

Obj. 6 – Recognize stroke equivalents in determining possible PHI or differential dx of stroke.		
1. Which presentation should lead EMS to consider potential PHI of stroke? A. Falls w/ c/o dizziness B. Sudden onset of blindness C. Agitation w/ constricted pupils D. Unilat. facial droop w/ inability to wrinkle forehead	2. Which presentation should lead EMS to consider potential PHI of stroke? A. Left arm pain w/ SOB B. Generalized weakness C. Photophobia w/ nausea D. Fever accompanied by confusion	3. Which presentation should lead EMS to consider potential PHI of stroke? A. Sore throat B. New onset atrial fibrillation C. New Rt lateral vision field loss D. Unilat. facial paralysis, including forehead
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4. Which etiology should be assessed for, when considering PHI of stroke in a patient presenting with altered mental status? A. Acute MI B. Head trauma C. Hyperglycemia D. Atrial fibrillation	5. Which etiology should be assessed for, when considering PHI of stroke in a patient presenting with altered mental status? A. Hypoglycemia B. Migraine headache C. Cranial nerve dysfunction D. Evidence of recent cranial surgery	6. Which etiology should be assessed for, when considering PHI of stroke in a patient presenting with altered mental status? A. Acidosis B. Hypercarbia C. Infection/sepsis D. Stimulant overdose
Obj. 8 – Explain the importance of, and methods of obtaining, reporting and documenting an accurate time of symptom onset/last seen normal.		
7. The witness to the onset of a patient's stroke symptoms cannot accompany EMS to the hospital. Which action is indicated? A. Obtain witness's contact information B. Confirm witness' intent to drive there later C. Ensure that the patient can provide valid information D. Obtain all necessary information prior to leaving scene	8. A pt w/ stroke symptoms was last known to be w/o S&S at 1:00 PM. It is now 3:30 PM. How might EMS ascertain a specific time of symptom onset? A. Inquire about pre or post symptom cell phone use B. Ask the patient if they napped between 1300 and 1530 C. Use the time half way between last seen normal & time of contact D. Provide ED w/ relative's phone number who will be available in 2 hours	9. A pt awoke w/ left side paralysis after retiring symptom-free at 10:30 the night before. How might EMS ascertain a specific time of onset? A. Inquire about time of routine night time wakefulness B. Ask neighbors if they saw pt's lights on during the night C. Stress importance of identifying a specific time of onset & ask them to make their best guess D. Inquire whether pt was awake or up to use the bathroom/get a drink at any time during the sleep cycle
Obj. 9 – Appropriate execution of CSS		
10. EMS instructs a patient to lift both arms, palms up, in front of them and hold for 10 seconds. The patient does not do so. What action should EMS take prior to assuming the patient has no control over their arms? A. Repeat the command in a louder voice B. Administer a painful stimulus to each arm and observe for a response C. Raise pt's arms and observe for asymmetrical drift, weakness or flaccidity D. Offer the index & middle fingers of each hand, then ask the patient to squeeze them as hard as they can	11. EMS is unable to assess for facial asymmetry (smile) as the patient's jaws are clenched. What other request should EMS make to the patient to allow evaluation for facial droop/asymmetry? A. Close eyelids tightly B. Open mouth and say "ah" C. Have pt sip liquid through a straw and observe for dribbling from either side D. Observe for symmetrical eye motion as the pt follows EMS' finger as it is moved in an "H" pattern	12. When assessing for facial asymmetry, which finding is more likely indicative of stroke rather than Bell's Palsy? A. One-sided drooling B. Unilateral inability to blink C. Unilat. facial droop w/ <i>ability</i> to wrinkle both sides of the forehead D. Unilat. facial droop w/ <i>inability</i> to wrinkle the forehead on the affected side

Obj 10: Interpret CSS findings to differential normal vs. abnormal results		
<p>13. A patient has left sided weakness from an old stroke. There is no facial asymmetry or speech deficit. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>	<p>14. A patient is responsive to painful stimuli only, makes no verbalization, & does not respond to CSS assessment commands. A left facial droop is noted. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>	<p>15. EMS is caring for a pt who had a seizure. Speech is clear but confused, there is no arm drift, and a symmetrical grimace w/ eyes squeezed tightly closed is noted when a cheek laceration is dressed. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>
Obj. 11: Discriminate selected assessment findings appropriate to documentation of CSS findings "non-conclusive"		
<p>16. A patient is responsive to painful stimuli w/ grimace only, makes no sounds, does not move or respond to commands. There is no obvious facial asymmetry. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>	<p>17. A patient does not speak English and there is no interpreter available. The pt does not seem to understand EMS' instructions for CSS assessment. There is no obvious facial asymmetry and one arm is in a sling. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>	<p>18. A patient w/ AMS is agitated and uncooperative w/ EMS attempts at CSS exam. CSS is</p> <p>A. normal. B. abnormal. C. inconclusive.</p>
Obj. 13: List steps in accurate & complete documentation of CSS findings using Field Bridge software.		
<p>19. The CSS field is accessed in the VS section of</p> <p>A. "Activities" tab. B. "SAMPLE" tab. C. "At Scene" tab. D. "Narrative" tab.</p>	<p>20. The individual components of the CSS field is accessed in the</p> <p>A. "Activities" tab. B. "SAMPLE" tab. C. "At Scene" tab. D. "Narrative" tab.</p>	<p>21. "Onset Date & Time" and "Duration of CC" fields are both accessed in which tab?</p> <p>A. "Activities" tab B. "SAMPLE" tab C. "At Scene" tab D. "Narrative" tab</p>
Obj. 14: Sequence approp IMC per SOP & rationale for interventions.		
<p>22. A pt presents w/ slurred speech and Lt arm weakness 20 min. ago. VS are normal, BG 114, GCS 15. ECG monitor-NSR. Pt has no other complaints. A 12 Lead ECG should be</p> <p>A. done enroute. B. deferred to ED. C. done on scene. D. done as part of IMC.</p>	<p>23. A pt presents w/ slurred speech and Lt arm weakness 30 min. ago. VS are normal, BG 98, GCS 15. ECG-NSR. Pt has no other complaints. IV access should be</p> <p>A. deferred to the ED B. established enroute. C. established on scene. D. established as part of IMC.</p>	<p>24. A pt is found unconscious. Airway is clear & patent, RR 10-12/min., mildly labored. SpO2 92%. Gag reflex is absent. Lt sided facial droop is noted. How should EMS manage this pt's airway?</p> <p>A. ETI or King – this pt's GCS is <8 B. Monitor closely & apply supplemental O2 only SpO2 < 92% C. Assist ventilations w/ BVM following insertion of OPA / NPA D. Insert OPA/NPA and supplemental O2 prior to other advanced interventions</p>

Obj. P-1: Technically accurate neuro exam for a patient w/ possible stroke symptoms		
<p>25. A 69 y/o pt reports severe dizziness & difficulty keeping her balance since awakening this am. What assessment is indicated?</p> <p>A. Cerebellar exam B. Sensory exam (face, limbs) C. Visual acuity, pupil check, EOM's D. Assess uvula & tongue for deviation away from center</p>	<p>26. A pt presents w/ sudden onset of double vision 30 min. ago. What assessment is indicated?</p> <p>A. Sensory exam (face, limbs) B. Visual acuity, pupil check, EOM's C. Have the pt say ABC's backwards D. Assess uvula & tongue for deviation away from center</p>	<p>27. A pt presents w/ tingling sensation on the left side of the face and arm. What assessment is indicated?</p> <p>A. Cerebellar exam B. Sensory exam (face, limbs) C. Visual acuity, pupil check, EOM's D. Assess uvula & tongue for deviation away from center.</p>
Obj. P-1: Technically accurate neuro exam for a patient w/ possible stroke symptoms		
<p>28. Sensory exam for the pt experiencing stroke S&S in left arm is done by instructing the pt to close their eyes, then having them</p> <p>A. rate their sensation as their hand is touched, as none, decreased, altered, or painful. B. identify when they feel any kind of sensation when touch is administered the entire length of the arm, proximal to distal. C. identify "sharp" vs "dull" sensation on the top of each hand separately, then to sense touch on each hand separately as well as both at the same time.</p>	<p>29. Cerebellar exam of the upper extremities for the patient experiencing stroke S&S is done by instructing them to</p> <p>A. repeatedly & rapidly touch their nose, then examiner's finger tip. B. rapidly & repeatedly pronate & supinate both hands w/ arms extended & eyes closed. C. repeatedly & rapidly clap their upright left palm w/ your right, then their right palm w/ your left.</p>	<p>30. Field of vision assessment for the patient w/ suspected stroke is done by</p> <p>A. covering each eye, one at a time, to assess for resolution of double vision. B. introducing a varied number of fingers in all quadrants of the visual field, one eye at a time. C. having the patient follow your finger w/ their eyes only, as it is moved in an "H" pattern, w/o moving their head.</p>