NORTH Dakota | Health & Human Services
Be Legendary.

ND STROKE TRIAGE AND TRANSFER GUIDELINE

For use at Clinics and Hospitals That Do Not Administer IV Thrombolytics

Patient experiencing one or more of the following stroke signs and symptoms:

- **B**alance- Sudden trouble walking, dizziness, loss of balance or coordination. *Perform bilateral index finger to nose test and bilateral heel to shin test.*
- **E**yes- Sudden double vision or trouble seeing out of one or both eyes*. Assess 4 quadrants of visual field.*
- **F**ace- Sudden drooping or numbness on one side of the face. *Ask the person to smile or show teeth.*
- **A**rm- Sudden numbness or weakness of the arm, especially on one side of the body. *Ask the person to close eyes, raise and extend both arms with palms up. Does one arm drift downward?*
- **S**peech- Sudden confusion, trouble speaking or understanding. *Have patient a repeat phrase such as "You can't teach an old dog new tricks".*
- **T**ime to dispatch transport- Consider timeliness of ground vs. air options
- Sudden severe headache with no known cause.

Contact nearest tertiary hospital to consult with neurologist regarding appropriate transfer destination. In most cases patient will be transferred to closest stroke ready hospital.

PATIENT SHOULD BE TRANSPORTED AS SOON AS EMS UNIT IS AVAILABLE

Door-in to Door-out Goal <30 minutes

1. Obtain vital signs stat and every 15 minutes
2. Monitor pulse oximetry and administer oxygen as needed to maintain a SpO2 of >94%; starting at 2L/min per nasal cannula. Oxygen is not recommended if patient able to maintain SpO2 >94% on room air.
3. Assess bedside glucose. Treat if <60 mg/dL.
4. Perform neuro assessment and FAST ED scoring if able (consider utilizing FAST ED app)
5. Establish last known well (LKW)- the time when the patient was last known to be neurologically normal. If the patient was sleeping and wakes up with symptoms, time last known well is the last time the patient was seen to be normal (i.e. before bed).
6. Keep NPO (including ice chips and meds)
7. Keep HOB elevated at 30 degrees
8. Insert 1-2 large bore IV sites if able (AC preferred). Maintain IV patency with 0.9% Normal Saline at TKO.
9. Acquire medical history. Determine if patient takes anticoagulants or has previous history of stroke.
10. Obtain weight in kg if able.
11. If time allows, complete Inclusion and Exclusion Criteria for IV Thrombolytic Treatment checklist to determine IV thrombolytic eligibility.

Report the following to accepting provider or nurse:

- **Symptom onset/Last Known Well**
- **Results of neuro assessment**
- **Vital Signs**
- **Anticoagulant status**
- **Weight in kg if available**
- **Blood glucose results (send with patient or fax)**
- **Medical History**
- **Contact information for family**