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Patient Addressograph

Name:
Date of Birth:
GWH Number:

ED Stroke Thrombolysis Proforma

Date:	Time:	Doctor:	Grade:	Bleep:

ROSIER	Yes	No
LOC or syncope at onset?	-1 ☐	0 ☐
Seizure at onset?	-1 ☐	0 ☐
New asymmetric facial weakness?	1 ☐	0 ☐
New asymmetric arm weakness?	1 ☐	0 ☐
New asymmetric leg weakness?	1 ☐	0 ☐
New speech disturbance?	1 ☐	0 ☐
New visual field defect?	1 ☐	0 ☐
Score 0 or less = unlikely stroke **Score 1 or more = likely stroke**	**Score:**	

Eligibility for Stroke Thrombolysis with IV alteplase

- Clinical diagnosis of stroke causing a measurable neurological deficit
- Time of symptom onset is known (excludes patients who woke with symptoms)
- Sufficient time available to assess **and treat** within the therapeutic window

Symptom Onset	Guidance for Thrombolysis Time Window
0 - 3 Hours	Consider thrombolysis for all patients **over 18 years old**
3 - 4 ½ Hours	Consider thrombolysis for all patients **over 18 years old AND under 80 years** Consider patients over 80 years of age **IF** fit and well prior to stroke (mRS 0-1)
4 ½ - 6 Hours	ON A CASE BY CASE BASIS Consider thrombolysis for all patients **over 18 years old AND under 80 years**

Thrombolysis is licensed treatment. You only require verbal ASSENT, not written consent from patient or Next of Kin. If unable, act in patient's best interest. Discuss with senior.

Activate Emergency Stroke Alert via Switchboard on 2222

Organise CT Brain Immediately

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Name:
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Focused History & Examination:

Symptom Onset **Date:** _____ **Time:** _____ ☐ **Precise** ☐ **Best Estimate**

A clear time of onset must be established and documented.

Pulse		
Resp. Rate		
GCS		
NIHSS		
ECG (Rhythm?)		
SaO_2 on air		
Give O_2 only if <95% on air.		
Temp.		
Give 1g paracetamol PR/IV if >37ºC. Please note subsequent doses should be adjusted to weight.		
BP Left		Use arm with higher reading.
BP Right		
If BP >185 syst and/or >110 diast on 2 consecutive measurements give Labetalol/nitrates as per guideline.		
BM		
If BM <2.8 mmol/l give 50ml of 20% glucose IV and reassess. If BM >11 mmol/l start IV insulin sliding scale.		
Weight		

- ☐ Full blood count
- ☐ Urea, creatinine and electrolytes
- ☐ Total cholesterol
- ☐ Clotting Screen (APTT/PT/INR if on warfarin)
- ☐ ESR
- ☐ Blood Glucose
- ☐ Liver function tests
- ☐ IV access x2

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Absolute Contraindications to Stroke Thrombolysis:	Yes	No
Active internal bleeding	☐	☐
Major surgery or serious trauma with in last 14 days	☐	☐
Clinical diagnosis of subarachnoid haemorrhage even if CT normal	☐	☐
Treatment dose low molecular weight within 24 hours	☐	☐
*Current treatment with one of the new oral anticoagulants (Dabigatran, Rivaroxaban, Apixaban)	☐	☐
You must tick 'No' to all absolute contraindications to continue.		

Relative Contraindications to Stroke Thrombolysis:	Yes	No
Recent CVA, head injury or cranial surgery (within 3 months)	☐	☐
Seizure at stroke onset	☐	☐
Any history of intracranial haemorrhage, brain tumour, intracranial AVM or aneurysm	☐	☐
Recent (< 48 hours) lumbar puncture or (<1 week) arterial/venous puncture at non-compressible site	☐	☐
Pregnancy – see notes below	☐	☐
If you have scored 'Yes' to any relative contraindication, discuss with ED Consultant or Network Consultant before proceeding with Stroke Thrombolysis.		

On Initial Assessment for Stroke Thrombolysis:	Yes	No
GCS <8	☐	☐
NIHSS <4, except isolated disabling symptoms (e.g. severe dysphasia, homonymous hemianopia)	☐	☐
Rapidly improving symptoms or signs	☐	☐
Capillary blood glucose <2.8 - treat with 20% glucose and reassess	☐	☐
Capillary blood glucose >22.0 - continue to assess, but await lab glucose results	☐	☐
SBP >185 and/or DBP>110 after treatment with Labetalol or nitrates	☐	☐
You must tick 'No' to all contraindications on initial assessment to continue.		

Contraindications of Lab Results (if available):	Yes	No
Plasma glucose <2.2 or >22.0 mmols/L	☐	☐
Platelets <100	☐	☐
INR >1.7	☐	☐
APTR >1.2	☐	☐
You must tick 'No' to all contraindications of lab results to continue.		

Contraindications of CT brain:	Yes	No
Intracranial haemorrhage	☐	☐
Other pathologies	☐	☐
You must tick 'No' to all contraindications of CT brain to continue.		

***Oral anticoagulants:**
Current Warfarin treatment is not an exclusion if the INR is less than or equal to 1.7.
Current treatment with Dabigatran/Rivaroxaban/Apixaban is an exclusion to thrombolysis.

Thrombolysis in pregnancy:
It is very difficult to give clear guidance on TL in pregnancy as this will be both a very rare clinical situation and one with very little evidence or RCT data to guide decision making. Each case will need to be assessed on an individual risk benefit basis by an expert in the delivery of thrombolysis in stroke. This should not be assessed on a remote expert basis.
The sparse evidence that does exist suggests that TL in acute ischemic stroke (AIS) in pregnancy probably carries a higher than usual risk of symptomatic intracerebral haemorrhage in the mother in the order of 10%. TL given for a number of conditions including pulmonary Embolism and AIS carries a risk of significant bleeding such as major uterine hematoma in the order of 8%. Foetal safety remains unproven. Anecdotal cases of successful resolution of maternal stroke post TL have been recorded in both the first trimester and the immediate post partum period.

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Post CT Scan:	
If no radiological exclusion criteria, reassess patient to exclude rapidly improving signs. You do not need to repeat NIHSS post CT Scan unless symptoms are rapidly improving.	☐
Obtain verbal consent from patient and document in notes (bottom of this page). If patient is unable to consent or lacks mental capacity, discuss with family but act in patient's best interest.	☐
Do not await blood results unless current anticoagulation. Stop infusion if subsequent results are outside tolerated limits.	☐
Mix and start rt-PA administration. Dose of rt-PA: 0.9mg/kg or 90mg whichever is lesser. Give 10 % as a bolus over 1 -2 min and the remaining 90% as a 1 hour infusion via syringe driver (see infusion table).	☐
Withhold aspirin, heparin and warfarin for 24 hours.	☐

Out of Hours Advice:		Yes	No
If OOH, have you discussed with:	1 - On-Call ED or Medical Consultant?	☐	☐
	2 - Stroke Network Consultant	☐	☐

If thrombolysis was DELAYED, please document the reasons why:

If the patient was NOT thrombolysed, please document the reasons why:

Consent:

I confirm that I have explained risk and benefits of Stroke Thrombolysis to patient (or carer/next of kin) and obtained verbal consent.

For 100 treated ~3 patients will have worsened outcome.
For 100 treated ~32 will benefit.
Likelihood of being helped vs. harmed is 10 times.

Signed:	

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Emergency Drug Chart:

Please reference the rt-PA Dose Ready Reckoner on page 16 for rt-PA dose.
Please sign medications appropraite for this patient.

Date	Time	Drug	Dose	Route	Prescribed By	Given By
		Normal Saline 0.9% over 8 hours	1000ml	IV		
		rt-PA - Bolus Dose over 1-2 minutes		IV		
		rt-PA - Infusion Dose over one hour		IV Infusion		
		Paracetamol	1g	IV/PO		
		Labetalol - Bolus Dose		IV		
		Glucose 20%	50ml	IV		

During Thrombolysis:

Check blood results and review eligibility to continue thrombolysis.

Monitor BP, P, SaO_2, RR and check tongue for any signs of swelling, GCS every 15 min for 2 hours, then ½ hourly for 4 hours.

If orolingual angioedema develops, alert Doctor immediately and give 200mg Hydrocortisone IV and Chlorpheniramine 10mg IV (i.m. Adrenaline is usually not required in isolated orolingual angioedema).

Stop infusion if:

- Anaphylaxis (incidence 1.5 % in 1 study), marked hypotension
- Neurological deterioration: ↓ conscious level (2 points GCS eye/motor score). ↑ NIHSS ≥ 4 points.
- ↑ BP >185/110 mmHg if sustained or associated with neurological deterioration.
- New severe headache.
- Major systemic bleeding.
- **If intracerebral haemorrhage suspected, follow ICH algorithm.**

Progress During Thrombolysis:

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Name:
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National Institute of Health Stroke Scale (NIHSS)

		Date:		Time:				
Item	**Title**	**Score**			**Arrival**	**Post Scan**	**30 mins**	**1 Hour**
1A	**Level of Consciousness**	0 1 2 3	Alert Drowsy Obtunded Coma/unresponsive				**After Start of IV**	
1B	**LOC Questions**	0 1 2	Answers both correctly Answers one correctly Answers neither correctly					
1C	**LOC Commands**	0 1 2	Performs both tasks correctly Performs one task correctly Performs neither task correctly					
2	**Best Gaze**	0 1 2	Normal horizontal movements Partial gaze palsy Complete gaze palsy					
3	**Visual**	0 1 2 3	No visual field defect Partial hemianopia Complete hemianopia Bilateral hemianopia					
4	**Facial Palsy**	0 1 2 3	Normal Minor facial weakness Partial facial weakness Complete unilateral palsy					
5	**Motor Arm** **a. Left** **b. Right**	0 1 2 3 4	No drift Drift before 5 seconds Falls before 10 seconds No effort against gravity No movement		Left Right	Left Right	Left Right	Left Right
6	**Motor Leg** **a. Left** **b. Right**	0 1 2 3 4	No drift Drift before 5 seconds Falls before 10 seconds No effort against gravity No movement		Left Right	Left Right	Left Right	Left Right
7	**Limb Ataxia**	0 1 2	No ataxia Ataxia in 1 limb Ataxia in 2 limbs					
8	**Sensory**	0 1 2	No sensory loss Mild sensory loss Severe sensory loss					
9	**Best Language**	0 1 2 3	Normal Mild aphasia Severe aphasia Mute or global aphasia					
10	**Dysarthria**	0 1 2	Normal Mild dysarthria Severe dysarthria					
11	**Extinction & Inattention**	0 1 2	Absent Mild (loss of 1 sensory modality) Severe (loss of 2 sensory modalities)					
		Total NIHSS Score:						
		Practitioner's Initials:						

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Patient Addressograph

Name:
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GWH Number:

National Institute of Health Stroke Scale (NIHSS)

		Date:		Time:				
Item	**Title**	**Score**			**2 Hours**	**6 Hours**	**24 Hours**	**7 Days**
1A	**Level of Consciousness**	0 1 2 3	Alert Drowsy Obtunded Coma/unresponsive		**After Start of IV**			
1B	**LOC Questions**	0 1 2	Answers both correctly Answers one correctly Answers neither correctly					
1C	**LOC Commands**	0 1 2	Performs both tasks correctly Performs one task correctly Performs neither task correctly					
2	**Best Gaze**	0 1 2	Normal horizontal movements Partial gaze palsy Complete gaze palsy					
3	**Visual**	0 1 2 3	No visual field defect Partial hemianopia Complete hemianopia Bilateral hemianopia					
4	**Facial Palsy**	0 1 2 3	Normal Minor facial weakness Partial facial weakness Complete unilateral palsy					
5	**Motor Arm** **a. Left** **b. Right**	0 1 2 3 4	No drift Drift before 5 seconds Falls before 10 seconds No effort against gravity No movement		Left Right	Left Right	Left Right	Left Right
6	**Motor Leg** **a. Left** **b. Right**	0 1 2 3 4	No drift Drift before 5 seconds Falls before 10 seconds No effort against gravity No movement		Left Right	Left Right	Left Right	Left Right
7	**Limb Ataxia**	0 1 2	No ataxia Ataxia in 1 limb Ataxia in 2 limbs					
8	**Sensory**	0 1 2	No sensory loss Mild sensory loss Severe sensory loss					
9	**Best Language**	0 1 2 3	Normal Mild aphasia Severe aphasia Mute or global aphasia					
10	**Dysarthria**	0 1 2	Normal Mild dysarthria Severe dysarthria					
11	**Extinction & Inattention**	0 1 2	Absent Mild (loss of 1 sensory modality) Severe (loss of 2 sensory modalities)					
		Total NIHSS Score:						
		Practitioner's Initials:						

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Patient Addressograph

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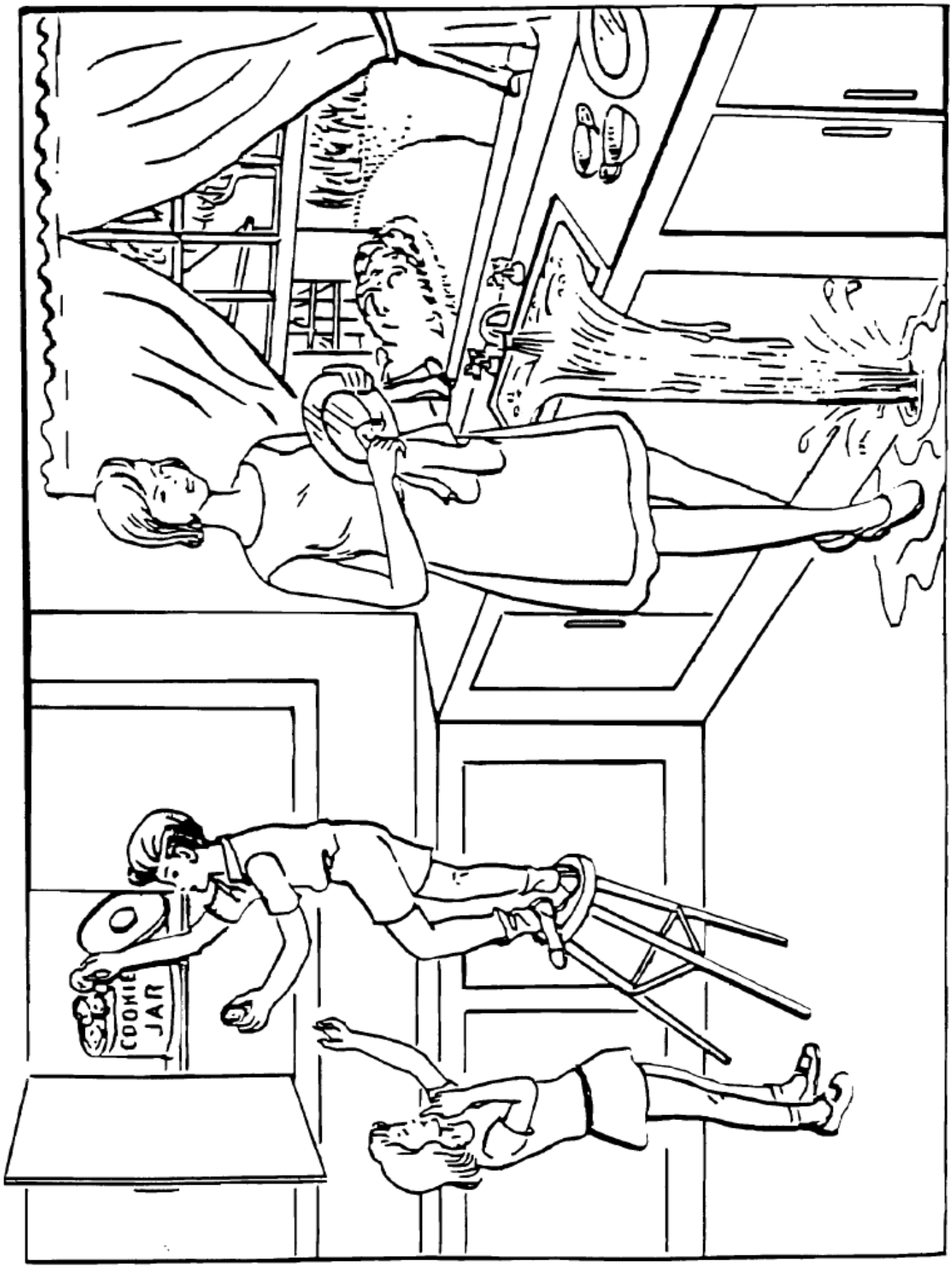

Patient Addressograph

Name:
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GWH Number:

You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.

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Patient Addressograph

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Patient Addressograph

Name:
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MAMA

TIP-TOP

FIFTY-FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

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Patient Addressograph

Name:
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NIHSS Guidance

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
1a. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.	**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: The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not "help" the patient with verbal or non-verbal cues.	**0** = Answers both questions correctly. **1** = Answers one question correctly. **2** = Answers neither question correctly.	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.	**0** = Performs both tasks correctly. **1** = Performs one task correctly. **2** = Performs neither task correctly.	_____
2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.	**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.	_____

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Instructions	Scale Definition	Score
3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.	**0** = No visual loss. **1** = Partial hemianopia. **2** = Complete hemianopia. **3** = Bilateral hemianopia (blind including cortical blindness).	_____
4. Facial Palsy: Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.	**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: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	**0** = No drift; limb holds 90 (or 45) degrees for full 10 seconds. **1** = Drift; limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. **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**	_____ _____

Patient Addressograph

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Instructions	Scale Definition	Score
6. Motor Leg: The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	**0** = No drift; leg holds 30-degree position for full 5 seconds. **1** = Drift; leg falls by the end of the 5-second period but does not hit bed. **2** = Some effort against gravity; leg falls to bed by 5 seconds, but has some effort against gravity. **3** = No effort against gravity; leg falls to bed immediately. **4** = No movement. **UN** = Amputation or joint fusion, explain: _____ **6a. Left Leg** **6b. Right Leg**	_____ _____
7. Limb Ataxia: This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.	**0** = Absent. **1** = Present in one limb. **2** = Present in two limbs. **UN** = Amputation or joint fusion, explain: _____	_____
8. Sensory: Sensation or grimace to pinprick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas (arms [not hands], legs, trunk, face) as needed to accurately check for hemisensory loss. A score of 2, "severe or total sensory loss," should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will, therefore, probably score 1 or 0. The patient with brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a coma (item 1a=3) are automatically given a 2 on this item.	**0** = Normal; no sensory loss. **1** = Mild-to-moderate sensory loss; patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. **2** = Severe to total sensory loss; patient is not aware of being touched in the face, arm, and leg.	_____

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Instructions	Scale Definition	Score
9. Best Language: A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, the patient is asked to describe what is happening in the attached picture, to name the items on the attached naming sheet and to read from the attached list of sentences. Comprehension is judged from responses here, as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for the patient with stupor or limited cooperation, but a score of 3 should be used only if the patient is mute and follows no one-step commands.	**0** = No aphasia; normal. **1** = Mild-to-moderate aphasia; some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response. **2** = Severe aphasia; all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. **3** = Mute, global aphasia; no usable speech or auditory comprehension.	_____
10. Dysarthria: If patient is thought to be normal, an adequate sample of speech must be obtained by asking patient to read or repeat words from the attached list. If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.	**0** = Normal. **1** = Mild-to-moderate dysarthria; patient slurs at least some words and, at worst, can be understood with some difficulty. **2** = Severe dysarthria; patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric. **UN** = Intubated or other physical barrier, explain: _____	_____
11. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.	**0** = No abnormality. **1** = Visual, tactile, auditory, spatial, or personal inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities. **2** = Profound hemi-inattention or extinction to more than one modality; does not recognize own hand or orients to only one side of space.	_____

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rt-PA Dose Ready Reckoner

- When the decision to treat has been made do not delay.
- Unless the patient knows their recent weight, estimate it to the nearest 5 kg.
- The total dose of rt-PA is 0.9mg/kg or 90mg, whichever is lower.
- Make up one or two vials of rt-PA using the 50ml diluent in each drug pack, making a solution of 1 mg/ml rt-PA.
- Draw up and give 10% as a bolus over 1-2 minutes using a 10ml syringe.
- Draw up the remaining 90% (the 'infusion dose') into one or two 50ml syringes and set up the syringe pump with the corresponding infusion rate in mls/hr. Doses above 50ml will need a change of syringe at some point within the hour's infusion.
- Do not give the cardiac dose.
- Do not give more than 90mg.

	1	2	3	4	5
	Estimate of Patient's Weight (kg)	**Equivalent Imperial Weight (st)**	**Total Dose (mg at 1mg/ml)**	**Bolus Dose (mls)** given over 1-2 minutes	**Infusion Dose (mls) = infusion rate in mls/hr**
One Vial	**45**	7 st 1 lb	40	4.0	36.0
	50	7 st 12 lb	45	4.5	40.5
	55	8 st 9 lb	49	4.9	44.1
Two Vials	**60**	9 st 6 lb	54	5.4	48.6
	65	10 st 3 lb	58	5.8	52.2
	70	11 st 0 lb	63	6.3	56.7
	75	11 st 11 lb	67	6.7	60.3
	80	12 st 8 lb	72	7.2	64.8
	85	13 st 5 lb	76	7.6	68.4
	90	14 st 2 lb	81	8.1	72.9
	95	14 st 13 lb	85	8.5	76.5
	≥100	15 st 10 lb	90	9.0	81.0

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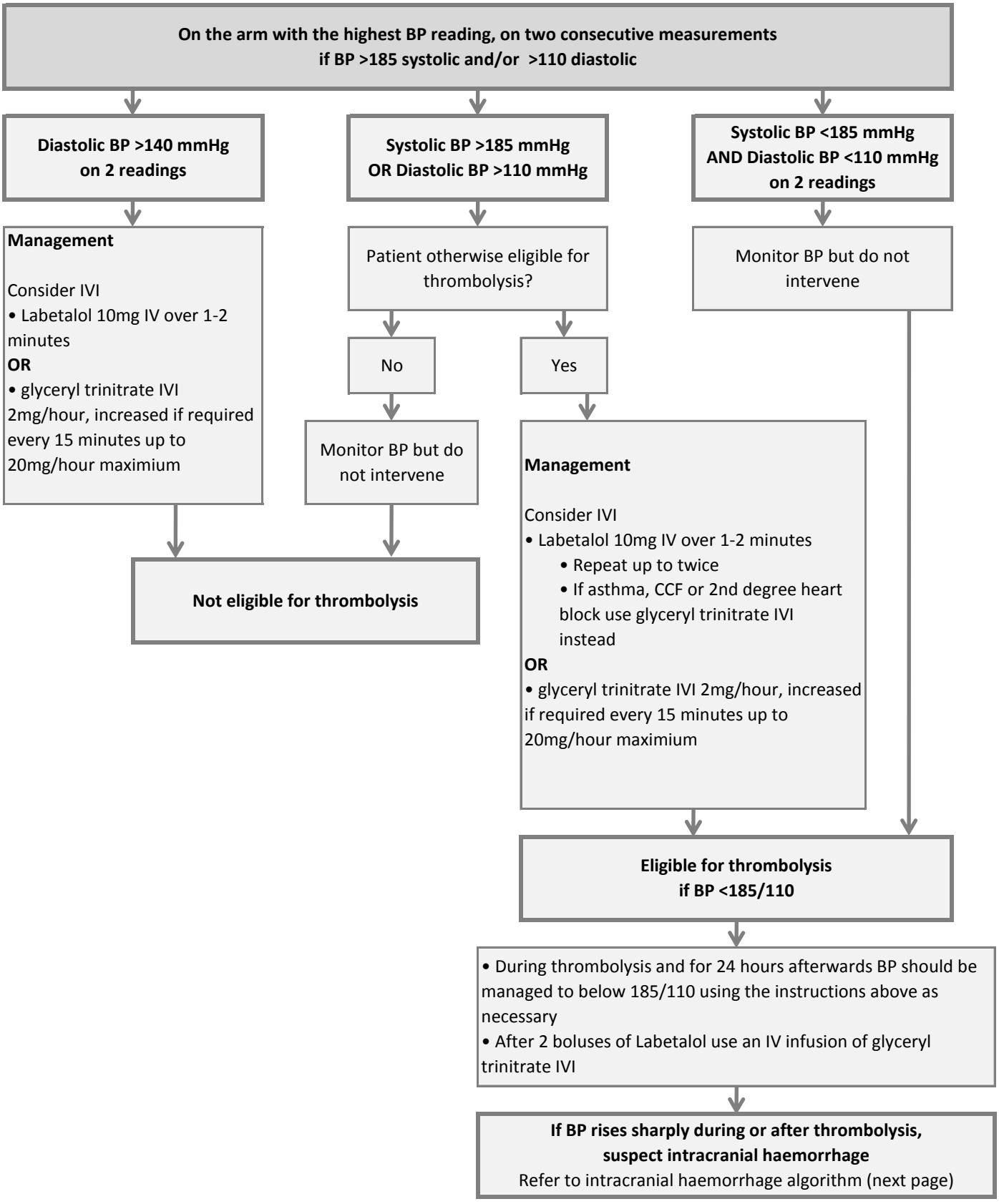
Management of Blood Pressure in Potential Stroke Thrombolysis Patients



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Name:
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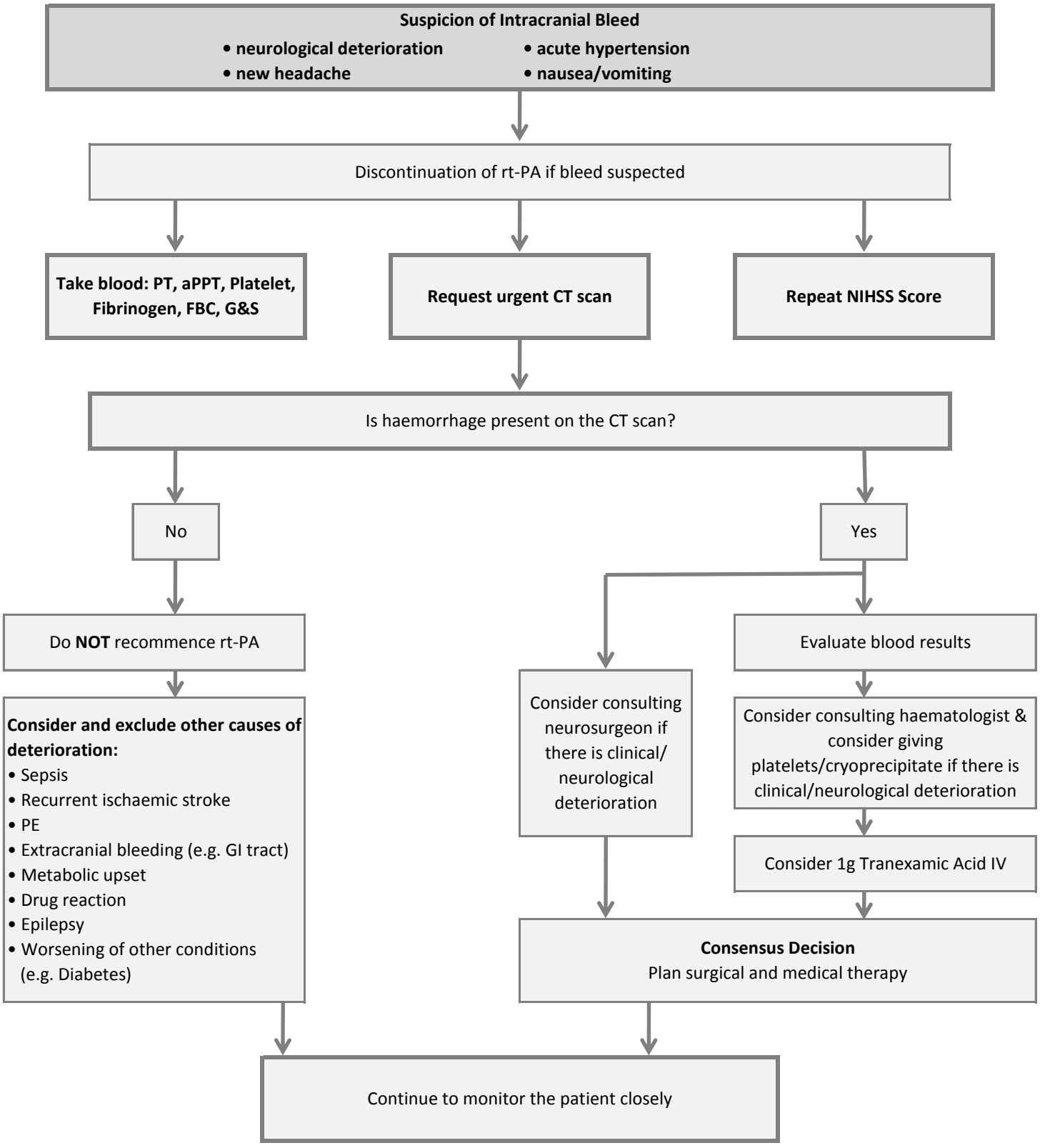
Intracranial Haemorrhage following Stroke Thrombolysis



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Additional Notes:

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Additional Notes: