This Inclusion/Exclusion Criteria Checklist is a tool to be used in the assessment of a patient in the acute setting. The final decision to use or not use IV tPA is at the discretion of the treating physician.

Inclusion Criteria

- **Onset of symptoms <3 hours** before beginning treatment (Onset time is defined as either the witnessed onset of symptoms or the time last known normal if symptom onset was not witnessed.)
- Diagnosis of ischemic stroke causing measurable neurological deficit
- Aged ≥18 years
- Potential risks and benefits of IV tPA treatment discussed with patient and/or family members and they have verbalized understanding (to be documented in patient’s record). If patient unable to give verbal consent and no family available, IV tPA can be given under Emergency Doctrine. Written informed consent not required for IV tPA when given within 3 hours of symptom onset.

Exclusion Criteria

- Significant head trauma or prior stroke in previous 3 months
- Symptoms suggest subarachnoid hemorrhage
- History of previous intracranial hemorrhage
- Intracranial neoplasm, arteriovenous malformation, or aneurysm
- Recent intracranial or intraspinal surgery
- Arterial puncture at noncompressible site in previous 7 days
- Elevated blood pressure (systolic >185 mm Hg or diastolic >110 mm Hg)
- Active internal bleeding
- Blood glucose concentration <50mg/dl (2.7mmol/L)
- *Acute bleeding diathesis*, including but not limited to: Platelet count <100 000/mm³ (In patients without history of thrombocytopenia, treatment with IV rtPA can be initiated before availability of platelet count but should be discontinued if platelet count is <100 000/mm³.)
- Heparin received within 48 hours, resulting in abnormally elevated aPTT greater than the upper limit of normal
- Current use of anticoagulant with INR >1.7 or PT >15 seconds (In patients without recent use of oral anticoagulants or heparin, treatment with IV rtPA can be initiated before availability of coagulation test results but should be discontinued if INR is >1.7 or PT is abnormally elevated by local laboratory standards.)
- Current use of direct thrombin inhibitors or direct factor Xa inhibitors with elevated sensitive laboratory tests (such as aPTT, INR, platelet count, and ECT; TT; or appropriate factor Xa activity assays)
- CT demonstrates multilobar infarction (hypodensity >1/3 cerebral hemisphere)

Relative Exclusion Criteria

Recent experience suggests that under some circumstances—with careful consideration and weighting of risk to benefit—patients may receive fibrinolytic therapy despite 1 or more relative contraindications. Consider risk to benefit of IV rtPA administration carefully if any of these relative contraindications are present:

- Only minor or rapidly improving stroke symptoms (clearing spontaneously)
- Seizure at onset with postictal residual neurological impairments
- Major surgery or serious trauma within previous 14 days
- Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)
- Pregnancy

To extend IV tPA to 4.5 hours from symptom onset/last known normal, the following additional criteria MUST be met:

- Patient is ≤80 years of age
- Patient does not have a history of both diabetes AND stroke
- Patient is not taking Warfarin (Coumadin) or any other anticoagulant regardless of INR/coagulation results
- NIHSS is ≤25
- Written informed consent obtained from patient and/or family - required when IV tPA given within the 3–4.5 hour window.

I have verified and documented the above mentioned checklist independently.

**ED Physician Signature:** ___________________________  **Date** _______ **Time** _______

*aPTT indicates activated partial thromboplastin time; CT, computed tomography; ECT, ecarin clotting time; FDA, Food and Drug Administration; INR, international normalized ratio; IV, intravenous; PT, partial thromboplastin time; rtPA, recombinant tissue plasminogen activator; and TT, thrombin time.*

*The checklist includes some FDA-approved indications and contraindications for administration of IV rtPA for acute ischemic stroke. Recent guideline revisions have modified the original FDA-approved indications. A physician with expertise in acute stroke care may modify this list.*