



# ***Regional Stroke Triage Plan***

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**LORD FAIRFAX EMERGENCY MEDICAL SERVICES COUNCIL, INC.  
REGIONAL STROKE TRIAGE PLAN**

## Revision History

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## Executive Summary

Under the *Code of Virginia § 32.1-111.3, "Statewide Emergency Medical Care System"*, The Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Stroke Triage Plan. The Statewide Stroke Triage Plan establishes a strategy through formal regional stroke triage plans that incorporate each region's geographic variations and acute stroke care capabilities and resources, including hospitals designated as "Primary Stroke Centers" through certification by the Joint Commission or a comparable process consistent with the recommendations of the Brain Attack Coalition. The Statewide Stroke Triage Plan is to include guidelines for pre-hospital patient care as well as inter-hospital patient transfers.

The Regional Stroke Triage Plan augments the State Plan by establishing a uniform set of criteria for the pre-hospital and inter-hospital triage care and transport of acute stroke patients within the Lord Fairfax Emergency Medical Services Council region. This plan addresses patients experiencing an "acute stroke" For purposes of this document, "acute stroke" is defined as any patient suspected of having an acute cerebral ischemic event or stroke with the onset of any one symptom within a three-hour period. The primary focus of this plan is to facilitate the early recognition of patients suffering from acute stroke and to expedite their transport to a center able to provide definitive care within an appropriate time window.

It is very important to note that because of the continuing evolution of scientific evidence indicating successful management of acute stroke greater than the three-hour time window, *real-time contact with on-line medical control shall be freely used to discuss individual cases outside the three-hour window*. In some cases, it may be determined that expeditious transfer or transport directly to a Designated Stroke Center may be most beneficial.

Some acute stroke types may benefit from intervention *up to 24 hours* following symptom onset. This Plan will also address consideration of what mode of transport would be most appropriate to transport the patient expeditiously to a Designated Stroke Center. Regardless of time of onset, the sooner an acute stroke is treated, the better the patient's potential outcome ("Time is Brain").

## *Stroke - Defined*

A stroke occurs when there is an interruption of blood supply to any part of the brain. A stroke is sometimes referred to as a “brain attack”. There are two major types of stroke,

1. Ischemic Stroke (accounts for about 87% of all strokes), occurs when there is a blood vessel that supplies the brain with blood becomes blocked by a blood clot, there are two ways that this can occur,
  - A clot forms in an artery that is already very narrow, known as a *thrombotic stroke*, or
  - A clot that has already formed in the brain or in some other area of the body, and has broken off and traveled to the brain, known as cerebral embolism or embolic stroke
- Plaque, is one main cause for ischemic strokes. Plaque is a sticky substance that has the potential to clog arteries
2. Hemorrhagic Stroke (accounts for about 13% of all strokes), occurs when there are weakened areas on the walls of vessels in the brain that burst open, causing blood to leak into the brain. Some of the population have defects in the blood vessels of the brain, which make them more susceptible to this. The defects are aneurysms and arteriovenous malformation (AVM).

## *Stroke Risks*

High blood pressure is the number one risk factor for strokes, other major risk factors include:

- Atrial fibrillation
- Diabetes
- Family history of stroke
- Race, Black Americans are more likely to die of a stroke
- High cholesterol
- Increasing age, > 55 years old

Other at risk populations are:

- History of heart disease
- Unhealthy, sedentary lifestyles
- Women, especially those who smoke and are > 35 years old, who take birth control
- People with three or more social determinants of health were nearly two and a half times more likely to have a stroke
- Stroke risk remained 50% higher among those with three or more social determinants of health after adjusting for other risk factors
- Black women were more likely to have a greater number of social determinants of health

Genetically, men have a higher risk for a stroke than women. Women do have a higher risk of stroke during pregnancy and in the weeks immediately following a pregnancy.

The following may increase the risk of bleeding into the brain, increasing the likelihood of a stroke:

- Alcohol use
- Drug usage
- Bleeding disorders
- Head injury

## *Stroke Incidence*

Stroke is the 4<sup>th</sup> leading cause of death in the United States. Approximately 800,000 people have a stroke annually, one American dies from a stroke every four minutes, on average. It is the leading cause of adult disability in the United States. Only 3% of patients who are eligible to receive “clot buster” (tPA, Activase®) treatment actually receive the treatment, since most patients don’t seek treatment quickly enough. In 2015, the Lord Fairfax EMS Council region, 12% of patients eligible to receive “clot buster” treatment do receive the treatment at the Regional Stroke Center.

In Virginia, stroke remains the 3<sup>rd</sup> leading cause of death equating to approximately 4,000 deaths annually. In Virginia, men have a slightly higher incidence of stroke than women. Also people of Black American ethnicity have a significantly higher incidence of stroke, as well as death from stroke.

## *Stroke Symptoms*

The symptoms of stroke depend on what part of the brain is damaged. In some cases, a patient may not even be aware that he or she has had a stroke.

Symptoms usually develop suddenly and without warning, or they may occur on and off for the first day or two. Symptoms are usually most severe when the stroke first happens, but they may slowly get worse.

Classic **signs and symptoms** of stroke include the following:

- **Sudden** numbness or weakness of the face, arm or leg (especially on one side of the body)
- **Sudden** confusion, trouble speaking or understanding speech
- **Sudden** trouble seeing in one or both eyes
- **Sudden** trouble walking, dizziness, loss of balance or coordination
- **Sudden** severe headache with no known cause

Other symptoms depend on the severity of the stroke and what part of the brain is affected. Symptoms may include:

- Change in alertness (including sleepiness, unconsciousness, and coma)
- Changes in hearing
- Changes in taste
- Clumsiness
- Confusion or loss of memory
- Difficulty swallowing
- Difficulty writing or reading
- Dizziness or abnormal sensation of movement (vertigo)
- Lack of control over the bladder or bowels
- Personality, mood, or emotional changes
- Problems with eyesight, including decreased vision, double vision, or total loss of vision
- Sensation changes that affect touch and the ability to feel pain, pressure, different temperatures, or other stimuli

Reference: The American Stroke Association <http://www.strokeassociation.org/STROKEORG/>

# LFEMS Pre-hospital Standard Patient Care Treatment Protocols

## Protocol 4.26

### MEDICAL – STROKE / TIA

1. Perform general patient management ([SECTION 1](#)).
2. Support life-threatening problems associated with airway, breathing, and circulation. **Be alert for aspiration, upper airway obstruction, and hypoventilation.**
3. Administer oxygen for patients experiencing respiratory distress or titrate oxygen to minimum necessary to achieve SpO2 ≥94%.
4. Determine time of last seen normal and time of onset of signs and symptoms. (See Key Points.)
5. Perform Cincinnati Pre-Hospital Stroke Scale evaluation. Initiate Stroke Protocol immediately after a positive Cincinnati Pre-Hospital Stroke Scale. If positive, perform Rapid Arterial Occlusion Evaluation (RACE).
6. Perform rapid glucose determination. If glucose less than 60 mg/dL or clinical signs and symptoms indicate hypoglycemia, refer to the [HYPOGLYCEMIA](#) protocol.
7. Position patient with head elevated 30° unless the patient shows signs or symptoms of hypoperfusion.
8. Transport rapidly, but carefully. **Notify the receiving hospital as early as possible.** Ensure hospital is notified of the time last seen normal and time of onset of signs and symptoms. Scene time should be less than 10 minutes.
9. Establish an INT or IV of Normal Saline at KVO. Unless the patient is hypotensive (SBP <90 mm Hg), intervention for blood pressure is not recommended.
10. Place patient on cardiac monitor and 12-Lead ECG if time permits.
11. Based on time of onset of symptoms.
  - a. If **≤6 hours since onset of symptoms**, preferentially transport to a Designated Stroke Center. Patients may be transported to Level 3 or 4 stroke-ready hospitals<sup>1</sup>.  
**Note:** *If patient does not have a patent airway and/or is hypotensive, consider transport to the closest hospital.*
  - b. If **>6 hours since onset of symptoms**, discuss case with **[Medical Control]** as a potential acute stroke for assistance in destination determination and mode of transport.
12. If RACE score is 7 or greater and if the transport time is greater than 30 minutes, consider rendezvous with air medical support. Do not delay patient transport.
13. **IMPORTANT:** Ensure that a witness accompanies the patient to the hospital/LZ or a contact telephone number for the witness is secured for the hospital. **Record the time last seen normal and witness telephone number on a piece of tape across the patient's chest.**
14. Perform reassessment as indicated.

	EMR	EMT	AEMT	INT	PM
1.	•	•	•	•	•
2.	•	•	•	•	•
3.	•	•	•	•	•
4.	•	•	•	•	•
5.	•	•	•	•	•
6.	•	•	•	•	•
7.	•	•	•	•	•
8.	•	•	•	•	•
9.			•	•	•
10.				•	•
11.		•	•	•	•
11a.		•	•	•	•
11b.		•	•	•	•
12.		•	•	•	•
13.	•	•	•	•	•
14.	•	•	•	•	•

**Protocol 4.26 – STROKE / CVA**

Cincinnati Pre-Hospital Stroke Scale	
<b>F-(face)</b>	<b>FACIAL DROOP: Have patient smile or show teeth. (Look for asymmetry.)</b> Normal: Both sides of the face move equally or not at all. Abnormal: One side of the patient's face droops.
<b>A-(arm)</b>	<b>MOTOR WEAKNESS: Arm drift (close eyes, extend arms, palms up)</b> Normal: Remain extended equally, drifts equally, or does not move at all. Abnormal: One arm drifts down when compared with the other.
<b>S-(speech)</b>	<b>"You can't teach an old dog new tricks." (repeat phrase)</b> Normal: Phrase is repeated clearly and correctly. Abnormal: Words are slurred (dysarthria) or abnormal (aphasia) or none.
<b>T-Time</b>	Time of <b>Symptom Onset</b> : _____

Rapid Arterial Occlusion Evaluation Scale (RACE)				
Item	Instruction	Result	Score	NIHSS Equivalent
<b>Facial Palsy</b>	Ask patient to show their teeth (smile)	<b>Absent</b> (symmetrical movement) <b>Mild</b> (slight asymmetrical) <b>Moderate to Severe</b> (completely asymmetrical)	<b>0</b> <b>1</b> <b>2</b>	0 – 3
<b>Arm Motor Function</b>	Extending the arm of the patient 90° (if sitting) or 45° (if supine)	<b>Normal to Mild</b> (limb upheld more than 10 seconds) <b>Moderate</b> (limb upheld less than 10 seconds) <b>Severe</b> (patient unable to raise arm against gravity)	<b>0</b> <b>1</b> <b>2</b>	0 – 4
<b>Leg Motor Function</b>	Extending the leg of the patient 30° (in supine)	<b>Normal to Mild</b> (limb upheld more than 5 seconds) <b>Moderate</b> (limb upheld less than 5 seconds) <b>Severe</b> (patient unable to raise leg against gravity)	<b>0</b> <b>1</b> <b>2</b>	0 – 4
<b>Head and Gaze Deviation</b>	Observe eyes and head deviation to one side	<b>Absent</b> (eye movements to both sides were possible and no head deviation was observed) <b>Present</b> (eyes and head deviation to one side was observed)	<b>0</b> <b>1</b>	0 – 2
<b>Aphasia (Right Side)</b>	Difficulty understanding spoken or written words. Ask patient to follow two simple commands: 1. Close your eyes. 2. Make a fist.	<b>Normal</b> (performs both tasks requested correctly) <b>Moderate</b> (performs only 1 of 2 tasks requested correctly) <b>Severe</b> (cannot perform either task requested correctly)	<b>0</b> <b>1</b> <b>2</b>	0 – 2
<b>Agnosia (Neglect) (Left Side)</b>	Inability to recognize familiar objects. Ask patient: 1. "Whose arm is this?" (while showing the affected arm) 2. "Can you move your arm?"	<b>Normal</b> (recognizes arm, and attempts to move arm) <b>Moderate</b> (does not recognize arm or is unaware of arm) <b>Severe</b> (does not recognize arm and is unaware of arm)	<b>0</b> <b>1</b> <b>2</b>	0 – 2
<b>RACE SCALE TOTAL</b>				

**A score above 7 is a high likelihood of an Large Vessel Occlusion (LVO)!**

### Key Points: STROKE / CVA

- A patient experiencing a Cerebrovascular Accident (CVA or stroke) may have a variety of presentations. Most commonly, the patient will experience a new onset of unilateral weakness (hemiparesis), paralysis (hemiplegia), difficulty speaking (aphasia), or a combination of these. The pre-hospital goal is to maintain stable vital signs, increase oxygen delivery, protect the patient's airway, and provide psychological support. Early recognition of stroke symptoms and early hospital notification is important.
- The Attendant-In-Charge should provide contact information to the receiving facility for any follow-up needed during transfer of care.
- Record time of onset of symptoms **on the patient**. Consider recording information on a tape and affixing to patient's chest.

<sup>1</sup>Local Variance: In some circumstances, transporting to a "stroke-ready" hospital may be appropriate. Hospital should conduct telemedicine and administer tPa.

### Key Points: RAPID ARTERIAL OCCLUSION EVALUATION SCALE (RACE)

- RACE is based on an abbreviated version of the National Institutes of Health Stroke Scale (NIHSS), the "gold standard" for evaluating stroke victims.
- The maximum score is 9 (not 11) because the evaluation is done on the left or right side not both simultaneously.
- The RACE is a 5 of 6 item scale. The last item is 1 of 2 based on which side the patient has deficits on previous scale items.
- The NIHSS equivalent is provided for the benefit of the receiving facility. The NIHSS score may be higher than the "snap shot" provided in the RACE because the NIHSS evaluates additional areas not covered in the RACE which is short by design for EMS field use.
- The RACE is a universal quantitative tool that is needed to determine the severity of a stroke and to identify strokes with large vessel occlusions (LVO) which would benefit going to a Stroke Center with interventional capabilities. This is similar to a 12-Lead ECG identifying a STEMI and being transported to a PCI Cardiac Center for intervention.
- The Cincinnati, the FAST, the Miami (MENDS), the Los Angeles (LAPSS) stroke scales are good scales that offer high degree of sensitivity for strokes, but they are all qualitative scores (positive or negative) and not quantitative (severity).
- A free online tool is available to calculate a RACE score at: <http://www.rccc.eu/race/RACEen.html>.
- For the study behind RACE see <http://stroke.ahajournals.org/content/45/1/87.full>.

Source Reference: LFEMS Pre-Hospital Standard Patient Treatment Protocols; 2017 (pages 78 & 79).

## National Institutes of Health Stroke Scale (NIHSS), Cincinnati Pre-Hospital Stroke Scale (CPSS), and Rapid Arterial Occlusion Evaluation (RACE)

All patients suspected of having an acute stroke should undergo a formal screening algorithm such as the NIHSS (if formally trained) or CPSS. Use of stroke algorithms has been shown to improve identification of acute strokes by EMS providers up to as much as 30 percent. The results of the NIHSS or the CPSS should be noted on the pre-hospital medical record. ANY abnormal (positive) finding which is suspected or known to be acute in onset is considered an indicator of potential acute stroke. With positive findings, the follow up screening should be RACE.

F-(face)	<p>FACIAL DROOP: Have patient smile or show teeth. (Look for asymmetry)</p> <p><b>Normal:</b> Both sides of the face move equally or not at all.</p> <p><b>Abnormal:</b> One side of the patient's face droops.</p>
A-(arm)	<p>MOTOR WEAKNESS: Arm drift (close eyes, extend arms, palms up)</p> <p><b>Normal:</b> Remain extended equally, drifts equally, or does not move at all.</p> <p><b>Abnormal:</b> One arm drifts down when compared with the other.</p>
S-(speech)	<p>"The sky is blue" or a similar phrase (repeat phrase)</p> <p><b>Normal:</b> Phrase is repeated clearly and correctly.</p> <p><b>Abnormal:</b> Words are slurred (dysarthria) or abnormal (aphasia) or none.</p>
T-(time)	<p>Time of SYMPTOM ONSET: _____</p>

\* Results of the F.A.S.T. should be included on the patient's pre-hospital medical record.

## LFEMS Pre-Hospital Acute Stroke Patient Transport Guidelines

Transport criteria directs acute stroke patients with a stable airway and without hypotension to Designated Stroke Centers if time of onset is less than or equal to six (6) hours of EMS assessment. If symptoms are acute, but are greater than six (6) hours since onset of symptoms, discuss case with Medical Control as a potential acute stroke for assistance in destination determination and mode of transport.

### ***RAPID TRANSPORTATION***

***Because stroke is a time-critical illness, time is of the essence, and EMS should rapidly initiate transport once acute stroke is suspected. Consideration should also be given to pre-hospital resources including using helicopter EMS (HEMS), if available, at the time of the incident, and other conditions such as transport time and weather conditions. Use of a helicopter can facilitate acute stroke patients reaching Designated Stroke Centers in a timeframe that allows for acute treatment interventions. The likelihood of benefit of acute stroke therapy decreases with time, but there are several therapy options which offer definite benefit outside the standard timeframe.***

Interventions available in our region include any or all of the following: specialty physician or ICU capability, medication therapy such as “clot busters” (tPA, Activase®) or new experimental therapies, radiologic evaluation and procedures (MRI, intra-arterial thrombolytics, mechanical thrombectomy), or life-saving emergent surgery (hemicraniectomy, large artery thrombus extraction).

- Medication therapy, such as tPA, could still be considered up to 4.5 hours after symptom onset. Intervention therapy can still be taken into consideration up to 6 hours after symptom onset.

Field transports of acute stroke patients by helicopter as defined in this plan:

- Should significantly lessen the time from scene to a Designated Stroke Center compared to ground transport.
- Should be utilized to achieve the goal of having acute stroke patients expeditiously transported to a Designated Stroke Center, ideally within 4.5 hours of symptom onset.
- Should only be to non-stroke centers in very unusual circumstances and after consultation with online medical control. If helicopter resource is used, the patient should be transported directly to a Designated Stroke Center.

## *Designated Stroke Centers*

The Commonwealth of Virginia defines a Designated Stroke Center as a hospital that has achieved Primary Stroke Center Certification by the Joint Commission. The process of Stroke Designation/Certification is entirely voluntary on the part of the hospitals and identifies hospitals that have established and maintain an acute stroke program that provides a specific level of medical, technical, and procedural expertise for acute stroke patients. Designation ensures that the hospital is prepared to provide definitive acute stroke care at all times and has an organized approach to providing clinical care, performance improvement, education etc.

*Note:* The list of hospitals becoming designated as stroke centers is increasing. A current list of The Joint Commission Primary Stroke Centers that meet the definition of Virginia Designated Stroke Centers is available at or by entering the state of interest at <http://www.qualitycheck.org/consumer/searchQCR.aspx>.

## *Inter-Hospital Triage Criteria*

When acute stroke patients cannot be transported directly to a Designated Stroke Center in a timely manner, ideally within the 4.5-hour window, consideration may be given to transport to a closer hospital. Various hospitals meet many of the components of a Designated Stroke Center based on national survey results and would be the next logical choice. The closest hospital may not be the most appropriate hospital.

These considerations are addressed in the Lord Fairfax EMS Council's *Regional Diversion Plan* which is consistent with the state stroke plan, and will be updated as hospital resource availability changes. The default destination for acute stroke patients should be a Designated Stroke Center.

The non-designated stroke hospitals in the Lord Fairfax EMS Council region have transfer guidelines and agreements in place for the expeditious and appropriate management of acute strokes when the care required exceeds their capabilities. This is especially critical for transfer of patients following thrombolysis since specific protocols must be followed to diminish the risk of cerebral or systemic hemorrhagic complications.

## *Stroke Triage Quality Monitoring*

The Virginia Office of EMS, acting on behalf of the Commissioner of Health, will report aggregate acute stroke triage findings on an intermittent basis, but no less than annually, to assist EMS systems and the Virginia Stroke Systems Task Force to improve the agency, regional, and Statewide Stroke Triage Plans. A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of (i) over and under triage to Designated Stroke Centers in comparison to the total number of acute stroke patients delivered to hospitals and (ii) inter-facility transfers that do not meet criteria for transfer to Designated Stroke Centers (iii) HEMS utilization. The program reports shall be used as a guide and resource for health care providers, EMS agencies, EMS regions, the Virginia Office of EMS, and the Virginia Stroke Systems Task Force. Additional specific data points to be collected within the EMS pre-hospital patient care report (written or electronic) will be established collaboratively between OEMS and VSSTF. Information to be contained in routine reports on both system and patient-level indicators and outcomes will be developed by OEMS to guide further system development in a patient focused way.

Hospitals, EMS agencies, and EMS regions are encouraged to utilize their performance improvement programs to perform quality monitoring and improve the delivery of acute stroke care within their regions. The Lord Fairfax EMS Council's *Performance Improvement Plan* includes review of appropriate transports of stroke patients, HEMS utilization, and reporting of the findings to the Medical Direction Committee and local Operation Medical Director for review, compliance enforcement, and potential Pre-Hospital Standard Patient Treatment Protocol revisions.

The local air medical transport service monitors and provides feedback to the Lord Fairfax EMS Council's Performance and Trauma Performance Improvement Committees on a quarterly basis. The detailed information includes but is not limited to the number of stroke patients and appropriated transports or transfer of inter-hospital stroke patients.

Annual reporting on the State Stroke Triage Plan will typically be provided through the OEMS, Division of Trauma/Critical Care's "Trends" report and on an ad-hoc basis in response to appropriate inquiries.

The Lord Fairfax EMS Council's Regional Stroke Triage Committee will actively engage in improving and analyzing data submitted by the stakeholders. This information will be disseminated to EMS providers in the form of an educational offering and performance improvement to improve patient care.

## **Stroke Related Resources and References**

Virginia Stroke System Web page: <https://www.vdh.virginia.gov/emergency-medical-services/trauma-critical-care/virginia-stroke-system/>

Virginia Office of EMS Stroke Web page:  
<http://www.vdh.virginia.gov/OEMS/Trauma/Stroke.htm>

Joint Commission:  
<http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/>

American Stroke Association: <http://www.strokeassociation.org/STROKEORG/>

Virginia Stroke Triage Plan:  
[http://www.vdh.state.va.us/OEMS/Files\\_page/trauma/StatewideStrokeTriagePlan.pdf](http://www.vdh.state.va.us/OEMS/Files_page/trauma/StatewideStrokeTriagePlan.pdf)

## Appendix A: Sample Thrombolytic Checklist

Date: \_\_\_\_\_ Time: \_\_\_\_\_ EMS Unit: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Estimated weight: \_\_\_\_\_ lbs/kg

1. Did patient awaken with symptoms? Yes / No
2. Time last known to be normal: \_\_\_\_\_
3. Time of symptom onset: \_\_\_\_\_
4. Onset witnessed or reported by: \_\_\_\_\_
5. Witness/Family or other individual able to legally provide consent for treatment coming to Emergency Department? \_\_\_\_\_ [ENCOURAGE TO DO SO].  
If not, phone # where such individuals will be immediately available for calls from hospital staff to assist in giving additional patient history and consent.

### Cincinnati Stroke Scale Score:

Symptoms from **Cincinnati Stroke Scale** (circle abnormal findings)

**ANY ONE FINDING = POSSIBLE STROKE=MINIMIZE ON SCENE TIME**

FACIAL DROOP:                      R                      L  
 ARM DRIFT:                         R                      L  
 SPEECH:                              slurred/ wrong words/ mute /unable to speak

<b>Acute Stroke Fibrinolytic Checklist</b>	<b>YES</b>	<b>NO</b>	<b>?</b>
Current use of anticoagulants (e.g. warfarin/coumadin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has blood pressure consistently over 185/110 mm Hg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witnessed seizure at symptom onset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intracranial hemorrhage history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI or GU bleeding history within 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This event within 3 months prior of prior stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This event within 3 months of serious head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This event within 21 days of myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This event within 21 days of lumbar puncture (spinal tap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This event within 14 days of major surgery or trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Receiving Site/Physician Printed Name: \_\_\_\_\_ Time \_\_\_\_\_

EMS Provider Name: \_\_\_\_\_ Signature \_\_\_\_\_

## ***Appendix B: Committee Membership***

While the Lord Fairfax EMS Council is mandated by contract to develop and implement regional planning documents such as this Regional Stroke Triage Plan, we realize the pre-hospital providers and allied stakeholders will actually bring this plan to life. This document belongs to every EMS agency, provider, hospital and allied medical professional within the Lord Fairfax EMS Council region. It is important for all of us to train for, prepare for and embrace the concepts and guidance contained herein to ensure that patients within our region receive the best pre-hospital care possible.

As your regional EMS organization, we would be remiss to not recognize the expertise and commitment of those partners and stakeholders who were instrumental in building this planning document. These individuals have answered the call to build a guidance document that you can be proud of.

The LFEMS staff wishes to thank each of these individuals for their sacrifice and commitment to quality pre-hospital care throughout the region. Without them, this plan could not sustain its own life.

### ***Committee Membership***

**Debbie Massie, RN, Chair** – Winchester Medical Center Neuroscience Program Coordinator

**Jordan Highland, EMT-Paramedic** – Shenandoah County Fire and Rescue

**Chris Tusing, EMT-Paramedic**- Shenandoah County Fire & Rescue

**Mark Barenklau, EMT-Intermediate** – Frederick County Fire and Rescue

In closing, we want to also take a moment to solicit your input and future involvement. The LFEMS Council has a number of on-going committees, planning documents and other opportunities for your participation. If you wish to chair a committee or merely share your ideas for an area of planning improvement, we want to hear for you. Again, this is your regional organization, these are your planning and guidance documents and it's our desire to make them work for you.

Please contact the LFEMS Council office with ideas or areas to get involved.

(540) 665-0014

<http://www.lfems.vaems.org>

Very Respectfully,  
LFEMS Regional Stroke Triage Committee