

DATE	TIME	ORDERS:	TIA / Stroke Discharge
		Allergies:	Weight in kg:
		Provider:	
		I. NIH SCORE NIH score on admit: _____ NIH score on discharge: _____	
		II. Provide Patient Education <ul style="list-style-type: none"> ● Stroke Education Pack ● Smoking Cessation Education if indicated ● Cardiac Diet Education 	
		III. Discharge Medication Orders <ul style="list-style-type: none"> ● Antihypertensive: _____ ● Lipid lowering agents: _____ ● Antiplatelet therapy: _____ ● Anticoagulation therapy for atrial fibrillation: _____ ● See Medication Reconciliation form 	
		IV. Follow up test <ul style="list-style-type: none"> ● Screen for dysphagia: _____ ● Laboratory: _____ ● Radiology _____ ● Heart Center: _____ 	
		V. Make discharge appointment within 24 hours with primary care physician	
		VI. Counsel patient and family Notify physician if you have any questions or concerns Take medications as prescribed until your physician tells you otherwise Call 911 immediately if you experience Sudden confusion or trouble understanding Sudden numbness/weakness in face, arm, or leg especially on one side of body Sudden trouble speaking Sudden trouble seeing in one or both eyes Sudden trouble walking, leaning, dizziness, loss of balance, or loss of coordination Sudden severe headache, worst headache of your life without a known cause	
		VII. Arrange follow up phone call with patient next day Assure correct phone number is in the medical record	

PHYSICIAN SIGNATURE: _____ Date/Time: _____

*****PATIENT LABEL*****