

VAN Stroke Scale

Patient's name:		Age:		Gender:	
Record number:		Assessment date:		Time:	
Preliminary information		Vitals and initial observations			
Time of symptom onset:		Blood pressure:		Heart rate:	
Current medication:		Respiratory rate:		Temperature:	
Relevant medical history (including prior strokes/TIAs):		Initial observations/concerns:			
Vision assessment		Aphasia assessment		Neglect assessment	
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.		Evaluate both expressive and receptive language abilities. Ask the patient to name objects, follow commands, and engage in conversation.		Conduct tests like line bisection, figure copying, and asking the patient to attend to stimuli on both sides.	
Left eye:	Right eye:	Expressive aphasia:	Receptive aphasia:	Bilateral simultaneous stimulation:	
<input type="checkbox"/> Full field <input type="checkbox"/> Partial hemianopia <input type="checkbox"/> Complete hemianopia <input type="checkbox"/> Quadrantanopia	<input type="checkbox"/> Full field <input type="checkbox"/> Partial hemianopia <input type="checkbox"/> Complete hemianopia <input type="checkbox"/> Quadrantanopia	<input type="checkbox"/> Absent <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Absent <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Normal response <input type="checkbox"/> Extinction or neglect	
		Repetition: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired		Observation of spontaneous activities:	
				<input type="checkbox"/> Symmetrical use of limbs <input type="checkbox"/> Ignoring one side	

Additional neurological examination		
Motor function:	Sensory function:	Cranial nerve examination:
Overall VAN assessment and plan		
<input type="checkbox"/> Low probability of LVO <input type="checkbox"/> Moderate probability of LVO <input type="checkbox"/> High probability of LVO		
Recommended actions/interventions:		
Additional notes:		
Examiner name:	Title:	
Signature:	Date:	