

# VAN Stroke Scale Template

## Patient Information

- Name: \_\_\_\_\_
- Age: \_\_\_\_\_
- Gender: \_\_\_\_\_
- Date of Assessment: \_\_\_\_\_
- Time of Assessment: \_\_\_\_\_
- Medical Record Number: \_\_\_\_\_

## Preliminary Information

- Time of Symptom Onset: \_\_\_\_\_
- Current Medications:
  
- Relevant Medical History (including prior strokes/TIAs):

## Vitals and Initial Observations

- Blood Pressure: \_\_\_\_\_
- Heart Rate: \_\_\_\_\_
- Respiratory Rate: \_\_\_\_\_
- Temperature: \_\_\_\_\_
- Initial Observations/Concerns:

## Vision Assessment (V)

### Visual Field Testing:

- **Instructions:** Perform a confrontation visual field test. Ask the patient to cover one eye and fixate on your nose. Wiggle your fingers in each quadrant of their visual field and ask them to tell you when they see the movement.

- **Right Eye:**

- Full Field
- Partial Hemianopia

- Complete Hemianopia
- Quadrantanopia
- **Left Eye:**
- Full Field
- Partial Hemianopia
- Complete Hemianopia
- Quadrantanopia

## Aphasia Assessment (A)

### Language and Speech Evaluation:

- **Instructions:** Evaluate both expressive and receptive language abilities. Ask the patient to name objects, follow commands, and engage in conversation.
- **Expressive Aphasia:**
- Absent
- Mild
- Moderate
- Severe
- **Receptive Aphasia:**
- Absent
- Mild
- Moderate
- Severe
- **Repetition:**
- Intact
- Impaired

## Neglect Assessment (N)

### Neglect and Spatial Attention Evaluation:

- **Instructions:** Conduct tests like line bisection, figure copying, and asking the patient to attend to stimuli on both sides.
- **Bilateral Simultaneous Stimulation:**
- Normal Response
- Extinction or Neglect
- **Observation of Spontaneous Activities:**

- Symmetrical Use of Limbs
- Ignoring One Side

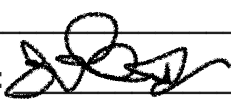
### **Additional Neurological Examination**

- **Motor Function:**
  
  
  
  
  
  
  
  
  
  
- **Sensory Function:**
  
  
  
  
  
  
  
  
  
  
- **Cranial Nerve Examination:**

### **Overall VAN Assessment and Plan**

- **VAN Score Interpretation:**
  - Low Probability of LVO
  - Moderate Probability of LVO
  - High Probability of LVO
- **Recommended Actions/Interventions:**
  
  
  
  
  
  
  
  
  
  
- **Referral to Stroke Team/Neurology:**

### **Examiner's Information**

- **Name:** \_\_\_\_\_
- **Title:** \_\_\_\_\_
- **Signature:**  \_\_\_\_\_
- **Date:** \_\_\_\_\_

### **Additional Notes:**