Chelan/Douglas County PRE-HOSPITAL **STROKE DATA FORM**			
DEMOGRAPHICS:			
FIRST NAME:	LAST NAME:	Middle Name:	
DOB:	Agency Run Number:	☐Male ☐Female	
CALL INFORMATION:			
Pre-hospital Agency Name:	Destination Name:	Date of Call:	
Time of Call PCEP/ Request Time: ______:______	Dispatch Time: ______:______	☐Transfer ☐911	☐ALS ☐BLS ☐ILS
En route to Scene Time: ______:______	Arrival on-scene Time: ______:______	Arrival at Patient Side: _____:_____	
Enroute to Destination Time: ______:______	Arrival at Destination Time: _____:_____		
TREATMENT INFORMATION:			
Activated "Stroke Alert" ☐YES ☐NO	Time of "Stoke Alert": ______:______	Last Time Normal: Date - ___/____/_____ Time- ______:______	
Glucose Level taken: ☐YES ☐NO ☐ N/A Glucose Level:___________	FAST taken: ☐YES ☐NO ☐N/A Positive: ☐FACE ☐ARM DRIFT ☐SPEECH	Glucose Given: ☐YES ☐NO Time: ______:______	

Complete this form with each Stoke Activation (every patient that meets stroke system triage criteria)

Send Completed form to:

- Destination Hospital
- and Local MPD