

<b>TIA Diagnosis Criteria</b>	<p style="text-align: center;"><b>The following criteria should be considered as a possible TIA:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> History of clinical symptoms including, but not limited to:           <ul style="list-style-type: none"> <li><b>Balance-</b> Sudden trouble walking, dizziness, loss of balance or coordination</li> <li><b>Eyes-</b> Sudden double vision or trouble seeing out of one or both eyes.</li> <li><b>Face-</b> Sudden drooping or numbness on one side of the face.</li> <li><b>Arm-</b> Sudden numbness or weakness of the arm, especially on one side of the body.</li> <li><b>Speech-</b> Sudden confusion, trouble speaking or understanding.</li> </ul> </li> <li><input type="checkbox"/> Complete resolution of symptoms with no active fluctuation.</li> <li><input type="checkbox"/> Stable neuro exam and NIHSS without any appreciable deficits as compared to baseline</li> </ul>
<b>Emergency Department Work-Up</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Neurology phone consult or in-house evaluation if available</li> <li><input type="checkbox"/> CT Scan head without contrast- rule out hemorrhage, early ischemia (ideally followed by an MRI brain if available)</li> <li><input type="checkbox"/> Basic Labs: Bedside Glucose, CBC, BMP, Platelets, PT-INR, PTT, Troponin</li> <li><input type="checkbox"/> 12 lead ECG</li> <li><input type="checkbox"/> Continuous cardiac monitoring for duration of ED visit</li> <li><input type="checkbox"/> Normal Saline 0.9% IV TKO</li> <li><input type="checkbox"/> Permissive hypertension if CT negative for hemorrhage (BP goal &lt;220/120)</li> <li><input type="checkbox"/> HOB 30 degrees until basic work-up is completed</li> </ul> <p><i>If Neurology confirms TIA diagnosis based on discussion, patient should have vascular imaging prior to discharge. If unavailable at the presenting facility, transfer to a *PSC/PSC Plus/TSC/CSC should be arranged.</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stat CTA or MRA head &amp; neck if available <b>OR</b></li> <li><input type="checkbox"/> Carotid duplex (only if contraindication to CTA/MRA)</li> </ul> <p style="text-align: center;"><i>Re-consult with Neurology based on findings of vascular imaging.</i></p>
<b>Transfer Criteria</b>	<p><b>Transfer to PSC/PSC Plus/TSC/CSC should be arranged for patients meeting any of the following criteria.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal vascular imaging (significant intracranial or extra cranial atherosclerotic disease -may need intervention vs close observation in intensive care unit)</li> <li><input type="checkbox"/> Ischemic lesion on CT/MRI brain- Diagnosis of stroke not TIA. (Tissue based definition update)</li> <li><input type="checkbox"/> Fluctuating symptoms with more than 1 TIA in the past one month</li> <li><input type="checkbox"/> Medical instability (New onset atrial fibrillation, hypertensive emergency, cardiac instability and others)</li> <li><input type="checkbox"/> ABCD<sup>2</sup> (Age, Blood Pressure, Clinical features of TIA, Duration/Diabetes-see guide) score 2-7</li> <li><input type="checkbox"/> ABCD2 score 0-1, but completion of stroke workup cannot be arranged within 7 days (based on availability of outpatient neurology provider urgent openings, non-compliance suspected)</li> </ul>
<b>Disposition</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> All TIA patients should be discussed with neurology prior to discharge.</li> <li><input type="checkbox"/> Ideally based on ABCD2 score, if the initial imaging workup is negative:           <ul style="list-style-type: none"> <li>ABCD2 score 0-1 → Refer to neurology clinic in 7 days</li> <li>ABCD2 score 2-7 → Admission to PSC/PSC Plus/TSC/CSC</li> </ul> <p style="text-align: center;"><i>These numbers are based on availability of neurology clinic appointment within 7 days.</i></p> </li> <li><input type="checkbox"/> For patients not currently on antithrombotic therapy with suspicion of TIA and no contraindications to antithrombotic therapy, Aspirin 325 mg po should be initiated.</li> <li><input type="checkbox"/> If decision to discharge; transthoracic echo, fasting lipid panel, HbA1c should be ordered prior to outpatient neurology follow up. Patients should also be scheduled for a 1 week follow up with PCP.</li> </ul>