

North Dakota Pre-hospital Stroke Screening Scale

1. Patient Name: _____
2. Informant/History from _____ Phone# () ____ - ____
- Patient Family Other
3. Time last seen normal/baseline and awake ____ : ____ / ____ / ____

Screening Criteria		No	Yes
<p>Facial Droop – ask patient to show teeth and smile</p>			
<p>Arm Drift – ask patient to extend arms, palms down, with eyes closed</p>			
<p>Speech Abnormal – ask patient to say “You can’t teach an old dog new tricks”</p>			
<p>Test</p>			

