St. Dominic's

Comprehensive Stroke Center

Call (601) 200-2777 to transfer a patient.
Fax number: (601) 200-5444

Transferring Hospital ______________________________

Transferring Physician ______________________________

Patient Name/Age/Gender ______________________________

____

Allergies:

Pertinent PMH (circle applicable):

A-fib   Pacemaker/Defibrillator   Falls/head injury/surgeries/ GI bleed last 3 months

Other PMH: ______________________________

Signs/symptoms:

Last Known Well*:__________ BP __________ Temp __________

NIHSS __________ HR __________ O2% __________

RA or __________ Liters

IV: __________ & __________ RR: __________

GCS __________ Foley: __________

*Time patient was last seen NORMAL/baseline state of health

Family contact name and mobile # (may list multiple):

____

Imaging: __________________ Powershare Yes/No

Taking any of the following? (circle)

Coumadin (warfarin)   Xarelto (rivaroxaban)   Eliquis (apixaban)

Pradaxa (dabigatran)   Lovenox (enoxaparin)   Other:

If YES, time of last dose:____:_____am/pm Date:___/___/ ___

Meds Given ______________________________

IV Lytic Bolus MG/Time ______________________________

☐ Alteplase (t-PA)   ☐ Tenecteplase (TNK)

IV Lytic Infusion Dose/Time ______________________________

IV Lytic Finished ______________________________

Creatinine______ PT/INR_______ Glucose __________

Next of kin Name and # ______________________________

Mode of arrival and estimated time of arrival ______________

Base line function (circle):

Ambulatory   Assist   Bed bound

Additional Info: ______________________________