

North Coast Emergency Medical Services

THROMBOLYTIC THERAPY PRE-ALERT CHECKLIST

EMT-II or EMT-P: Please complete for each patient with suspected acute myocardial infarction (AMI) and attach one copy to each Patient Care Report (PCR).

PATIENT'S NAME: _____ DATE: _____

Time: _____ Completed by: _____

(Please Print)

Agency: _____ (Circle one) EMT-I EMT-II EMT-P

Inclusion Criteria

Clinical finding consistent with AMI such as: (Circle U-Unknown, Y-Yes, N-No)

Chest pain > 30 minutes? – Possibly accompanied by jaw, arm, or back pain. U Y N

Sudden onset shortness of breath? U Y N

Nausea/vomiting? U Y N

Pale, cool, diaphoretic skin? U Y N

12-lead EKG evidence of AMI, if available? U Y N

Recent onset of AMI symptoms (< 6 hours)? U Y N

Time of onset: _____

Exclusion Criteria

Absolute: (Circle U-Unknown, Y-Yes, N-No)

Do you have active internal bleeding? U Y N

Have you ever had a stroke? U Y N

Have you had brain or spine surgery or injury within the past 2 months? U Y N

Do you have a brain tumor, growth, or aneurysm? U Y N

Do you have a bleeding disorder (e.g., hemophilia)? U Y N

Do you have severe uncontrolled high blood pressure? U Y N

Exclusion Criteria (cont.)

Relative:	(Circle U-Unknown, Y-Yes, N-No)		
Have you had major surgery or injury within the past 10 years?	U	Y	N
Do you have disease of the blood vessels of the brain?	U	Y	N
Have you had any internal bleeding within the past 10 days (e.g., blood in your urine or stool)?	U	Y	N
Do you have high blood pressure? (Systolic blood pressure (BP) > 180 and/or diastolic BP > 110)	U	Y	N
Do you have acute pericarditis or subacute bacterial endocarditis (inflammation of or around the membrane lining the heart)?	U	Y	N
Do you have severe liver or kidney disease?	U	Y	N
Are you pregnant?	U	Y	N
Do you have diabetic-related eye or vision problems?	U	Y	N
Do you have septic thrombophlebitis (infection of a vein, especially of the legs)?	U	Y	N
Are you older than 75 years?	U	Y	N
Are you currently receiving oral anticoagulants (blood-thinners) (e.g., Coumadin)?	U	Y	N
Do you have any other condition in which bleeding would be dangerous or would be particularly difficult to manage because of its location?	U	Y	N

SIGNATURE OF ATTENDANT: _____

ARRIVAL TIME AT RECEIVING HOSPITAL: _____