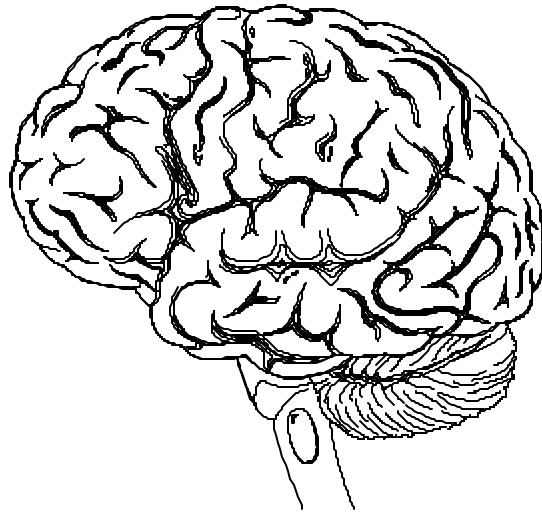


STROKE

RISK SCREENING



STROKE RISK SCREENING

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I.

GENERAL

STROKE RISK SCREENING

A. Stroke is a “Brain Attack”

Stroke is no longer considered to be a “cerebrovascular accident.” Stroke is a “brain attack,” that can be prevented and treated.(1) Aggressive identification and treatment of individuals at high risk will reduce the number of strokes, disability and death. Poor public knowledge of stroke is an impediment to solving this major health problem. (3) The majority of the population is unaware of stroke warning signs, risk factors or treatment options. (2)

Stroke screening is urgently needed to identify individuals at risk and to educate the public on stroke detection. Participation in a stroke screening program has the potential to save lives and reduce physical and mental disability from brain damage. Public education is urgently needed to reach individuals unaware of conditions that place them at high risk, e.g., hypertension or atrial fibrillation and the danger of risk behaviors, e.g., cigarettes, the use of drugs or excessive alcohol.

With an estimated 600,000 to 750,000 stroke events annually (2), participation in a **Stroke Screening Program** will help to reduce the number of people who suffer a stroke and improve the outcome of those who seek immediate medical treatment. The personal and financial losses of the more than 3,000,000 people currently living with stroke is enormous. It has been estimated that approximately 160,000 Americans will die from stroke this year. (2)

B. What is Stroke Risk Screening?

Many individuals in the community who engage in high risk behaviors or who have a medical history for known and established risk factors for stroke are not being followed medically. This is an important population to target for screening. **Stroke Risk Screening** may be their first encounter with a healthcare provider to have a blood pressure and pulse check and a review of the risk factors. The screening serves as a preliminary step to detect characteristics or conditions that may require further investigation and evaluation.

Recent studies have found that approximately 50% of Americans over the age of 65 are functionally illiterate which may help to explain the limited response from the elderly to public education. **Stroke Risk Screening** for the elderly may be their first 1:1 contact with a healthcare provider assessing the risk for stroke. **Stroke Risk Screening** has the potential to identify the elderly and other under-served populations and to connect these individuals to community healthcare resources.

C. Purpose

Stroke Risk Screening was designed by nurses to screen adults over the age of 18 for the risk of stroke. Three key elements of the screening include: a review of an individual's risk factors, a blood pressure and pulse check, and teaching the warning signs of stroke with the emphasis that stroke is an emergency that demands an immediate call to "911."

Nurses, with their expertise in assessment and patient education, are ideally suited to conduct **Stroke Risk Screenings**. Nurses are also the largest single group of healthcare professionals in America. Nurses who practice in various clinical settings have more opportunities than perhaps other healthcare providers to conduct individual or group **Stroke Risk Screenings**.

Nurses who conduct **Stroke Risk Screenings** will make an impact on the incidence, morbidity and mortality of stroke. Today, only 3.6 percent of stroke patients receive appropriate treatment. (2)

The purpose of the **Stroke Risk Screening** are to: 1) Introduce and make available the first scientifically grounded nursing instrument to screen individuals at risk for stroke, 2) Provide an instrument that is quick and easy to use, 3) Provide an instrument, without copyright, that is suitable for and can easily be integrated into any clinical practice, and 4) Standardize stroke risk screening for data collection that can be analyzed to conduct patient follow-up and measure outcomes.

Nurses and other healthcare providers are encouraged to volunteer and organize a **Stroke Risk Screening** in community settings for individuals, particularly the elderly, who may not have access to primary care, e.g., public shopping areas, churches, senior citizen facilities, health fairs, and public events.

Nursing faculty can include the **Stroke Risk Screening** as part of the curriculum on stroke. They can motivate and supervise students to conduct community projects for stroke prevention. Hospitals are free to duplicate the instrument and to create a hospital document that is readily available for staff. Office nurses, home health agencies, longterm care providers and others with a population at risk for stroke will find this an ideal instrument for nurses and healthcare providers to use in their everyday practice

D. Instrument

The **Stroke Risk Screening** contains eight parts. The first six parts are used to collect specific information that will help to determine the individual's risk for stroke. Part VII identifies the person's risk for stroke and gives a recommendation. Part VIII is a vital part of the public education plan to increase awareness of the signs and symptoms of a stroke with instructions to call "911" immediately for transportation to the emergency department for urgent treatment. It is important to educate the public that a stroke is a medical emergency!

Preparation

A training session will be conducted by an experienced healthcare provider to prepare volunteers for community screening. The **Stroke Risk Screening** form is reviewed and questions answered. Healthcare providers familiar with stroke management require minimum preparation to conduct the screening. The forms and guidelines are self-explanatory. It is important to remind volunteers of the difference between “stroke screening” and their usual practice of assessment and physical examination. Where large numbers of participants are screened, the time for each participant may be restricted to about eight minutes.

Follow Up

The type of follow-up depends on how the instrument was used. If the participants were from a community setting, the sponsor undertaking the stroke risk screening will determine how the data will be collected and reported. The sponsor will plan appropriate follow-up. If the **Stroke Risk Screening** was conducted as part of a patient’s assessment and recorded in their file, the institution will make decisions on the extent of data collection, research, and patient follow-up.

The **Stroke Screening Data Collection Form** was designed to be completed by the designated sponsoring healthcare volunteer(s) or agency. If a community setting was used, a follow-up letter is sent by those undertaking the stroke risk screening to the community site with an analysis of the results. If possible, a follow-up plan for those individuals found to be at risk will be implemented by those undertaking the stroke risk screening. A telephone survey with documentation of results can be added to the original data collection for analysis.

Outcomes

There are many criteria that can be used to determine the effectiveness of local, state, or national **Stroke Risk Screening**. For example, city, county and state statistics can be analyzed to track pre- and post-screening incidence of stroke morbidity, mortality, admissions to longterm care facilities, and economic factors. Hospital emergency department (ED) stroke admissions can be analyzed for sharp increases in patients arriving within the therapeutic three-hour time frame. Practice settings can be surveyed for information on increases in the number of patients receiving preventive care for stroke or disease management. Thus, individual nurses or healthcare agencies have the opportunity to gain valuable information about their clients.

II. COMPLETING THE STROKE RISK SCREENING FORM

A. INTRODUCTION

Stroke Risk Screening was designed to screen adults over the age of 18 for the risk of stroke. Through participation, individuals have agreed to have their blood pressure and pulse taken and provide demographic and health information. Participants are told that the screening does not substitute for evaluation by a healthcare provider. A risk profile based on screening is developed with recommendations. The recommendations are made with preliminary findings that can change after a visit to a healthcare provider who conducts a complete medical checkup.

The following instructions are provided to assist in your use of the **Stroke Risk Screening** form. Additional information is available to enable all data collection to have a uniform knowledge base. In addition, you may wish to share some or all of this information with participants.

Begin with an introduction of yourself. Explain the significance of identifying individuals who are at risk for stroke through **Stroke Risk Screening** and the importance of following the recommendations provided. Enter the name and address of the screening site with the date. Each screening should take about six to eight minutes.

B. Part I: - DEMOGRAPHICS

Complete the demographics and information as provided by the individual. If the information is not known, enter N/A, and continue. Don't spend time guessing or changing information. Don't erase. Put a line through the incorrect information and enter the correct data above it. Print neatly. If the individual prefers to enter the data, they may do so as long as they use a black pen, print legibly and press hard to make the copy.

C. Part II: - HISTORY FOR KNOWN AND ESTABLISHED HIGH RISK FACTORS

1. Have you ever been told that you have high blood pressure? Use the following guidelines from the 1997 Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure from the National Institutes of Health, National Heart, Lung, and Blood Institute, National High Blood Pressure Education Program:

Blood Pressure Recording	Systolic (mm Hg)		Diastolic (mm Hg)
* Optimal+	<120	and	< 80
* Normal	< 130	and	< 85
* High-Normal	130-139	or	85-89
* Hypertension++			
Stage I	140-159	or	90-99
Stage II	160-179	or	100-109

stroke is justified. Aspirin is also prescribed for anticoagulation. (10) Although older patients are more at risk of adverse events, anticoagulation is more cost-effective in this group. (11)

4. Have you ever been checked for or been told that you have narrowing of the arteries to the brain? Carotid artery disease or narrowing of the vessels to the brain restricts cerebral circulation and increases the risk for stroke. Patients who have experienced a TIA and who have carotid stenosis may benefit from a surgical procedure called a carotid endarterectomy (CEA). Carotid stenosis increases the risk of stroke. CEA has been considered appropriate for patients with symptomatic carotid stenosis >70%. (12)

5. Have you had a heart attack, heart by-pass surgery, angioplasty or another disease of the heart? Heart disease that includes, congenital heart defects, congestive heart failure, rheumatic heart disease, valvular heart disease, arrhythmias, cardiomyopathy, angina, heart surgery, angioplasty or myocardial infarction are coronary disorders that can increase the risk of stroke. These conditions are considered “non-modifiable” risk factors. (13) The individual should be aware of the increased risks and focus on reduction of the “modifiable” risk factors to reduce the risk of stroke.

6. Have you had a previous stroke, mini-stroke or TIA? History of a previous stroke may increase the risk of stroke up to ten times.(13) The individual, therefore, should not consider themselves “inoculated” against future strokes. Quite the contrary, the person should be extra diligent in adhering to a medical plan of prevention. Another stroke can be more debilitating, or even fatal.

7. Do you have diabetes mellitus (DM) or are you on insulin or medication for high blood sugar? Individuals with diabetes may have problems with obesity, elevated cholesterol levels, hypertension, poor diet, and small vessel changes which has the potential to increase their risk for stroke. (13) Uncontrolled diabetes mellitus is an independent risk factor for the development of stroke and may increase the risk two-to-four times. Damage may result from the overall hypermetabolic state and the concurrent hyperglycemic state. (13)

8. Have you ever smoked cigarettes? Tobacco use, cigarettes in particular, has been shown to be an independent risk factor. (13) In fact, the risk may be as great as two-to-four times. Smoking causes a rise in blood pressure each time a person smokes a cigarette. It is not entirely clear how smoking damages the vessels but the toxic effects of nicotine may be related to the alkaloid and other byproducts found in tobacco. Once the vessels have been damaged, there is no easy way to determine recovery from cigarette smoking.

9. Do you currently smoke cigarettes? As described in item 8, people who smoke, women using birth control pills and smoke, people with diabetics and heart disease who smoke are increasing their risk factors. Stopping smoking is a risk that can be eliminated. Referral to a smoke cessation program is an important recommendation for smokers of all ages. Avoidance of tobacco in any form is an important message to smokers. (4). Questions 8 and 9 are one risk.

D. PART III - HISTORY FOR SIGNIFICANT BUT SLIGHTLY LOWER RISK FACTORS

10. Has a family member under the age of 45 had a stroke or heart attack? Individuals who have had a family member experience a stroke before the age of 45 may be at greater risk for stroke. Evaluation of the person's family medical history may reveal multiple risk factors that help to prevent or explain early stroke. Recommendations to modify an individual's lifestyle may be important in such cases. The threat of familial tendency toward stroke (heterofamilial traits) is frightening to relatives. Nurses must be aware of the often-unexpressed questions related to this. (13)

11. Do you consume more than two ounces of alcohol on a daily basis? Drinking more than two ounces of alcohol at one time, or excessive drinking, raises blood pressure which increases the risk of stroke. (4) In particular, binge drinking and other forms of alcohol abuse increase the risk of stroke. Excessive alcohol may actually cause resistance to antihypertensive medications. Because women have been found to absorb more alcohol than men, excessive drinking is more problematic for females. Drinking cessation programs offer not only a way to stop drinking, but also offer protection that can reduce the risk of stroke. If you stop drinking, your stroke risk will drop significantly within two years. (14)

12. Do you have a cholesterol level greater than 200? Increased levels of cholesterol above 200 mg/dl may be associated with atherosclerosis.(13) Excessive levels of serum cholesterol have been linked to poor diet, cigarette smoking, and hypertension. Serum cholesterol that make up low-density lipoproteins (LDL) can build up in the arteries. High-density lipoproteins (HDL) are the "good" lipoproteins and carry cholesterol back to the liver for removal. According to the National Heart, Lung and Blood Institute, a cholesterol level for 240 mg/dl or greater runs twice the risk of heart disease when compared with a 200 mg/dl. (4) For smokers, this risk increases twenty fold. Factors other than diet also play a role in high cholesterol levels, such as family history, history of heart disease before age 55, diabetes, vascular disease, and obesity. High cholesterol is another "silent killer" with few outward symptoms that something is wrong. (14)

E. PART V - HISTORY OF UNCOMMON BUT IMPORTANT RISK FACTORS

13. Do you smoke cigarettes and take birth control pills? Women in their childbearing years, who use birth control pills and smoke, have a significant increase in stroke incidence and its relative risk. (13) Women are unaware of this lethal combination and can easily take steps to eliminate this particular risk.

14. Do you have Sickle Cell Anemia? Sickle Cell disease is an inherited blood disorder that affects about 90,000 Americans, mostly African-Americans. (15) is the production of sickle-shaped erythrocytes in the circulation. In Sickle Cell Anemia (SCA), the patient has an abnormal hemoglobin and distorted erythrocytes with clumps that obstruct blood vessels. Sickle cell crises causes the red blood cells (RBCs) to become stiff with a crescent, or sickle. This leads to vaso-occlusion, infarction,

and stroke.

15. Do you use one or more of the following drugs: Cocaine, Crack, Heroin, Amphetamines?

The use of illicit drugs among young adults may contributing to the increase in stroke in the 45 years of age and under group. (16) The number of cases, however, appears to be on the rise as adolescents experiment with new and more dangerous drugs. Each drug has unique side effects and complications. Drug combinations are even more difficult to assess for risk of stroke. The deadly affects of an overdose have not been a deterrent to drug abuse and the risk of stroke probably has even less affect. More education on the dangers of drug abuse and stroke is needed.

F. PART V - ASSESSMENT

Blood Pressure: Refer to **PART II, Question 1.** It is important to select the correct size blood pressure cuff, use proper technique and have the participant in the seated position to record the blood pressure (BP).The bladder within the cuff should encircle at least 80% of the arm. (4) If you do not have a cuff in the appropriate size, record “cuff not available.” A reading that appears extremely abnormal should be repeated in five minutes.

Pulse: Take the pulse measurement from the right or left radial artery for one full minute and record. Note the rhythm for regular or irregular beat. A rapid pulse that appears irregular may indicate that the person is at risk for “atrial fibrillation” (AF). This will factor into the final risk evaluation. Treatment for AF, such as anticoagulation, may be indicated, which could reduce the risk of stroke. According to a report from the National Stroke Association (NSA), warfarin, an anticoagulant commonly use to prevent strokes, is not prescribed as often as it should be. (17)

G. PART VI - AGE AND ETHNICITY

Enter date of birth and age in years. Check appropriate ethnic category. These data will be important for age and population groups studies on a geographic basis. The specific group(s) and residence areas can be targeted for stroke education and screening. Hypertension remains the #1 treatable risk factor and is especially prominent in ethnic minorities, African-Americans, in particular. (2)

Stroke is a growing threat to the well being and productivity of aging Americans, including those who are now middle age. (1) Approximately 28% of all stroke victims are under the age of 65. (14) After the age of Over age 65, however, the incidence of stroke rises rapidly. (13) For people over age 55, the incidence of stroke more than doubles in each successive decade. (18) According to the National Stroke Association (NSA), women account for more than 60% of all stroke deaths. The NSA also reports that stroke kills more than twice as many American women every year as breast cancer.

H. PART VII - IDENTIFICATION OF RISK FOR STROKE AND RECOMMENDATION

Stroke Risk Screening was designed to screen adults over the age of 18 for the risk of stroke. Participants are told that the screening does not substitute for evaluation and treatment by a healthcare provider. A risk profile based on the screening is developed with recommendations. The recommendations are made with preliminary findings which can change after a visit to a healthcare provider who conducts a complete medical checkup.

Findings of “no risk” of stroke is also no guarantee -- only that the information did not indicate a risk for stroke. The screening is provided without any guarantees but with the hope that it will heighten the person’s awareness of stroke, the risk factors of stroke, stroke prevention measures, the symptoms of stroke and when to call “911” for immediate transportation to a hospital for diagnosis and treatment.

#1. Low Risk for Stroke: Indicates that the participant was under the age of 55 and responded “NO” to questions 1 through 15 (self-reported risk factors). The individual was **not** identified to have an irregular pulse rate, or a measured Systolic BP > 140 or a Diastolic BP > 90. The recommendation given is to take the completed screening form to a healthcare provider at the next regularly scheduled appointment. For example, a 42-year-old-male whose BP was measured as 139/89 would receive a recommendation to take the completed stroke screening results to his/her healthcare provider at the next regularly scheduled appointment. If the individual develops any risk factors prior to their scheduled visit, a healthcare provider should be contacted immediately.

#2. Moderate Risk for Stroke: All participants over the age of 55 are at moderate risk. And the risk for stroke doubles with every decade over 55. This category is checked even if the participant has **no** self-reported risk factors and does not have an irregular pulse or a measured Systolic BP > 140 or a Diastolic > 90.

Participants age up to age 64 are at moderate risk with one self-reported risk factor, or an identified irregular pulse, or a measured Systolic BP > 140, or a Diastolic > 90. The participant will be given a recommendation to notify their healthcare provider within one week to request an appointment for a checkup and evaluation. If they are currently under medical supervision, they will benefit from the stroke screening, education, and teaching on prompt recognition of stroke symptoms. The fact that the individuals are under medical supervision is no guarantee that they have complete knowledge of all the information provided during the screening and that they will respond appropriately if they have a stroke. For example, a 72-year-old-female whose BP reading was 142/94 and indicated that she had not been previously diagnosed with hypertension would receive a recommendation to notify a healthcare provider within a week with results of the screening and request an appointment for an evaluation, and management of hypertension for stroke prevention.

#3. High Risk for Stroke: This is the group age 65 or older with one self-reported risk factor, or **any age with two or more risk factors**, either self-reported and/or identified on measurement with an

irregular pulse or a measured Systolic BP > 140, or a Diastolic > 90. These individuals are given a recommendation to notify a healthcare provider **today** with the results of the screening and request an appointment. For example, a 50-year-old woman who has diabetes and hypertension would be at high risk because she has two risk factors. The 68-year-old male who smokes one-half pack of cigarettes daily may not consider himself at high risk for stroke when he receives the recommendation. His risk is “high” because his age is greater than 65 and he has one risk factor. He may walk away and toss the recommendation in the nearest trash receptacle unless he understands the dangers of smoking at his age, the need to stop using tobacco products, how to recognize the warning symptoms of a stroke and the need to call 911 immediately at the onset of stroke symptoms.

#4. Recommendation for immediate call to “911.” In conducting a screening, there may be the rare situation where an individual will present with active warning signs of a stroke, or TIA (mini-stroke). In the instance where the healthcare provider feels that an individual is in immediate need of medical care: **RECOMMEND THAT THE INDIVIDUAL, OR THEIR FAMILY MEMBER, CALL “911” IMMEDIATELY.** If possible, have the person sign the screening form that they have received the recommendation. Note a refusal to do so. You are only providing a screening and are not in a position to demand that a person seek immediate help. You may reinforce the importance of medical care and the risks for not accepting the recommendation. The final decision belongs to the individual.

I. PART VIII - THE WARNING SIGNS OF STROKE

At the completion of the screening, verbally list the warning signs of a stroke. Ask if the individual understands the importance of recognizing that the seriousness of the symptoms and when they warrant a call to “911.” Ask if they have any questions. Thank each individual for his/her participation in the screening. Provide each participant with a copy of the screening results and recommendations. Encourage participation in future stroke screenings.

J. FINAL DETAILS

Thank the host or agency for their sponsorship and leave any literature or posters on stroke at the site for future use or distribution. If there were any difficulties with the screening, leave a note with the screening results for follow-up and resolution of the problems. Clean the area of any debris, return the tables and chairs and leave the site as you found it. The lead volunteer will be responsible for completing the data summary.

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APPENDIX

for

STROKE

RISK SCREENING

CHECK LIST FOR STROKE RISK SCREENING

The equipment and supplies required will depend on the site for the **Stroke Risk Screening**. For example, at a public site for a health fair, request **tables and chairs** placed in a well-lighted area situated where the noise level is low and fully accessible for handicapped individuals. If possible, request a site where posters and displays can be exhibited, or temporarily attached to flat walls.

The following items will be needed, unless provided by the sponsor:

- ___ 1. List of all volunteer nurses, or healthcare providers
- ___ 2. Signed "Letter of Agreement" that indicates the date, time, and location with the name of the contact person
- ___ 3. **Stroke Risk Screening** Packets
- ___ 4. Pens with black ink to enter data
- ___ 5. Stethoscopes for all volunteers
- ___ 6. Sphygmomanometers of all sizes, especially extra-large
- ___ 7. Alcohol swabs to clean equipment
- ___ 8. Posters, brochures, handouts and other educational materials on stroke to be available for the public/patients

In a hospital, or other healthcare facility, for public or outpatient screening, also select a site where the room is well-lighted, the noise level is low, and the area is fully handicapped accessible.

For in-patient screening, select a time when there will be no or few interruptions and the patient is comfortable. Once the screening is completed, follow hospital guidelines for placing the form in the patient's record and for making an entry in the medical record to document completion of the screening and results. Follow the protocol for notifying the patient's clinical treating team, patient, and/or family members with the results of the **Stroke Risk Screening**.