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| **NBT Stroke Thrombectomy Referral Form** | | |
| **NBT Receiving Consultant** | | **Date and Time** |
| **Patient Details**  Name  Age  DOB  NHS Number | | **Referrers Details**  Consultant Name  Hospital  Telephone for immediate contact  Telephone and name for repatriation  E-mail |
| **History**  NIHSS  Thrombolysed – Y/N Aspirin 300mg – Y/N | | **Past Medical History/Drug History and Allergies** |
| **Imaging**  CT and CTA – Y/N | | |
| **Premorbid Performance Status**  mRS Rockwood Frailty Score | | |
| **ABCDE Assessment** | | |
| Airway | Safe for transfer without anaesthetic support – Y/N | |
| Breathing | RR SpO2 FiO2 O2 delivery – NS/FM/ NRB | |
| Circulation | HR SBP Labetolol Nitrates ECG | |
| Disability | \*GCS \_/15 BM  \*If GCS </=8 have anaesthetists reviewed the airway – Y/N | |
| Exposure | Anything else we should be aware of? | |
| **Neuroradiologist Discussion** | | |
| Name –  Time:  Outcome – accept/reject | | |
| Time Decision Communicated to Referrer:  **Save completed form in folder N:\Stroke Team\THROMBECTOMY REFERRALS** | | |