Perfusion

☐ Hemorrhage

☐ Hyperdense vessel

☐ LVO
- ☐ Carotid T
- ☐ Carotid L
- ☐ M1
- ☐ M2
- ☐ M3

Time: _____

ASPECT: 0

NIHSS: 0

GCS: _____

☐ **antiplatelet agent, specify:** _____

☐ **anticoagulant, specify:** _____

IV tPA:

○ Yes ○ No **Needle time:** _____

If not given, why: _____

EVT:

○ Yes ○ No

Hospital: _____

Age of Patient: _____

Date of Stroke: _____

	Time (HHMM)	+ day
Stroke Onset:		
Last seen normal:	_____	
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Services Provided: Review of Imaging and Videoconference

Comments (technical problems, concerns, feedback):

☐ **Telestroke Consult Sent**