MARCUS STROKE & NEUROSCIENCE CENTER

Grady

Stroke Transfer Information Form

Date/Time: ______________________________

Referring Hospital: ______________________________

Patient Name: ______________________________

Time of Onset: ______________________________

NIHSS Symptoms: ______________________________

Was t-PA given: [ ] Yes [ ] No Time ______________ Dose ______________

Weight: ______________ Height: ______________ Vitals: ______________

IV's: ______________ Foley: [ ] Yes [ ] No

Femoral Sheath: [ ] Yes [ ] No Has it been secured? [ ] Yes [ ] No

Allergies: ______________________________

Medications:

[ ] Smoker [ ] ETOH [ ] Substance Abuse If yes, please elaborate: ______________

Past medical history: ______________________________

EKG? [ ] Yes [ ] No

Family history of anesthesia complications? [ ] Yes [ ] No

If yes, please elaborate: ______________________________

Abnormal labs: ______________________________

PLEASE COMPLETE INFORMATION BELOW.

Family members' names and phone numbers (Cell and Home):

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