DATE:_____ PATIENT NAME/MR#_____

CODE STROKE ACTIVATION TIME RECORD

Note: To Be Completed By the RRT Nurse (or as assigned) on **ALL** In-Patients that require CODE STROKE ACTIVATION.

Documentation of the following times:

CODE ACTIVATION TIME: _____

NEUROLOGY AT BEDSIDE TIME: _____

EKG COMPLETED: _____

LAB TECH ARRIVAL: _____

TIME OF LAB RESULTS: _____

TIME TO CT: _____

t-PA/Alteplase ADMINISTERED: ☐ NO ☐ Yes

Time of Infusion: _____ ☐ NA

LOCATION OF t-PA ADMINISTRATION: ☐ NSICU ☐ AED

DISPOSITION OF PATIENT: ☐ RETURN TO ORIGINAL ROOM

☐ NSICU ☐ ACUTE STROKE UNIT ☐ 4 SOUTH/4 NORTH

Signature:_____(RRT NURSE)

FAX TO: Neal Kiihnl 5-7537(Fax)(601.573.6785 = Pager/Cell)