ACVS Assessment Form

Fax to central intake at (250) 727-4356.
Patient will be referred to either VGH or NRGH Stroke Rapid Assessment Units as appropriate given the patient's address.

Name:	
DOB:	
PHN:	
Address:	
Phone:	

Symptom Timing and Vitals

Onset of Event: **Date:** **Time:**

Duration of Symptoms: **Hours:** **Minutes:** **Seconds:**

BP: **mmHg**

Patient Symptoms (please check all that apply)

Have Symptoms Resolved? ☐ No ☐ Yes

Symptoms like this have happened before? ☐ No ☐ Yes

Sudden Onset of Symptoms? ☐ No ☐ Yes

Onset occurred on change of head position? ☐ No ☐ Yes

Communication

- ☐ Language Disturbance (garbled, gibberish, word finding)
- ☐ Speech Disturbance slurred, drunk sounding)
- ☐ Confusion (new)
- ☐ Amnesia
- ☐ Concentration, Loss of

Sensory

- ☐ Sensory "March" Across Body

Vision

- ☐ Blurred Vision
- ☐ Loss of Vision (i.e. darkness)
- ☐ Curtain/Shade over vision
- ☐ Double Vision
- ☐ Visual Disturbance with colour, brightness, shape, or movement

Vestibular/Balance

- ☐ Dizziness
- ☐ Vertigo - Spinning Sensation
- ☐ Nausea
- ☐ Lightheaded Sensation

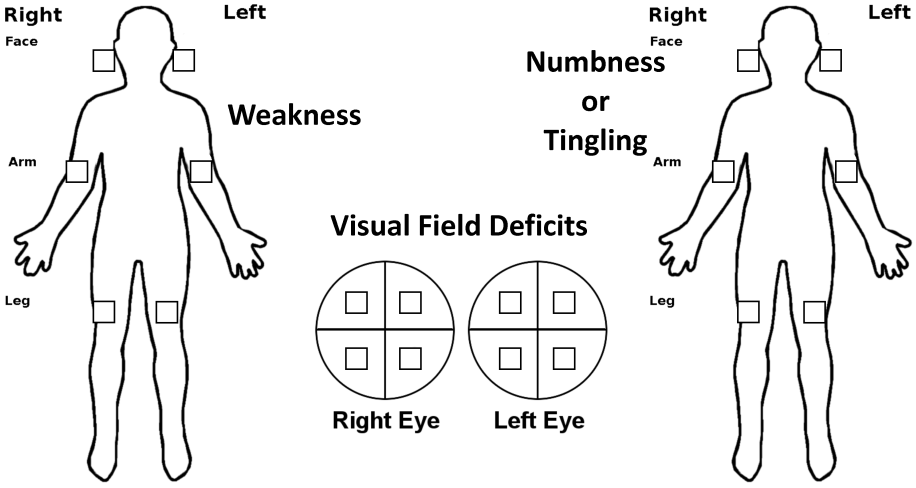
Constitutional/General

- ☐ Headache
- ☐ Neck Pain
- ☐ Anxiety/Panic/Stress
- ☐ Altered Level of Consciousness
- ☐ Loss of Consciousness or Syncope

Motor

- ☐ Face Droop
- ☐ Eye Droop - "Ptosis"
- ☐ Unsteadiness
- ☐ Involuntary Movement

Please check all body regions manifesting



Known Medical Conditions

- ☐ Atrial Fibrillation ☐ Diabetes
- ☐ Hyperlipidaemia ☐ Hypertension
- ☐ History of Migraine ☐ Smoking

Medications (as of time of referral)

- ☐ ASA ☐ Plavix ☐ Statin
- ☐ Antihypertensive ☐ Anticoagulant

Investigations Initiated

- ☐ CT ☐ ECG (Please attach a copy)
- ☐ GFR/Creat. ***(Please attach a copy)

(***must be within 3 months)

Notes:

Date: **Physician's Name:** **Site:**

Version 2.0