**Hospital to EMS Quality Report**

**EMS pre-notification to ED**

[ ]  Yes

[ ]  No

**EMS total on-scene time \_\_\_\_\_**

**Demographics**

Years old: \_\_\_\_\_ Gender:

 [ ]  Male

 [ ]  Female

Race/Ethnicity:

[ ]  American Indian/Alaska Native [ ]  Hispanic Ethnicity

[ ]  Asian [ ]  Native Hawaiian/Pacific Islander

[ ]  Black or African American [ ]  White

[ ]  Unable to Determine

**Significant Information**

Date andTime of arrival to ED: \_\_\_/\_\_/\_\_\_\_ \_\_\_:\_\_\_

Presenting Symptoms in the Field:

Last Known Normal:

[ ]  Date and Time known \_\_\_/\_\_\_/\_\_\_\_ \_\_\_:\_\_\_

[ ]  Date only known \_\_\_/\_\_\_/\_\_\_\_

[ ]  Date and Time unknown

Notes:

Pre-hospital Stroke Scale Completed: Blood glucose checked:

[ ]  Yes [ ]  Yes

[ ]  No [ ]  No

Were appropriate therapies and interventions provided by EMS?

[ ]  Yes

[ ]  No

If no, which therapies/interventions were not provided?

Hospital-Specific Notes:

Inter-facility Transport Notes:

**Complete if applicable: Inter-facility transport**

Blood pressure guidelines maintained:

[ ]  Yes

[ ]  No

Vital signs and neurological checks monitored according to guidelines:

[ ]  Yes

[ ]  No

**Findings and Treatment**

ED Findings:

[ ]  Ischemic stroke [ ]  Intracerebral Hemorrhage (ICH)

[ ]  Transient Ischemic Attack (TIA) [ ]  No stroke/stroke mimic or other

[ ]  Subarachnoid Hemorrhage (SAH)

Treatment in ED:

[ ]  IV t-PA

[ ]  Endovascular intervention

[ ]  No IV t-PA or intervention. Treated in the ED and transferred to the ICU/floor (Please see Treatment Notes below for reason)

[ ]  Transferred to another facility

Treatment Notes:

**Discharge/Outcome**

Discharge Date: \_\_\_/\_\_/\_\_\_\_

Discharge Primary Diagnosis:

[ ]  Ischemic stroke [ ]  Intracerebral Hemorrhage (ICH)

[ ]  Transient Ischemic Attack (TIA) [ ]  No stroke/stroke mimic or other (specify below)

[ ]  Subarachnoid Hemorrhage (SAH) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Destination:

[ ]  Home [ ]  Hospice

[ ]  Rehab [ ]  Expired

[ ]  Nursing Home [ ]  Other

[ ]  Skilled Nursing Facility

[ ]  Long-term acute care

Clinical Outcome Notes:

Thank you for your collaboration in taking care of this patient.

Please provide me with any feedback on how we can improve our communication with you.

Your name

Your title

Your hospital

Your phone #