**CORK UNIVERSITY HOSPITAL ACUTE STROKE ASSESSMENT**

**TIME IS BRAIN – ACT FAST**

(Insert this document into patient’s notes)

<table>
<thead>
<tr>
<th>FAST</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARMS</td>
<td></td>
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<tr>
<td>SPEECH</td>
<td></td>
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</tr>
<tr>
<td>TIME</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ROSIER</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has there been loss of consciousness or syncope?</td>
<td>Y (-1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>Has there been seizure activity?</td>
<td>Y (-1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>Is there a NEW ACUTE onset of any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Asymmetric facial weakness</td>
<td>Y (+1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>II. Asymmetric arm weakness</td>
<td>Y (+1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>III. Asymmetric leg weakness</td>
<td>Y (+1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>IV. Speech disturbance</td>
<td>Y (+1) □</td>
<td>N (0) □</td>
</tr>
<tr>
<td>V. Visual field defect</td>
<td>Y (+1) □</td>
<td>N (0) □</td>
</tr>
</tbody>
</table>

Total Score _____ (-2 to +5)

Stroke is likely if total scores are > 0

The stroke registrar on call (see Staff Directory Neurology / Geriatrics on call) should be contacted if onset of symptoms was within the past 4.5 hours and symptoms are still present.

Date: _____________________________

Time of onset of neurologic symptoms: _____________________________

Time of arrival at Emergency Department (ED): _____________________________

If you suspect acute stroke, Rosier score is between 1-5 and the onset of symptoms was within the last 4.5 hours, don’t delay:

- Contact registrar on call for stroke □
- Inform ED Registrar □
- ED registrar to request urgent CT head (code stroke) □
- 2 IV cannulas □
  (One must be green (18 gauge) to facilitate perfusion scanning)
- Bloods (FBC, U&E, coagulation, group and hold, glucose, troponin) □
- ECG □
Cork University Hospital Stroke Thrombolysis Checklist

REMEMBER! **TIME IS BRAIN**: The aim is to administer thrombolysis, if appropriate, as soon as **safely feasible**, not just before the time window expires.

This checklist should be completed and filed in the medical notes of all stroke patients considered for intravenous thrombolysis with alteplase (rt-PA).

Date ______________________________  
Time of symptom onset ______________________________  
Time of arrival ______________________________  
Time of assessment ______________________________  
Time of head CT ______________________________  
Capillary glucose ______________________________ (If < 3.5 treat and reassess once glucose normal)  
Premorbid Rankin /6 (See Modified Rankin Scale)  
Initial NIHSS /42 Time:__________ (See attached NIHSS sheet. Use long form if unsure on scoring)  
Patient weight ______________________________  
Exclusion criteria Yes ☐ No ☐ (See contraindication sheet)  
2 IV cannulas Yes ☐ No ☐ (Ideally at least one green)  
Bloods sent Yes ☐ No ☐  
ECG Yes ☐ No ☐  
Relevant stroke consultant informed Yes ☐ No ☐  
CT Brain result _______________________________________________________________  
Risks and benefits explained Yes ☐ No ☐ (See patient information sheet)  
Patient consent Yes ☐ No ☐ (Verbal acceptable)  
If consent not possible is thrombolysis judged to be in the best interests of the patient? Yes ☐ No ☐  
Reason for not offering thrombolytic therapy: _______________________________________________________________  

Final check

Is a neurological deficit still present? NIHSS /42  
BP <180/90mmHg Yes ☐ No ☐  
Still within time window Yes ☐ No ☐  
Consultant agreement Yes ☐ No ☐  

Administration of Alteplase

0.9mg/kg (maximum dose 90mg).  
Give 10% as bolus over 2 min then 90% by infusion over 60 min as per infusion protocol.  

Time of alteplase bolus ______________________________  
Time of start of infusion ______________________________  
Post thrombolysis NIHSS (2 hours) ______________________________  

Registrar (Print Name)____________________ Bleep ______________ Date______________ MCRN______________

Agreed by Departments of Geriatric Medicine, Neurology and Emergency Medicine. Prepared by Dr Carmel Curran, Dr. Paul Gallagher and Dr. Simon Cronin. Valid from 01.07.2012. Review 01.02.2013.
Exclusion Criteria*

1. Extremely severe stroke (National Institute of Health Stroke Score (NIHSS) > 25)  
2. Minor neurological deficit (NIHSS < 4) (except isolated homonymous hemianopia, isolated aphasias and ‘cortical hand’ where thrombolysis SHOULD be strongly considered)  
3. Symptoms completely resolved before start of infusion (remember “rapidly improving symptoms” may not resolve completely and may return)  
4. Unconscious patient – however consider thrombolysis if basilar artery thrombosis confirmed  
5. Fixed head or eye deviation.  
6. Pre-stroke Rankin > 3. Life expectancy less than one year from another cause  
7. Seizure at onset of stroke (relative – proceed to perfusion scan for confirmation if stroke suspected)  
8. Symptoms suggestive of subarachnoid haemorrhage, even if the CT scan is normal.  
9. Infective endocarditis or acute pericarditis  
10. Recent (< 10 days) traumatic external heart massage  
11. Recent (< 10 days) puncture of a non-compressible blood vessel (e.g. subclavian or jugular vein puncture, arterial puncture, or lumbar puncture within 7 days). 24 hrs may suffice if min trauma from arterial puncture  
12. Trauma with internal injuries, surgery or visceral biopsy within previous 4 weeks.  
13. Serious head trauma or C.N.S surgery within the previous 3 months.  
14. Any history of central nervous system damage (i.e. neoplasm, aneurysm, intracranial or spinal surgery)  
15. Pregnancy, or childbirth within the previous 4 weeks.  
16. Colitis, oesophageal varices, active peptic ulcer disease  
17. Abdominal aortic aneurysm  
18. Proliferative diabetic retinopathy  
19. Acute pancreatitis  
20. Severe liver disease, incl. hepatic failure, cirrhosis, portal hypertension, oesophageal varices and active hepatitis  
21. Blood Glucose < 3.5 mmols/l or > 22 mmols/l  
22. Hereditary or acquired bleeding disorder  
23. Current uncontrolled hypertension (systolic > 180mmHg or diastolic > 105mmHg)  
24. Recent severe or dangerous bleeding  
25. Known history of or suspected intracranial haemorrhage  
26. Platelet count < 100 x 10^9 / l  
27. Haematocrit < 25%  
28. Current anticoagulant therapy (excepting INR < 1.4 whilst on warfarin)  
29. Administration of heparin within the previous 48 hours and or an elevated thromboplastin time  
30. Previous stroke within 1 month (in EMEA licence but is a relative contraindication)  
31. Caution if history of migraine and typical headache at onset of symptom onset  
32. Peritoneal dialysis or haemodialysis  
33. Neoplasm with increased bleeding risk

CT Exclusion criteria

1. High density lesion consistent with intracranial haemorrhage  
2. Hypodensity in > 1/3 M.C.A. territory or equivalent (difficulty with reproducibility and reliability – patients with seemingly hypodense areas were included in the NINDS trial within 3 hours)  
3. Extensive CT changes of evolving infarction or mass effect on CT

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Valid from 01.07.2012. Review 01.02.2013
Modified Rankin Scale

0 No symptoms at all
1 No significant disability despite symptoms; able to carry out all usual duties and activities
2 Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3 Moderate disability; requiring some help, but able to walk without assistance
4 Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5 Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6 Dead

Acute Ischaemic Stroke Care

### Schedule of observations from admission

<table>
<thead>
<tr>
<th>1. Pulse, BP, Oxygen Saturations, Temperature and Glasgow Coma Scale.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL Strokes:</strong> every 15 minutes for first hour every 4 hours for 4 hours every 4 hours for 24 hours every 15 minutes for first hour every 30 minutes x 6 hours every hour x 17 hours.</td>
</tr>
<tr>
<td><strong>POST rt-PA:</strong> every 15 minutes for first hour every 30 minutes x 6 hours every hour x 17 hours.</td>
</tr>
<tr>
<td>2. Capillary glucose: Measure on admission and - 4 hourly if abnormal or diabetic - 12 hourly if normal and non-diabetic</td>
</tr>
<tr>
<td>3. ECG: Continuous for 24 hours.</td>
</tr>
</tbody>
</table>

### Indications for urgent repeat CT Scan

- New acute headache or worsening severity of headache
- Acute hypertension
- Nausea and vomiting
- Agitation
- Seizure
- Neurological deterioration is classified as significant if there is:
  - A deterioration of > 2 points on the Glasgow Coma Score
  - A drop in the NIHSS > 4 points
  - any potential motor signs on the opposite side to the patient’s initial presenting weakness.

STOP the rt-PA infusion IF:

- Anaphylaxis.
- BP systolic <100mmHg
- BP systolic rises to >180/105 mmHg and is sustained after 5 minutes despite treatment, or associated with neurological deterioration of any sort
- Major systemic bleeding
- Neurological deterioration of 2 points on GCS eye/motor scale.
- Seizure – repeat CT and restart infusion if no haemorrhage

### General Management Post Stroke

- Bed rest for 24 hours (may not be essential if patient very stable)
- Pulse oximetry - maintain O2 saturations above 95%
- Maintain normal temperature. Paracetamol if temp > 37.5°C
- Blood Glucose: maintain blood glucose < 10 mmol/l using IV insulin if necessary
- No arterial punctures, IM injections, NG tubes or central lines for 24 hours
- No urinary catheters for at least 1 hour after infusion ended
- Avoid suctioning whenever possible, caution giving mouthcare
- Repeat CT head at 24-36 hours
- No Aspirin, Clopidogrel, Dipyridamole or anticoagulant (heparin, low molecular weight heparin or warfarin) for 24 hours post thrombolysis until repeat CT performed
- Hydration / Nutrition
- Falls prevention and pressure area care
- Admission policy
  - 1a if possible for all stroke patients > 65
  - Admission to 1a obs or CCU post thrombolysis
  - To remain in resus post thrombolysis until appropriate ward bed available

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### Acute Ischaemic Stroke Adverse Events Guide

|----------------|-----------------------------------|--------------------------------------------------|-------------------------------|-------------------|--------------------------------|---------------------------|-----------------------------|-----------------------------|
| May occur with or without thrombolysis. rt-PA is rapidly cleared from the plasma. Fibrinogen is depleted in the first few hours (<40% at 4 hours) but is back to 80% of normal level by 24 hours. Bleeding after 36 hours is rarely due to rt-PA. **Symptomatic Intracranial Haemorrhage** | **Suspect if:**
| o Headache
| o Nausea and vomiting
| o Fall in GCS
| o New focal neurological signs or acute hypertension | **Action:**
| o Immediately discontinue rt-PA infusion if still running
| o Call for immediate medical review.
| o Full Medical and Neurological reassessment with documentation of new neurological deficit
| o Check fibrinogen (if thrombolysed), PT, APTT, FBC, group and save
| o Arrange urgent CT head scan
| o Inform relevant consultant on call for stroke. | **Immediately check and document**
| o Pulse, temperature, BP, O2 saturations, capillary glucose
| o Ask for medical review
| o Consider intracerebral haemorrhage, seizure, sepsis, dehydration, drug reaction, cardiac failure, dysrhythmia, MI, DVT/PE, metabolic derangement, urinary retention etc. | **Check airway, reposition and suction only if clearly necessary.**
| o Give O2 by mask or nasal cannulae and titrate to achieve saturations >95%
| o If persistent and/or needing >24% O2, ask for medical review
| o Consider aspiration, pulmonary oedema, PE etc | **Cooling measures**
| o Give paracetamol 1g if >37.5°C
| o Ask for medical review if persists or >38°C
| o Septic screen | **Ensure accurate reading (caution in AF - Check manually if in any doubt**
| o Raise foot of bed | **Administer 24% O2 even if normal saturations**
| o Medical review | **Consider drug effects and may need IV 0.9% saline or colloid**
| o A drop in blood pressure will reduce flow to the penumbral regions. Aim for MAP > 130 mmHg in hypertensive patients and 110 in normotensive patients in the first 24 hours. | **If persistent and/or needing >24% O2, consider further oxygen therapy (24% for at least 1 hour)**
| o If thrombolysed consider treatment | **If persistent and/or needing >24% O2, consider further oxygen therapy (24% for at least 1 hour)**
| o Involving surgical team for haemostasis if appropriate | **If there is no other signs of angioedema or anaphylaxis it would be reasonable to continue the rt-PA infusion** | **If there is no other signs of angioedema or anaphylaxis it would be reasonable to continue the rt-PA infusion** | **If there is no other signs of angioedema or anaphylaxis it would be reasonable to continue the rt-PA infusion** | **If there is no other signs of angioedema or anaphylaxis it would be reasonable to continue the rt-PA infusion** |

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Alteplase dose calculation sheet

<table>
<thead>
<tr>
<th>Body Weight (Stones)</th>
<th>Body Weight (Kg)</th>
<th>Total rTpa Dose (mg)</th>
<th>10% Bolus (ml)</th>
<th>90% IV Infusion (ml/hr)</th>
<th>No. of 50mg rt-PA vials needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>6st 4</td>
<td>40</td>
<td>36</td>
<td>4</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>6st 8</td>
<td>42</td>
<td>38</td>
<td>4</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>7st</td>
<td>44</td>
<td>40</td>
<td>4</td>
<td>36</td>
<td>1</td>
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<tr>
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<td>41</td>
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<td>4</td>
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<td>1</td>
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<tr>
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<td>5</td>
<td>40</td>
<td>1</td>
</tr>
<tr>
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<td>5</td>
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<tr>
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<td>49</td>
<td>5</td>
<td>44</td>
<td>1</td>
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<tr>
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<td>56</td>
<td>50</td>
<td>5</td>
<td>45</td>
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<tr>
<td>9st 1</td>
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<td>2</td>
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<tr>
<td>9st 6</td>
<td>60</td>
<td>54</td>
<td>5</td>
<td>49</td>
<td>2</td>
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<tr>
<td>9st 10</td>
<td>62</td>
<td>56</td>
<td>6</td>
<td>50</td>
<td>2</td>
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<tr>
<td>10st</td>
<td>64</td>
<td>58</td>
<td>6</td>
<td>52</td>
<td>2</td>
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<tr>
<td>10st 5</td>
<td>66</td>
<td>59</td>
<td>6</td>
<td>53</td>
<td>2</td>
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<tr>
<td>10st 9</td>
<td>68</td>
<td>61</td>
<td>6</td>
<td>55</td>
<td>2</td>
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<tr>
<td>11st</td>
<td>70</td>
<td>63</td>
<td>6</td>
<td>57</td>
<td>2</td>
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<tr>
<td>11st 4</td>
<td>72</td>
<td>65</td>
<td>6</td>
<td>59</td>
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<tr>
<td>11st 9</td>
<td>74</td>
<td>67</td>
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<td>60</td>
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<tr>
<td>12st</td>
<td>76</td>
<td>68</td>
<td>7</td>
<td>61</td>
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<td>78</td>
<td>70</td>
<td>7</td>
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<tr>
<td>12st 8</td>
<td>80</td>
<td>72</td>
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<td>65</td>
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<td>12st 12</td>
<td>82</td>
<td>74</td>
<td>7</td>
<td>67</td>
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<tr>
<td>13st 3</td>
<td>84</td>
<td>76</td>
<td>8</td>
<td>68</td>
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<td>13st 7</td>
<td>86</td>
<td>77</td>
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<td>13st 12</td>
<td>88</td>
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<td>71</td>
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<td>14st</td>
<td>90</td>
<td>81</td>
<td>8</td>
<td>73</td>
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<td>14st 11</td>
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<td>9</td>
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<td>15st 7</td>
<td>98</td>
<td>88</td>
<td>9</td>
<td>79</td>
<td>2</td>
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<tr>
<td>15st 10</td>
<td>100</td>
<td>90</td>
<td>9</td>
<td>81</td>
<td>2</td>
</tr>
</tbody>
</table>

1. Total dose: 0.9mg/kg. **MAXIMUM DOSE IS 90 MG** (See weight/dose chart above)
2. Administration of Alteplase should be sanctioned by the relevant physician on call for stroke.
3. 10% of total dose given as an I.V push over 2 minutes.
4. Give remaining 90% of dose I.V over 60 minutes via infusion pump.
<table>
<thead>
<tr>
<th>NIHSS</th>
<th>On arrival</th>
<th>Pre-lysis</th>
<th>At 2 hours</th>
<th>At 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time_____</td>
<td>Time_____</td>
<td>Time_____</td>
<td>Time_____</td>
</tr>
</tbody>
</table>

1a. Level of Consciousness  
0 = Alert; keenly responsive.  
1 = Not alert; but arousable by minor stimulation to obey, answer, or respond.  
2 = Not alert; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped).  
3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.  

1b. LOC Questions  
0 = Answers both questions correctly.  
1 = Answers one question correctly.  
2 = Answers neither question correctly.  

1c. LOC Commands  
0 = Performs both tasks correctly.  
1 = Performs one task correctly.  
2 = Performs neither task correctly.  

2. Best Gaze  
0 = Normal.  
1 = Partial gaze palsy; gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present.  
2 = Forced deviation, or total gaze paresis not overcome by the oculocephalic maneuver.  

3. Visual  
0 = No visual loss.  
1 = Partial hemianopia.  
2 = Complete hemianopia.  
3 = Bilateral hemianopia (blind including cortical blindness).  

4. Facial Palsy  
0 = Normal symmetrical movements.  
1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling).  
2 = Partial paralysis (total or near-total paralysis of lower face).  
3 = Complete paralysis of one or both sides (absence of facial movement in the upper and lower face).  

5. Motor Arm  
0 = No drift; limb holds 90 (or 45) degrees for 10 sec  
1 = Drift; limb holds 90 (or 45) degrees, but drifts down before 10 sec; does not hit bed.  
2 = Some effort against gravity; limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity.  
3 = No effort against gravity; limb falls.  
4 = No movement.  
UN = Amputation or joint fusion, explain:  
5a. Left Arm  
5b. Right Arm
<table>
<thead>
<tr>
<th></th>
<th>On arrival Time</th>
<th>Pre-lysis Time</th>
<th>At 2 hours Time</th>
<th>At 24 hours Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Motor Leg</td>
<td>0 = No drift; leg holds 30-degree position for full 5 seconds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 = Drift; leg falls by the end of the 5-second period but does not hit bed.</td>
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<tr>
<td></td>
<td>2 = Some effort against gravity; leg falls to bed by 5 seconds, but has some effort against gravity.</td>
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<tr>
<td></td>
<td>3 = No effort against gravity; leg falls to bed immediately.</td>
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<tr>
<td></td>
<td>4 = No movement.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>UN = Amputation or joint fusion, explain: __________________________________________</td>
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<tr>
<td></td>
<td>6a. Left Leg</td>
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<tr>
<td></td>
<td>6b. Right Leg</td>
<td></td>
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<tr>
<td>7. Limb Ataxia</td>
<td>0 = Absent.</td>
<td></td>
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<tr>
<td></td>
<td>1 = Present in one limb.</td>
<td></td>
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<tr>
<td></td>
<td>2 = Present in two limbs.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>UN = Amputation or joint fusion, explain: __________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Sensory</td>
<td>0 = Normal; no sensory loss.</td>
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<tr>
<td></td>
<td>1 = Mild-to-moderate sensory loss</td>
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<tr>
<td></td>
<td>2 = Severe to total sensory loss</td>
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<tr>
<td>9. Best Language</td>
<td>0 = No aphasia; normal.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 = Mild-to-moderate aphasia</td>
<td></td>
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<tr>
<td></td>
<td>2 = Severe aphasia</td>
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<tr>
<td></td>
<td>3 = Mute, global aphasia; no usable speech or auditory comprehension.</td>
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<td>10. Dysarthria</td>
<td>0 = Normal.</td>
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<td></td>
<td>1 = Mild-to-moderate dysarthria</td>
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<td>2 = Severe dysarthria</td>
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<td></td>
<td>UN = Intubated or other physical barrier, explain: __________________________________________</td>
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<td>11. Extinction and Inattention (formerly Neglect)</td>
<td>0 = No abnormality.</td>
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<td></td>
<td>1 = Visual, tactile, auditory, spatial, or personal inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities.</td>
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<td></td>
<td>2 = Profound hemi-inattention or extinction to more than one modality; does not recognize own hand or orients to only one side of space.</td>
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</tbody>
</table>

NIHSS total score
References for alterations in exclusion criteria.

- Outcome of Stroke With Mild or Rapidly Improving Symptoms Nedeltchev K, Schwegler B, Haefeli T et al. Stroke 2007, 38:2531-2535
- Challenging the validity of imposing contraindications to thrombolysis for acute ischemic stroke. Demaerschalk B, Neurology 2011;77:1862–1863
- The benefits and harms of intravenous thrombolysis with recombinant tissue plasminogen activator within 6 h of acute ischaemic stroke (the third international stroke trial [IST-3]): a randomised controlled trial. The IST-3 collaborative group. Lancet 2012; 379: 2352–63