American CME FAST-ED Scoring Checklist

Patient Name: **DOB: / /**

Last-known-well date and time: / / @ :

Symptom discovery date and time: / / @ :

Assessment Items	Score
Facial Palsy – Ask the patient to show their teeth or smile.	
1. Both sides of the face move equally or not at all.	**0**
2. One side of the face droops or is clearly asymmetric.	**1**
Arm Weakness – Ask the patient to extend both arms with palms up out in front of them, close their eyes, and hold them there for a count of 10.	
1. Both arms remain up for >10 seconds or slowly move down equally.	**0**
2. Patient can raise arms but one arm drifts down in <10 seconds.	**1**
3. One or both arms fall rapidly, cannot be lifted, or no movement occurs at all.	**2**
Speech Changes	
Dysarthria – Ask the patient to repeat the phrase: **"*The sky is blue in Michigan*."**	
Is slurred speech present? (circle one)	**Yes** ☐ **No** ☐
Expressive Aphasia – Ask the patient to name 3 common items.	
1. Names 2 to 3 items correctly.	**0**
2. Names only 0 - 1 items correctly.	**1**
Receptive Aphasia – Ask the patient to perform a simple command. Example: Ask the patient, **"*show me two fingers*."**	
1. Normal, patient can follow the simple command.	**0**
2. Unable to follow the simple command.	**1**
Eye Deviation	
1. No deviation, eyes move equally to both sides.	**0**
2. Patient has clear difficulty when looking to one side (left or right).	**1**
3. Eyes are deviated to one side and do not move to the other side.	**2**
Denial/Neglect – (Do not perform if expressive or receptive aphasia is present)	
Anosognosia – Show the patient their affected arm and ask, **"*Do you feel weakness in this arm*?"**	
1. Patient **recognizes** the weakness in their weak arm.	**0**
2. Patient **does NOT recognize** the weakness in their weak arm.	**1**
Asomatognosia – Show the patient their affected arm and ask, **"*Whose arm is this*?"**	
1. Patient **recognizes** their weak arm.	**0**
2. Patient **does NOT recognize** their weak arm.	**1**
A FAST-ED score greater than or equal to* 4 *indicates a high likelihood of LVO stroke	**Total Score**

Notes:

Vital Signs	
Time	
Blood Pressure	
Heart Rate	
Breathing Rate	
SpO2	
Blood Sugar	

Does the patient have a previous history of stroke? (circle one): **Yes** **No**

Anticoagulant Medication Use

Anticoagulants	No	Yes	If yes, document the date and time of last dose, if available
Coumadin/Warfarin	☐	☐	Date: Time: :
Pradaxa/Dabigatran	☐	☐	Date: Time: :
Eliquis/Apixaban	☐	☐	Date: Time: :
Xarelto/Rivaroxaban	☐	☐	Date: Time: :
Savaysa/Edoxaban	☐	☐	Date: Time: :
Heparin/Enoxaparin	☐	☐	Date: Time: :
Other anticoagulant:	☐	☐	Date: Time: :

☐ **Unable to obtain a list of medications for this patient**

Next of kin information		
Name	**Relationship**	**Phone number**