

VAN ASSESSMENT

VAN is an acute stroke screening tool designed to identify emergent large vessel occlusions by assessing **V**ision, **A**phasia, and **N**eglect.

STEP 1—Assess for arm weakness by having patient close eyes and holding arms straight out for 10 seconds.

Is arm weakness (mild drift, severe weakness or paralysis) present?

If no, the patient is VAN negative and the VAN assessment should be stopped.

If yes, continue with the VAN assessment

**Exceptions are confused or comatose patients with dizziness, focal findings or no reason for their altered mental status, then basilar artery thrombus must be considered.*

STEP 2—Assess **V**ision, **A**phasia, and **N**eglect

	Assessment	Positive Findings
Visual Disturbance	Have patient look at your nose and assess patient's peripheral vision by testing four visual fields (right upper, right lower, left upper, left lower and having the patient identify the number of fingers you are holding up in each quadrant.	• Double vision • Uneven eyes • Field cut • New onset blindness
Aphasia	Assess the patient's ability to understand, ability to produce speech and ability to repeat. • Have patient name two objects i.e. pen, watch • Have patient repeat "today's a sunny day" • Have patient follow two commands i.e. close your eyes/open your eyes, make a fist/open	• Expressive aphasia • Inability to name objects or repeat • Inability to follow simple commands <i>*Slurred speech is NOT a positive finding.</i>
Neglect	Look at the patient and determine if the patient's eyes are forced to right or left. • Ask the patient to identify if you are touching their right arm, left arm or both then conduct assessment including combination of all 3.	• Forced gaze or inability to track to one side • Unable to feel both sides at the same time or unable to identify which arm is being touched • Ignoring one side

Patients are considered VAN positive if they have weakness and any positive finding above.