

LABEL HERE

PLEASE CHANGE ANY INCORRECT
INFORMATION ON THE LABEL

INSTRUCTIONS: Please answer EACH of the following questions.

1. Are the following pre-hospital and educational services available in your institution or within your community?

- a. Emergency Medical Services (EMS) in-the-field stroke victim assessment tool (e.g., Los Angeles pre-hospital screen, Cincinnati stroke scale) Yes No
- b. Mechanism to pre-notify hospital by EMS of potential stroke victim. Yes No
- c. Community stroke awareness program Yes No

2. Are the following services or programs available in your institution?

- a. An Emergency Department Yes No
- b. Written Emergency Department stroke protocol Yes No
- c. Written Tissue Plasminogen Activator (rTPA) protocol for thrombolytic therapy of acute ischemic stroke (including patients who may be transferred after Rx) Yes No
- d. Established relationship with another hospital to transfer patients for acute stroke care Yes No

IF YES . . .

d1. To which institution(s) do you most frequently transfer stroke patients? _____

3. Does your institution have stroke diagnostic capabilities available?

- Yes -- IF **YES**, please complete **a through k** of this question below
- No -- IF **NO**, skip to Question 4

- a. Cranial computed tomography (CAT Scan/CT of the Head) Yes No
IF YES . . .
a1. Available 24/7? Yes No
- b. CT angiography Yes No
- c. Magnetic resonance imaging (MRI) Yes No
- d. Magnetic resonance angiography (MRA) Yes No
- e. Diffusion-weighted MRI Yes No
- f. Perfusion MRI Yes No
- g. Carotid ultrasound/duplex Yes No
- h. Transcranial doppler Yes No
- i. Conventional (catheter) cerebral angiography Yes No
- j. Transthoracic echocardiography Yes No
- k. Transesophageal echocardiography Yes No

4. Are the following services or programs available in your institution?

- a. An Intensive Care Unit Yes No
- b. Acute stroke team Yes No
IF YES . . .
b1. Available 24/7? Yes No
- c. Acute stroke care map or pathway Yes No
- d. Stroke Unit Yes No
- e. Neurologist Yes No

IF YES . . .

- e1. How many? _____
- e2. Available 24/7 in **PERSON**? . . . Yes No
- e3. Available 24/7 by **PHONE**? . . . Yes No

PLEASE CONTINUE ON NEXT PAGE >>>>>>>>>>

Question 4 (continued . . . Availability of Services or Programs)

f. Neurosurgeon Yes No

IF YES . . .

f1. How many? _____

g. Intervention capability Yes No

IF YES . . .

g1. Available 24/7. Yes No

g2. Intrarterial thrombolysis . . . Yes No

g3. Carotid stenting Yes No

g4. Intracerebral angioplasty . . . Yes No

5. Are the following stroke rehabilitation and other services or programs available in your institution OR within your community?

a. Rehabilitation services available Yes No

IF YES . . .

a1. Is this a dedicated rehabilitation unit? Yes No

a2. Is this unit outpatient? Yes No

a3. Is this unit inpatient? Yes No

b. Services to follow chronic anticoagulation? Yes No

IF YES . . .

b1. Is this a dedicated clinic specific to anti-coagulation? Yes No

Thank you for completing this assessment!

Please return the completed form in the self-addressed stamped envelope or **fax** to **406-444-7465** by **May 28, 2004**, Attention Carrie Oser (coser@state.mt.us), Montana Department of Public Health and Human Services, Montana Cardiovascular Health Program, Cogswell Bldg., C-317, PO Box 202951, Helena, MT 59620-2951.

**STROKE DIAGNOSTIC, TREATMENT, AND
EDUCATIONAL SERVICES ASSESSMENT**

**MONTANA CARDIOVASCULAR HEALTH PROGRAM
(2004)**