History and Physical:

Historical Findings	Physical Findings
▪ Time of onset	▪ AMS ▪ Hypertension ▪ Unilateral weakness ▪ Paralysis ▪ Facial drooping ▪ Ataxia ▪ Aphasia/dysphasia ▪ Headache ▪ Visual disturbance

Assessment:

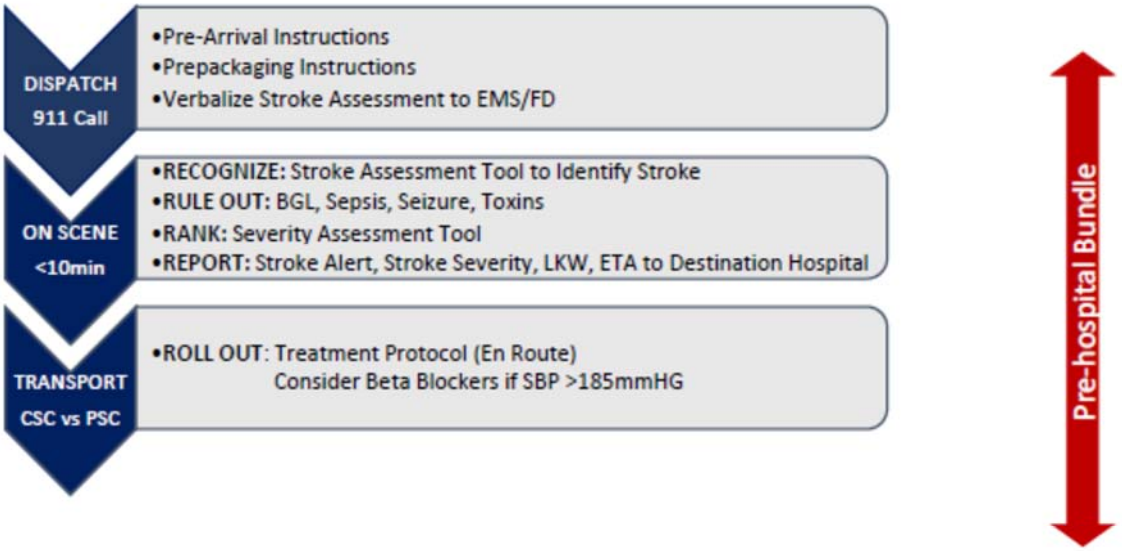
- Medical Assessment
- Neurological Evaluation
- Differential Diagnoses: Hypo/hyperglycemia, Seizure, Electrolyte Imbalance, Toxins, Trauma

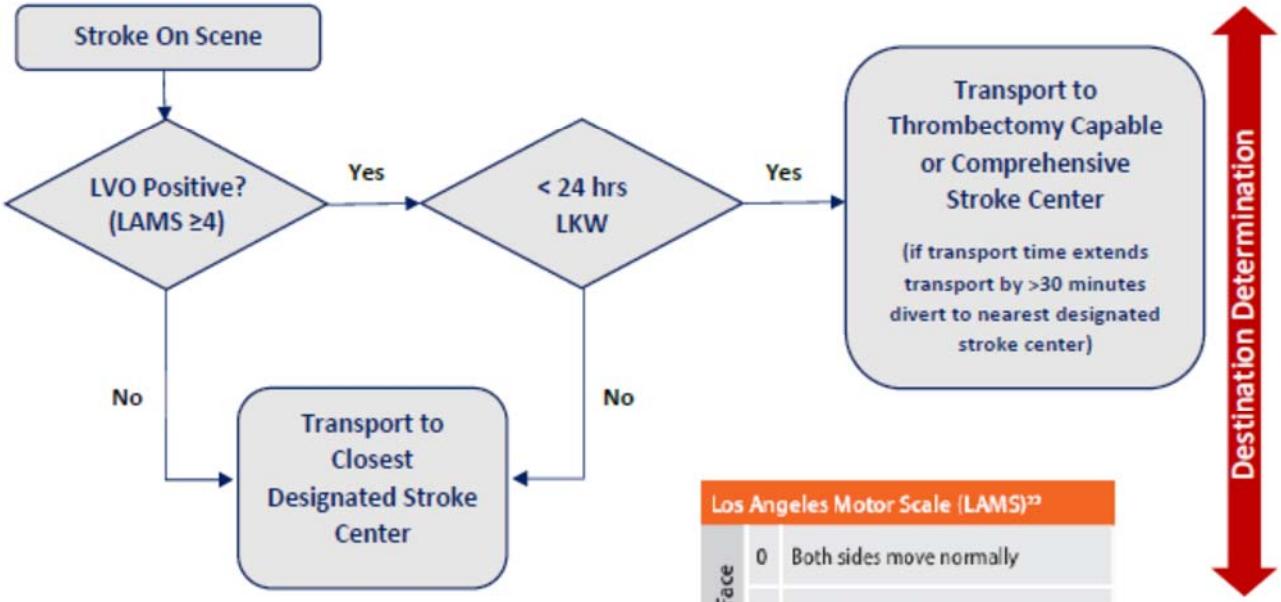
Clinical Management Options:

Interventions	Pharmacology
▪ General Therapies as Appropriate ▪ Oxygen therapy as appropriate ▪ Vascular Access ▪ For Systolic B/P > 185 mmHg and/or Diastolic B/P > 110 mmHg, reassess B/P ▪ Rapid transport to appropriate facility with head of stretcher at 15 degrees ▪ Call "Stroke Alert"—Contact receiving facility and report patient status (MUST REPORT WHEN THE PATIENT WAS LAST KNOWN WELL)	▪ Nausea/Vomiting Management ▪ Pain Management (Avoid Ketorolac) ▪ **Labetalol** 10 mg over 2 minutes IV/IO o If systolic >185 or diastolic > 110 o May repeat x 1 q 15 minutes if B/P remains > 185/110

Considerations:

- It is important to remember that an elevated blood pressure may cause a stroke or it may be the result of a stroke. You should always consider that overly aggressive management of the blood pressure may decrease perfusion to the brain due to the ischemia present.
- **TITRATE TO A 10% SYSTOLIC BP REDUCTION**





Los Angeles Motor Scale (LAMS)[23]		
Face	0	Both sides move normally
	1	One side is weak or flaccid
Arm	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Grip	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Total	0–5	