

# Stroke Assessment for Nurses

## Patient Information

Name:

Date of Birth:

Medical Record Number:

Date/Time of Assessment:

## Primary Assessment

### 1. ABCs

Airway:

Breathing:

Circulation:

### 2. Neurological Assessment

Level of consciousness (Glasgow Coma Scale):

Pupillary response:

Motor function:

Sensory function:

### 3. FAST

Facial droop:

Arm drift:

Speech:

### 4. Time of Onset

## Secondary Assessment

### 1. Vital Signs

Blood pressure:

Heart rate:

Respiratory rate:

Temperature:

Oxygen saturation:

**2. Medical History**

Current medications:

**3. Stroke Risk Factors**

**4. Blood Glucose Level**

**5. NIH Stroke Scale Score**

**6. Imaging and Lab Work**

**7. Differential Diagnosis**

**Plan of Care**

**1. Consult with Neurology**

**2. Medication Administration**

**3. Monitor and Document**

#### **4. Patient and Family Education**

#### **5. Follow-Up**