Updated April 2020

| **Patient ID:** | | **Bold Question = Required** |
|---|---|---|

## DEMOGRAPHICS *Demographics Tab*

| | | | |
|---|---|---|---|
| **Gender** | ○ Male | ○ Female | ○ Unknown |
| **Date of Birth:** _____/_____/_____ | | **Age:** | _____ |
| Zip Code: _____ - _____ | ☐ Homeless | | |

| | | | |
|---|---|---|---|
| Payment Source | ☐ Medicare Title 18 | ☐ Medicaid Title 19 | ☐ Medicare – Private/ HMO/ PPO/ Other |
| | ☐ Medicaid – Private/ HMO/ PPO/ Other | ☐ Private/ HMO/ PPO/ Other | ☐ VA/ CHAMPVA/ Tricare |
| | ☐ Self Pay/ No Insurance | ☐ Other/ Not Documented/ UTD | |

## RACE AND ETHNICITY

**Race (Select all that apply):**

- ☐ American Indian/Alaska Native
- ☐ Asian
  - [if Asian selected]
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
  - [if native Hawaiian or pacific islander selected]
  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ UTD

| | | | |
|---|---|---|---|
| **Hispanic Ethnicity:** | ○ Yes | ○ No/UTD | |
| If Yes, | ☐ Mexican, Mexican American, Chicano/a | ☐ Puerto Rican | ☐ Cuban |
| | ☐ Another Hispanic, Latino or Spanish Origin | | |

## ADMIN *Admin Tab*

| | | |
|---|---|---|
| **Final clinical diagnosis related to stroke** | ○ Ischemic Stroke | ○ Intracerebral Hemorrhage |
| | ○ Transient Ischemic Attack (<24 hours) | ○ Stroke not otherwise specified |
| | ○ Subarachnoid Hemorrhage | ○ No stroke related diagnosis |
| | | ○ Elective Carotid Intervention only |
| If not Stroke Related Diagnosis: | ○ Migraine | ○ Electrolyte or metabolic imbalance |
| | ○ Seizure | ○ Functional disorder |
| | ○ Delirium | ○ Other |
| | | ○ Uncertain |

| | | |
|---|---|---|
| Was the Stroke etiology documented in the patient medical record: | ○ Yes | No |

Select documented stroke etiology (select all that apply**):**

- ○ 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis)
- ○ 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI)
- ○ 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm)
- ○ 4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders.
  - ○ Dissection
  - ○ Hypercoagulability
  - ○ Other
- ○ 5: Cryptogenic stroke (stroke of undetermined etiology)
  - ○ Multiple potential etiologies identified
  - ○ Stroke of undetermined etiology
  - ○ Unspecified

| | | | | |
|---|---|---|---|---|
| **When is the earliest documentation of comfort measures only?** | ○Day 0 or 1 | ○Day 2 or after | ○Timing unclear | ○Not Documented/UTD |

| | | | | |
|---|---|---|---|---|
| **Arrival Date/Time:** | ____/_____/_____:____ | ☐ MM/DD/YYYY only<br>☐ Unknown | **Admit Date:** | _____/_____/_____ |

| | | | |
|---|---|---|---|
| Not Admitted: | ○ Yes, not admitted<br>○ No, patient admitted as in patient | Reason Not Admitted: | ○ Transferred from your ED to another acute care hospital<br>○ Discharged directly from ED to home or other location that is not an acute care hospital<br>○ Left from ED AMA<br>○ Died in ED<br>○ Discharged from observation status without an inpatient admission<br>○ other |

| | |
|---|---|
| If patient transferred from your ED to another hospital, specify hospital name | [Select hospital name from picker list]<br>☐ Hospital not on list<br>☐ Hospital not documented |
| Select reason(s) for why patient transferred | ☐ Evaluation for IV alteplase up to 4.5 hours<br>☐ Post Management of IV alteplase (e.g. Drip and Ship)<br>☐ Evaluation for Endovascular thrombectomy<br>☐ Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy)<br>☐ Patient/family request<br>☐ Other advanced care (not stroke related)<br>☐ Not documented |
| **Discharge Date:** | ____/_____/_____:____ ☐ MM/DD/YYYY only |
| Documented reason for delay in transfer to referral facility? | ○ Yes ○ No/ND |
| Specific reason for delay documented in transfer patient (check all that apply): | ☐ Social/religious<br>☐ Initial refusal<br>☐ Care team unable to determine eligibility<br>☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation)<br>☐ Investigational or experimental protocol for reperfusion<br>☐ Delay in stroke diagnosis *<br>☐ In-hospital time delay *<br>☐ Equipment-related delay *<br>☐ Need for additional imaging*<br>☐ Catheter lab not available*<br>☐ Other * |
| **For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?** | ☐ 1 – Home<br>☐ 2 – Hospice – Home<br>☐ 3 – Hospice – Health Care Facility<br>☐ 4 – Acute Care Facility<br>☐ 5 – Other Health Care Facility<br>☐ 6 – Expired<br>☐ 7 – Left Against medical Advise / AMA<br>☐ 8 – Not Documented or Unable to Determine (UTD) |
| **If Other Health Care Facility** | ○ Inpatient Rehabilitation Facility (IRF)<br>○ Intermediate Care facility (ICF)<br>○ Long Term Care Hospital (LTCH)<br>○ Skilled Nursing Facility (SNF)<br>○ Other |

**DIAGNOSIS CODE** ***Clinical Codes Tab***

| | |
|---|---|
| ICD-9CM or ICD-10-CM Principal Diagnosis Code<br>ICD-9CM or ICD-10-CM Other Diagnosis Codes | _____ |
| ICD-9-CM or ICD-10-PCS Principal Procedure Code<br>ICD-9-CM or ICD-10-PCS Other Procedure Codes | _____ |
| ICD-9-CM Discharge Diagnosis Related to Stroke<br>ICD-10-CM Discharge Diagnosis Related to Stroke | _____ |
| No Stroke or TIA Related ICD-9-CM Code Present<br>No Stroke or TIA Related ICD-10-CM Code Present | ☐<br>☐ |

## ARRIVAL AND ADMISSION INFORMATION — *Admission Tab*

| | |
|---|---|
| **During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. STK,VTE)?** | ○ Yes ○ No |
| **Was this patient admitted for the sole purpose of performance of elective carotid intervention?** | ○ Yes ○ No |

**Patient location when stroke symptoms discovered**

- ○ Not in a healthcare setting
- ○ Another acute care facility
- ○ Chronic health care facility
- ○ Outpatient healthcare setting
- ○ Stroke occurred after hospital arrival (in ED/Obs/inpatient)
- ○ ND or Cannot be determined

**How patient arrived at your hospital**

○ EMS from home/scene ○ Mobile Stroke Unit ○ Private Transportation/Taxi/Other from home/scene ○ Transfer from another hospital ○ ND or Unknown

Referring hospital discharge Date/ Time: ____/_____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown

If transferred from another hospital, specify hospital name

[Select hospital name from picker list]
- ☐ Hospital not on list
- ☐ Hospital not documented

Referring hospital arrival date/ time: ____/_____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown

If patient transferred to your hospital, select transfer reason(s)

- ☐ Evaluation for IV alteplase up to 4.5 hours
- ☐ Post Management of IV alteplase (e.g. Drip and Ship)
- ☐ Evaluation for Endovascular thrombectomy
- ☐ Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy)
- ☐ Patient/family request
- ☐ Other advanced care (not stroke related)
- ☐ Not documented

Where patient first received care at your hospital: ☐ Emergency Department / Urgent Care ☐ Direct Admit, not through ED ☐ Imaging suite ☐ ND or Cannot be determined

**Advanced Notification by EMS or MSU?** ○ Yes ○ No/ND

Where was the patient cared for and by whom? Check all that apply.

- ☐ Neuro Admit
- ☐ Stroke Consult
- ☐ In Stroke Unit
- ☐ Other Service Admission
- ☐ No Stroke Consult
- ☐ Not in Stroke Unit

Physician / Provider NPI:

## MEDICAL HISTORY

**Previously known medical hx of:**

- ☐ None
- ☐ Atrial Fib/Flutter
- ☐ Current Pregnancy (up to 6 weeks post-partum)
- ☐ Diabetes Mellitus
  - ○ Type I
  - ○ Type II
  - ○ ND

  Duration:
- ☐ CAD/ Prior MI
- ☐ DVT/ PE
- ☐ Drugs/ Alcohol Abuse
- ☐ Familial Hypercholesterolemia
- ☐ HRT
- ☐ Obesity/ Overweight
- ☐ Prosthetic Heart Valve
- ☐ Sickle Cell
- ☐ Carotid Stenosis
- ☐ Depression
- ☐ Dyslipidemia
- ☐ Family History of Stroke
- ☐ Hypertension
- ☐ Previous Stroke
  - ☐ Ischemic Stroke

| | |
|---|---|
| | ○ < 5 years<br>○ 5 - < 10 years<br>○ 10 - < 20 years<br>○ >= 20 years<br>○ Unknown<br>☐ E-Cigarette Use (Vaping)<br>☐ HF<br>☐ Migraine<br>☐ Previous TIA<br>☐ Renal Insufficiency – Chronic<br>☐ Smoker<br>☐ ICH<br>☐ SAH<br>☐ Not Specified<br>☐ PVD<br>☐ Sleep Apnea |
| Ambulatory status prior to current event | ○ Able to ambulate independently (no help from another person) w/ or w/o device<br>○ With assistance (from person)<br>○ Unable to ambulate<br>○ ND |

**DIAGNOSIS & EVALUATION**

| | |
|---|---|
| Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours) | ○ Less than 10 minutes ○ 10 – 59 minutes ○ > = 60 minutes ○ ND |
| Had stroke symptoms resolved at time of presentation? | ○ Yes ○ No ○ ND |
| **Initial NIH Stroke Scale** | ○ Yes ○ No/ND |
| If yes: | ○ Actual ○ Estimate from record ○ ND |
| **Total Score:** | _____ (refer to web program for questions) |
| NIHSS score obtained from transferring facility: | _____ ○ ND |
| Initial exam findings (Select all that apply) | ☐ Weakness/Paresis ☐ Altered Level of Consciousness ☐ Disturbance Aphasia/Language<br>☐ Other neurological signs/symptoms ☐ No neurological signs/symptoms ☐ND |
| Ambulatory status on admission | ○ Able to ambulate independently (no help from another person) w/ or w/o device<br>○ With assistance (from person)<br>○ Unable to ambulate<br>○ ND |

**MEDICATION PRIOR TO ADMISSION**

| | |
|---|---|
| No medications prior to admission | ☐ |
| **Antiplatelet or Anticoagulant Medication(s):** | ☐ Yes ☐ No/ND |
| ☐ **Antiplatelet Medication**<br>○ aspirin<br>○ aspirin/dipyridamole (Aggrenox)<br>○ clopidogrel (Plavix)<br>○ prasugrel (Effient)<br>○ ticagrelor (Brilinta)<br>○ ticlopidine (Ticlid)<br>○ Other Antiplatelet | ☐ **Anticoagulant Medication**<br>○ apixaban (Eliquis)<br>○ argatroban<br>○ dabigatran (Pradaxa)<br>○ desirudin (Iprivask)<br>○ endoxaban (Savaysa)<br>○ fondaparinux (Arixtra)<br>○ full dose LMW heparin<br>○ lepirudin (Refludan)<br>○ rivaroxaban (Xarelto)<br>○ unfractionated heparin IV<br>○ warfarin (Coumadin)<br>○ other Anticoagulant |
| Antihypertensive | ○ Yes ○ No/ND |
| **Cholesterol-Reducer** | ○ Yes ○ No/ND |
| **Anti-hyperglycemic medications:** | ○ Yes ○ No/ND |
| If yes, select medications (select all that apply) | ☐ DPP-4 Inhibitors ☐ SGLT2 inhibitor ☐ Other injectable/ subcutaneous agent ☐ GLP-1 receptor agonist ☐ Sulfonylurea ☐ Insulin ☐ Thiazolidinedione ☐ Metformin ☐ Other oral agent |

| | |
|---|---|
| Antidepressant medication | ○ Yes ○ No/ND |

**SYMPTOM TIMELINE** *Hospitalization Tab*

| Date/Time Patient last known to be well? | | Date/Time of discovery of stroke symptoms? |
|---|---|---|
| ____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown | ☐ Time of Discovery same as Last Known well | ____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown |
| Comments: | | |

**BRAIN IMAGING**

| | | | |
|---|---|---|---|
| **Brain imaging completed at your hospital for this episode of care?** | ○ Yes ☐ CT ☐ MRI ○ No/ND ○ NC | **Date/Time Brain Imaging First Initiated at your hospital:** | ____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown |

| | | | |
|---|---|---|---|
| Interpretation of first brain image after symptom onset, done at any facility: | ○ Acute Hemorrhage ○ No Acute Hemorrhage ○ Not Available | | |
| Was acute Vascular or perfusion imaging (e.g. CTA, MRA, DSA) performed at your hospital? | ○ Yes ○ No | Date/Time 1st vessel or perfusion imaging initiated at your hospital: ___/____/_____:____ | ☐ MM/DD/YYYY only ☐ Unknown |
| If yes, type of vascular imaging (select all that apply) | ☐ CTA ☐ CT Perfusion ☐ MRA ☐ MR Perfusion ☐ DSA (catheter angiography) ☐ Image type not documented | | |
| Was a target lesion (large vessel occlusion) visualized? | ○ Yes ○ No/ND | | |
| If yes, select site of large vessel occlusion (select al that apply): | ☐ ICA ☐ Intracranial ICA ☐ Cervical ICA ☐ Other/UTD ☐ MCA ☐ M1 ☐ M2 ☐ Other/UTD ☐ Basilar ☐ Other cerebral artery branch ☐ Vertebral Artery | | |

**ADDITIONAL TIME TRACKER**

| | | | |
|---|---|---|---|
| Date/Time Stroke Team Activated: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A | Date/Time Stroke Team Arrived: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown |
| Date/Time of ED Physician Assessment: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A | Date/Time Neurosurgical services consult: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown |
| Date/Time Brain Imaging Ordered: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A | Date/Time Brain Imaging Interpreted: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown |
| Date/Time IV alteplase Ordered: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A | | |
| Date/Time Lab Tests Ordered: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown N/A | Date/Time lab Tests Completed: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown |
| Date/Time ECG Ordered: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A | Date/Time ECG Completed: ____/____/_____ ____:_____ | Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown |

| | | | |
|---|---|---|---|
| Date/Time Chest X-ray Ordered:<br>____/____/_____ ____:_____ | Select one option<br>O MM/DD/YYYY HH:MM<br>O MM/DD/YYYY<br>O Unknown<br>O N/A | Date/Time Chest X-ray Completed:<br>____/____/_____ ____:_____ | Select one option<br>O MM/DD/YYYY HH:MM<br>O MM/DD/YYYY<br>O Unknown |
| Additional Comments: | | | |

**IV THROMBOLYTIC THERAPY**

| | | | |
|---|---|---|---|
| **IV alteplase initiated at this hospital?** | O Yes O No | **Date/Time IV alteplase initiated:** | **____/____/_____ ____:_____** |
| **Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?** | | | O Yes O No |
| Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window? | | | O Yes O No |

***SHOW ALL***

***If yes, documented exclusions for 0 -3-hour treatment window or 3 – 4.5 treatment window, select reason for exclusion.***

For discharges on or after 1 April 2016

*Exclusion Criteria (contraindications) 0-3 hr treatment window. Select all that apply:*

- ☐ *C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment*
- ☐ *C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months*
- ☐ *C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm*
- ☐ *C4: Active internal bleeding*
- ☐ *C5: Acute bleeding diathesis (low platelet count, increased PTT, INR >= 1.7 or use of NOAC)*
- ☐ *C6: Symptoms suggest subarachnoid hemorrhage*
- ☐ *C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere)*
- ☐ *C8: Arterial puncture at non-compressible site in previous 7 days*
- ☐ *C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L)*

*Relative Exclusion Criteria (Warnings) 0-3 hr treatment window. Select all that apply:*

- ☐ *W1: Care-team unable to determine eligibility*
- ☐ *W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival*
- ☐ *W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission*
- ☐ *W4: Pregnancy*
- ☐ *W5: Patient/family refusal*
- ☐ *W7: Stroke severity too mild (non-disabling)*
- ☐ *W8: Recent acute myocardial infarction (within previous 3 months)*
- ☐ *W9: Seizure at onset with postictal residual neurological impairments*
- ☐ *W10: Major surgery or serious trauma within previous 14 days*
- ☐ *W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)*

*Exclusion Criteria (contraindications) 3-4.5 hr treatment window. Select all that apply:*

- ☐ *C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment*
- ☐ *C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months*
- ☐ *C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm*
- ☐ *C4: Active internal bleeding*
- ☐ *C5: Acute bleeding diathesis (low platelet count, increased PTT, INR ≥ 1.7 or use of NOAC)*
- ☐ *C6: Symptoms suggest subarachnoid hemorrhage*
- ☐ *C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere)*
- ☐ *C8: Arterial puncture at non-compressible site in previous 7 days*
- ☐ *C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L*

*Relative Exclusion Criteria (Warnings) 3-4.5 hr treatment window. Select all that apply:*

- ☐ *W1: Care-team unable to determine eligibility*

☐ *W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival*
☐ *W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission*
☐ *W4: Pregnancy*
☐ *W5: Patient/family refusal*
☐ *W7: Stroke severity too mild (non-disabling)*
☐ *W8: Recent acute myocardial infarction (within previous 3 months)*
☐ *W9: Seizure at onset with postictal residual neurological impairments*
☐ *W10: Major surgery or serious trauma within previous 14 days*
☐ *W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)*

*Additional Relative Exclusion Criteria 3-4.5 hr treatment window. Select all that apply:*

☐ *AW1: Age > 80*
☐ *AW2: History of both diabetes and prior ischemic stroke*
☐ *AW3: Taking an oral anticoagulant regardless of INR*
☐ *AW4: Severe Stroke (NIHSS > 25)*

*Other Reasons (Hospital-related or other factors) 0-3-hour treatment window.*

☐ *Delay in Patient Arrival*
☐ *In-hospital Time Delay*
☐ *Delay in Stroke diagnosis*
☐ *No IV access*
☐ *Rapid or Early Improvement*
☐ *Advanced Age*
☐ *Stroke too severe*
☐ *Other – requires specific reason to be entered in the PMT when this option is selected.*

*Other Reasons (Hospital-related or other factors) 3-4.5-hour treatment window.*

☐ *Delay in Patient Arrival*
☐ *In-hospital Time Delay*
☐ *Delay in Stroke diagnosis*
☐ *No IV access*
☐ *Rapid or Early Improvement*
☐ *Other – requires specific reason to be entered in the PMT when this option is selected*

| | |
|---|---|
| **If IV alteplase was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:** | ○ Yes ○ No |
| **If IV alteplase was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:** | ○ Yes ○ No |
| **If IV alteplase was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:** | ○ Yes ○ No |
| Eligibility Reason(s): | ☐ Social/Religious<br>☐ Initial refusal<br>☐ Care-team unable to determine eligibility<br>☐ Specify eligibility reason:_____ |
| Medical Reason(s): | ☐ Hypertension requiring aggressive control with IV medications<br>☐ Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 50), seizures, or major metabolic disorders<br>☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation)<br>☐ Investigational or experimental protocol for thrombolysis<br>☐ Need for additional PPE for suspected/ confirmed infectious disease<br>☐ Specify medical reason: _____ |
| Hospital Related or Other Reason(s): | ☐ Delay in stroke diagnosis<br>☐ In-hospital time delay<br>☐ Equipment-related delay<br>☐ Other _____ |
| **IV alteplase at an outside hospital or Mobile Stroke Unit?** | ○ Yes ○ No |

| | |
|---|---|
| Investigational or experimental protocol for thrombolysis? | ○ Yes ○ No If yes, specify_____ |
| Additional Comments Related to Thrombolytics: | |

**ENDOVASCULAR THERAPY**

| | | |
|---|---|---|
| Catheter-based stroke treatment at this hospital? | ○ Yes ○ No | |
| IA alteplase or MER Initiation Date/Time | ____/____/_____ ____:_____ | ○ MM/DD/YYYY only ○ Unknown |
| Catheter-based stroke treatment at outside hospital? | ○ Yes ○ No | |

*Note, if your hospital is collecting data for the Comprehensive Stroke Center and/or Mechanical Endovascular Reperfusion measure set, please ensure you complete additional data entry on the Advanced Stroke Care.*

**COMPLICATIONS**

| | | |
|---|---|---|
| **Complications of Reperfusion Therapy (Thrombolytic or MER)** | ☐ Symptomatic Intracranial hemorrhage <36 hours<br>☐ Life threatening, serious systemic hemorrhage <36 hours<br>☐ UTD | ☐ Other serious complications<br>☐ No serious complications |
| **If bleeding complications occur in patient after IV alteplase:** | ○ Symptomatic hemorrhage detected prior to patient transfer<br>○ Symptomatic hemorrhage detected only after patient transfer | ○ Unable to determine<br>○ N/A |

**OTHER IN-HOSPITAL TREATMENT AND SCREENING**

**Dysphagia Screening**

| | | | |
|---|---|---|---|
| **Patient NPO throughout the entire hospital stay?** | ○ Yes | ○ No/ND | |
| **Was patient screened for dysphagia prior to any oral intake including water or medications?** | ○ Yes | ○ No/ND | ○ NC |
| If yes, Dysphagia screening results: | ○ Pass | ○ Fail | ○ ND |
| Treatment for Hospital-Acquired Pneumonia | ○ Yes | ○ No | ○ NC |

| | | |
|---|---|---|
| **VTE Interventions** | ☐ 1- Low dose unfractionated heparin (LDUH)<br>☐ 2- Low molecular weight heparin (LMWH)<br>☐ 3- Intermittent pneumatic compression devices (IPC)<br>☐ 4- Graduated compression stockings (GCS)<br>☐ 5- Factor Xa Inhibitor<br>☐ 6- Warfarin | ☐ 7- Venous foot pumps (VFP)<br>☐ 8-Oral Factor Xa Inhibator<br>☐ 9- Aspirin<br>☐ A- None of the above or ND |

| | | |
|---|---|---|
| What date was the initial VTE prophylaxis administered after hospital admission? | _____/_____/_____ | ☐ Unknown |
| Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission? | ○ Yes | ○ No |
| For discharges on or after 01/01/2013: Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis? | ○ Yes | ○ No |

| | | | |
|---|---|---|---|
| Other Therapeutic Anticoagulation | ☐ apixaban (Eliquis)<br>☐ argatroba<br>☐ dabigatran (Pradaxa) | ☐ desirrudin (Iprivask)<br>☐ endoxaban (Savaysa)<br>☐ lepirudin (Refludan) | ☐ rivaroxaban (Xaralto)<br>☐ unfractionated heparin IV<br>☐ other anticoagulant |

| | | | |
|---|---|---|---|
| Was DVT or PE documented? | ○ Yes | ○ No/ND | |
| Was antithrombotic therapy administered by the end of hospital day 2? | ○ Yes | ○ No/ND | ○ NC |
| If yes, select all that apply | ☐ Antiplatelet | ☐ Anticoagulant | |

| | | | |
|---|---|---|---|
| **Active bacterial or viral infection at admission or during hospitalization:** | ☐ Seasonal cold or flu<br>☐ Emerging Infectious Disease<br>☐ SARS-COV-1<br>☐ SARS-COV-2 (COVID-19)<br>☐ MERS<br>☐ Other Infectious Respiratory Pathogen | ☐ Bacterial Infection | ☐ None/ ND |

| MEASUREMENTS (first measurement upon presentation to your hospital) | | | | |
|---|---|---|---|---|
| Total Chol: _____ mg/dl | Triglycerides: _____ mg/dl | HDL: _____ mg/dl | **LDL: _____ mg/dl** | ☐ Lipids: NC<br>☐ Lipids: ND |
| $A_1C$: _____ % $A_1C$<br>☐ ND | Blood Glucose (required if patient received IV alteplase): _____ mg/dl | ☐ ND<br>☐ Too Low<br>☐ Too High | | |
| Serum Creatine: _____ ☐ ND | | | | |
| INR: _____ ☐ ND ☐ NC | | | | |
| Vital Signs: | Heart Rate (beats per minute): _____ bpm<br>^What is the first blood pressure obtained prior to or after hospital arrival? (required if patient received IV alteplase) _____/_____<br>☐ Vital signs UTD | | | |
| **Height: _____** | ○in ○cm ○ND | | | |
| **Weight: _____** | ○lbs ○kg ○ND | | | |
| Waist Circumference: _____ | ○in ○cm ○ND | | | |
| **BMI: _____** ☐ ND | | | | |

| DISCHARGE INFORMATION | *Discharge Tab* |
|---|---|
| GWTG Ischemic Stroke-Only Estimated Mortality Rate | [Calculated in the PMT] |
| GWTG Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke NOS) | [Calculated in the PMT] |
| **Modified Rankin Scale at Discharge** | ○Yes ○No/ND |
| If Yes: | ○Actual ○Estimated from record ○ND |
| **Total Score:** | _____ |
| Ambulatory status at discharge | ○ Able to ambulate independently (no help from another person) w/ or w/o device<br>○ With assistance (from person)<br>○ Unable to ambulate<br>○ ND |
| Discharge Blood Pressure (Measurement closest to discharge) | _____/_____ mmHg (Systolic/Diastolic) ☐ND |

**DISCHARGE TREATMENTS**

| | | | | |
|---|---|---|---|---|
| Antithrombotic Therapy approved in stroke | Prescribed? ○Yes ○No/ND ○NC | | | |
| | If yes, | | | |
| | ☐ Antiplatelet | ☐ Anticoagulant | | |
| | ○ aspirin<br>○ aspirin/dipyridamole (Aggrenox)<br>○ clopidogrel (Plavix)<br>○ ticlopidine (Ticlid) | ○ apixaban (Eliquis)<br>○ argatroban<br>○ dabigatran (Pradaxa)<br>○ endoxaban (Savaysa)<br>○ fondaparinux (Arixtra) | ○ full dose LMW heparin<br>○ lepirudin (Refludan)<br>○ rivaroxaban (Xarelto)<br>○ Unfractionated heparin IV<br>○ warfarin (Coumadin) | |
| | Dosage<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Frequency<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Dosage<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Frequency<br>1. _____<br>2. _____<br>3. _____<br>4. _____ |

| | | |
|---|---|---|
| | If NC, documented contraindications | ☐ Allergy to or complications r/t antithrombotic<br>☐ Patient/Family refused<br>☐ Risk for bleeding or discontinued due to bleeding<br>☐ Serious side effect to medication<br>☐ Terminal illness/Comfort Measures Only<br>☐ Other |
| Other Antithrombotic(s) | Prescribed? | ○ Yes ○ No |
| | If yes, | |

| | | |
|---|---|---|
| | Medication:<br>☐ Desirudin (Iprivask)<br>☐ Ticagrelor (Brilinta)<br>☐ Prasugrel (Effient) *contraindicated in stroke and TIA<br>☐ Other | Dosage<br>1. _____<br>2. _____<br>3. _____<br>4. _____<br>Frequency<br>1. _____<br>2. _____<br>3. _____<br>4. _____ |

| | |
|---|---|
| **Persistent or Paroxysmal Atrial Fibrillation/Flutter** | ○ Yes ○ No |
| **If atrial fib/flutter or history of PAF documented, was patient discharged on anticoagulation?** | ○ Yes ○ No/ND ○ NC |
| If NC, documented reasons for no anticoagulation | ☐ Allergy to or complication r/t warfarin or heparins<br>☐ Mental status<br>☐ Patient refused<br>☐ Risk for bleeding or discontinued due to bleeding<br>☐ Risk for falls<br>☐ Serious side effect to medication<br>☐ Terminal illness/Comfort Measures Only |
| Anti-hypertensive Tx (Select all that apply) | ☐ None prescribed/ND<br>☐ Other anti-hypertensive med<br>☐ Ace Inhibitors<br>☐ Beta Blockers<br>☐ None - Contraindicated<br>☐ Diuretics<br>☐ ARB<br>☐ CA++ Channel Blockers |
| **Cholesterol-Reducing Tx (Select all that apply)** | ☐ None prescribed/ND<br>☐ None – contraindicated<br>☐ Statin<br>☐ Fibrate<br>☐ Niacin<br>☐ Absorption Inhibitor<br>☐ PCSK 9 inhibitor<br>☐ Other med |

| | | | |
|---|---|---|---|
| **Statin Medication:** | ☐ Amlodipine + Atorvastatin (Caduet)<br>☐ Atorvastatin (Lipitor)<br>☐ Ezetimibe + Simvastatin (Vytorin)<br>☐ Fluvastatin (Lescol)<br>☐ Fluvastatin XL (Lescol XL)<br>☐ Lovastatin (Altoprev)<br>☐ Lovastatin (Mevacor)<br>☐ Lovastatin + Niacin (Advicor)<br>☐ Pitavastatin (Livalo)<br>☐ Pravastatin (Pravachol)<br>☐ Rosuvastatin (Crestor)<br>☐ Simvastatin ( Zocor)<br>☐ Simvastatin + Niacin (Simcor) | **Statin Total Daily Dose:** | _____ |

| | |
|---|---|
| **Documented Reason for Not Prescribing Guideline Recommended Dose?** | ☐ Intolerant to moderate (>75yr) or high (<=75yr) intensity statin<br>☐ No evidence of atherosclerosis (cerebral, coronary, or peripheral vascular disease)<br>☐ Other documented reason<br>☐ Unknown/ND |
| **Documented reason for not prescribing a statin medication at discharge?** | ○ Yes ○ No |
| **New Diagnosis of Diabetes?** | ○ Yes ○ No ○ ND |
| Basis for Diagnosis (Select all that apply) | ☐ HbA1c<br>☐ Oral Glucose Tolerance<br>☐ Fasting Blood Sugar<br>☐ Test Other |

| | | | |
|---|---|---|---|
| **Anti-hyperglycemic medications:** | **Prescribed?** | ○ Yes ○ No ○ NC | |
| | If yes, | Class: | Medication: |
| | | Class: | Medication: |

| | | | |
|---|---|---|---|
| | | Class: | Medication: |
| | | Class: | Medication: |
| | Was there a documented reason for not prescribing a medication with proven CVD benefit? | ○ Yes ○ No/ND | |
| **Follow-up appointment scheduled for diabetes management?** | ○ Yes ○ No/ND ○ NC | | |
| **Date of scheduled diabetes follow-up appointment:** | _____/_____/_____ ○ Unknown | | |

| | |
|---|---|
| **Anti-Smoking Tx** | ○ Yes ○ No/ND ○ NC |
| Smoking Cessation Therapies Prescribed (select all that apply | ☐ Counseling<br>☐ Over the Counter Nicotine Replacement Therapy<br>☐ Prescription Medications<br>☐ Other<br>☐ Treatment not specified |
| Was the patient prescribed any antidepressant class of medication at discharge? | ○ Yes, SSRI ○ Yes, any other antidepressant class ○ No/ND |

**OTHER LIFESTYLE INTERVENTIONS**

| | |
|---|---|
| **Reducing weight and/or increasing activity recommendations** | ○ Yes ○ No/ND ○ NC |
| **TLC Diet or Equivalent** | ○ Yes ○ No/ND ○ NC |
| Antihypertensive Diet | ○ Yes ○ No/ND ○ NC |
| Was Diabetic Teaching Provided? | ○ Yes ○ No/ND ○ NC |

**STROKE EDUCATION**

**Patient and/or caregiver received education and/or resource materials regarding all the following:**

Check all as Yes: ☐

| | | | |
|---|---|---|---|
| **Risk Factors for Stroke** | ○ Yes ○ No | **Stroke Warning Signs and Symptoms** | ○ Yes ○ No |
| **How to Activate EMS for Stroke** | ○ Yes ○ No | **Need for Follow-Up After Discharge** | ○ Yes ○ No |
| **Their Prescribed medications** | ○ Yes ○ No | | |

**STROKE REHABILITATION**

| | |
|---|---|
| **Patient assessed for and/or received rehabilitation services during this hospitalization?** | ○ Yes ○ No |
| Check all rehab services that patient received or was assessed for: | ☐ Patient received rehabilitation services during hospitalization<br>☐ Patient transferred to rehabilitation facility<br>☐ Patient referred to rehabilitation services following discharge<br>☐ Patient ineligible to receive rehabilitation services because symptoms resolved<br>☐ Patient ineligible to receive rehabilitation services due to impairment (i.e. poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen |

**STROKE DIAGNOSTIC TESTS AND INTERVENTIONS**

| | | |
|---|---|---|
| Cardiac ultrasound/echocardiography<br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | Extended implantable cardiac rhythm monitoring<br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | Carotid imaging<br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned |

| | | |
|---|---|---|
| Hypercoagulability testing<br><br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | Carotid revascularization<br><br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | Extended surface cardiac rhythm monitoring > 7 days<br><br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned |
| Intracranial vascular imaging<br><br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | Short-term cardiac rhythm monitoring <= 7 days<br><br>○ Performed during this admission or in the 3 months prior<br>○ Planned post discharge<br>○ Not performed or planned | |

| **OPTIONAL FIELDS – Please do not enter any patient identifiers in this section** | | | | ***Optional Fields Tab*** |
|---|---|---|---|---|
| Field 1 | Field 2 | Field 3 | Field 4 | Field 5 |
| Field 6 | Field 7 | Field 8 | Field 9 | Field10 |
| Field 11 | | Field 12 | | |
| Field 13 | ____/____/____ ____:____ ☐MM/DD/YYY ☐Unknown | Field 14 | ____/____/____ ____:____ ☐MM/DD/YYY ☐Unknown | |
| Additional Comments: | | | | |

| **Administrative** | | | |
|---|---|---|---|
| PMT used concurrently or retrospectively or combination? | ○ Concurrently | ○ Retrospectively | ○ Combination |
| Was a stroke admission order set used in this patient? | ○ Yes | ○ No | |
| Was a stroke discharge checklist used in this patient? | ○ Yes | ○ No | |
| Patient adherence contract/compact used? | ○ Yes | ○ No | |

**END OF FORM**