

TELESTROKE REFERRING SITE APPLICATION

The purpose of this documentation is to record a site's readiness and need in participating in the Ontario Provincial Telestroke Program as a referring site.

This application should be completed in conjunction with your Regional/District Stroke Centre

Section	Name	Description
A	Requesting Organization Information	General contact information
B	Readiness	To determine administrative, financial & technical readiness for telestroke.
C	Clinical Profile	To determine level of clinical preparedness for telestroke.
D	Post Telestroke Care	To determine how best practice stroke care will be provided post tPA administration.

A: REQUESTING ORGANIZATION INFORMATION

Organization Name: _____

Site: _____ Facility Number: _____

Full mailing Address: _____

LHIN#: _____ Stroke Region: _____

Primary Contact Person Name: _____

Title: _____

Phone: _____ Fax: _____ Email: _____

Telemedicine Coordinator Name (if applicable): _____

Phone: _____ Email: _____

Technical Contact Name (if applicable): _____

Phone: _____ Email: _____

Site Status: Existing Member OTN Site # (if known) _____ New Site

Anticipated Telestroke Model: 24/7 PRN Set Schedule

Telestroke Model Definitions:

24/7 - Referring site physicians rely on Telestroke to delivery tPA 24 hrs./day, 7 days per week

PRN - Not all the referring site physicians require the use of Telestroke to deliver tPA; Telestroke is used when required

Set Schedule - Referring site has a set schedule where Telestroke is required to ensure coverage for tPA delivery (e.g. Mon thru Friday you do not use Telestroke, but required on weekends)

B: READINESS

HUMAN RESOURCES

ED physicians/internists willing to participate?	Yes	No
Are they willing to be available for telestroke 365 days/year?	Yes	No
Additional comments?		

Emergency Department MAC Chair supports telestroke application:	Yes _____	
	No _____	(name)

Emergency Administrative Director supports telestroke application:	Yes _____	
	No _____	(name)

CT Techs available 24/7?	Yes	No
Additional comments?		

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LEADERSHIP

Endorsement by hospital administration/senior management team/ MAC to move a telestroke initiative forward?	Yes	No
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Organization telestroke point of contact/liaison identified:	Yes _____	
	No _____	(name)

Designated physician champion: _____	Yes	No
		(name)

Designated leadership champion: _____	Yes	No
		(name)

Designated clinical staff champion: _____	Yes	No
		(name)

Regional Stroke Steering Committee and/or District Stroke Steering Committee Letter of Support enclosed?	Yes	No
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LHIN CEO support/approval; letter of support enclosed	Yes	No
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ADMINISTRATIVE

Agreement, in principle, to participate in data collection activities?	Yes	No
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FINANCIAL

Funding available for training of all relevant personnel (e.g. MDs, RNs, ED staff, tech support, DI)?	Yes	No
	In development	

Funding for OTN network drops in ED?	Yes	No
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Funding for telemedicine equipment?	Yes	No
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Comments:		N/A (e.g. equipment available)
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TRAINING

Commitment to undergo clinical training and collaboration with Regional Stroke Centre re. stroke and tPA administration in ED?	Yes	No
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Commitment to undergo training of telemedicine technology and telestroke processes in ED with the Ontario Telemedicine Network?	Yes	No
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TECHNICAL

Is there any existing telemedicine equipment available for use in the Emergency Department? Yes No

System Type: Cisco Polycom Specify equipment model _____
(please identify)

Willing to comply with "OTN Standard Telestroke Equipment" and configuration? Yes No

Willing to accommodate network infrastructure changes as required? Yes No

Does your CT Scanner currently push CT heads to ENITS? Yes No

Have you implemented the CT/mCTA protocol with ENITS? If no, describe plans to address. Yes No

Do you have an MRI? Yes No

If yes, does your MRI push to ENITS? Yes No

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ADDITIONAL INFORMATION

Please provide any other relevant information:

C: CLINICAL OPPORTUNITY/PROFILE

STROKE STATISTICS

Approx. # of stroke patients per year (if known): _____

Is tPA currently administered on site? Yes No

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DISTANCE FROM

Closest Regional or District Stroke Centre _____ km Name of Regional or District Stroke Centre _____

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NEUROIMAGING

CT scanner available 24/7? Yes No

-CTA available 24/7? Yes No

CT technician on-site 24/7? Yes No

-CT technician on-site able to do CTA 24/7? Yes No

Comments

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PATIENT MODEL TO BE DEVELOPED

Drip and keep patient post tPA Drip and ship patient post tPA

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CLINICAL PROTOCOLS

Note - protocols listed as 'in development' must be completed and submitted for approval prior to a site going live with telestroke services.

Commitment to participate in the regional medical redirect, if applicable? Please indicate if in development.

Yes In development: _____
No *Anticipated date of completion*

If yes, please indicate - With or to?

Approved clinical telestroke protocol for tPA administration and monitoring in ED:

Yes In development: _____
No *Anticipated date of completion*

Triage process developed for access into ED within 10 minutes or less, 24/7:

Yes In development: _____
No *Anticipated date of completion*

Triage protocol (Code Stroke) established and documented:

Yes In development: _____
No *Anticipated date of completion*

Process for STAT CT/mCTA 24/7 (target door to CT 15 minutes):

Yes In development: _____
No *Anticipated date of completion*

Protocol for acute ischemic stroke tPA administration in accordance with best practice guidelines established:

Yes In development: _____
No *Anticipated date of completion*

STAT Lab services and communication of results processes established 24/7:

Yes In development: _____
No *Anticipated date of completion*

Pharmacy preparedness for t-PA based on projected volumes (e.g. stock/supplies, distribution, budget):

Yes In development: _____
No *Anticipated date of completion*

Development of t-PA administration protocol including post infusion care (24 hours):

Yes In development: _____
No *Anticipated date of completion*

D: POST tPA CARE

STROKE UNIT CARE

Stroke Unit on Site

Yes No
In development

If yes, describe stroke unit model, # of beds, staffing model/complement/existing care pathways/protocols, monitored beds.

(A stroke unit is defined as a geographical unit with identifiable co-located beds (e.g., 5A-7, 5A-8, 5A-9, 5A-10) that are occupied by stroke patients 75% of the time and have a dedicated inter-professional team with expertise in stroke care including, at a minimum, nursing, physiotherapy, occupational therapy and speech-language pathology.)

Development of plans to manage acute stroke inpatients based on best practice guidelines:

Yes In development Anticipated completion date
No

Development of transfer protocol to stroke unit:

Yes No
In development

Please describe transfer protocol:

ADDITIONAL COMMENTS

SIGNATURES

Physician Champion

Signature

Date

Leadership Champion

Signature

Date

Clinical Staff Champion

Signature

Date

Emergency Department Chair

Signature

Date

Emergency Program Director

Signature

Date

Regional Program/
District Stroke Director

Signature

Date