

Patient ID:		Bold Question = Required	
DEMOGRAPHICS <i>Demographics Tab</i>			
Sex	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Patient Gender Identity	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="radio"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="radio"/> Genderqueer, neither exclusively male nor female <input type="radio"/> Additional gender category or other: _____ <input type="radio"/> Did not disclose		
Patient-Identified Sexual Orientation	<input type="radio"/> Straight or heterosexual <input type="radio"/> Lesbian or gay <input type="radio"/> Bisexual <input type="radio"/> Queer, pansexual, and/or questioning <input type="radio"/> Something else, please specify: _____ <input type="radio"/> Don't know <input type="radio"/> Declined to answer		
Date of Birth:	____/____/____	Age:	_____
Zip Code:	_____ - _____	<input type="checkbox"/> Homeless	
Payment Source	<input type="checkbox"/> Medicare Title 18 <input type="checkbox"/> Medicaid Title 19 <input type="checkbox"/> Medicare – Private/ HMO/ PPO/ Other <input type="checkbox"/> Medicaid – Private/ HMO/ PPO/ Other <input type="checkbox"/> Private/ HMO/ PPO/ Other <input type="checkbox"/> Other <input type="checkbox"/> Self Pay/ No Insurance <input type="checkbox"/> Other/ Not Documented/ UTD <input type="checkbox"/> VA/ CHAMPVA/ Tricare		
RACE AND ETHNICITY			
Race (Select all that apply):	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander [if Asian selected] [if native Hawaiian or pacific islander selected] <input type="checkbox"/> Asian Indian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Other Asian <input type="checkbox"/> UTD		
Hispanic Ethnicity:	<input type="radio"/> Yes <input type="radio"/> No/UTD		
If Yes,	<input type="radio"/> Mexican, Mexican American, Chicano/a <input type="radio"/> Puerto Rican <input type="radio"/> Cuban <input type="radio"/> Another Hispanic, Latino or Spanish Origin		
ADMIN <i>Admin Tab</i>			
Final clinical diagnosis related to stroke	<input type="radio"/> Ischemic Stroke <input type="radio"/> Intracerebral Hemorrhage <input type="radio"/> Transient Ischemic Attack (<24 hours) <input type="radio"/> Stroke not otherwise specified <input type="radio"/> Subarachnoid Hemorrhage <input type="radio"/> No stroke related diagnosis <input type="radio"/> Elective Carotid Intervention only		
If not Stroke Related Diagnosis:	<input type="radio"/> Migraine <input type="radio"/> Electrolyte or metabolic imbalance <input type="radio"/> Seizure <input type="radio"/> Functional disorder <input type="radio"/> Delirium <input type="radio"/> Other <input type="radio"/> Uncertain		
Was the Stroke etiology documented in the patient medical record:		<input type="radio"/> Yes <input type="radio"/> No	

Select documented stroke etiology (select all that apply):	<input type="radio"/> 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis) <input type="radio"/> 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI) <input type="radio"/> 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm) <input type="radio"/> 4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders. <input type="radio"/> Dissection <input type="radio"/> Hypercoagulability <input type="radio"/> Other <input type="radio"/> 5: Cryptogenic stroke (stroke of undetermined etiology) <input type="radio"/> Multiple potential etiologies identified <input type="radio"/> Stroke of undetermined etiology <input type="radio"/> Unspecified				
When is the earliest documentation of comfort measures only?		<input type="radio"/> Day 0 or 1	<input type="radio"/> Day 2 or after	<input type="radio"/> Timing unclear	<input type="radio"/> Not Documented/UTD
Arrival Date/Time:	____/____/____:____		<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	Admit Date:	____/____/____
Not Admitted:	<input type="radio"/> Yes, not admitted <input type="radio"/> No, patient admitted as in patient	Reason Not Admitted:	<input type="radio"/> Transferred from your ED to another acute care hospital <input type="radio"/> Discharged directly from ED to home or other location that is not an acute care hospital <input type="radio"/> Left from ED AMA <input type="radio"/> Died in ED <input type="radio"/> Discharged from observation status without an inpatient admission <input type="radio"/> other		
If patient transferred from your ED to another hospital, specify hospital name	[Select hospital name from picker list] <input type="checkbox"/> Hospital not on list <input type="checkbox"/> Hospital not documented				
Select reason(s) for why patient transferred	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented				
Discharge Date:	____/____/____:____		<input type="checkbox"/> MM/DD/YYYY only		
Documented reason for delay in transfer to referral facility?	<input type="radio"/> Yes <input type="radio"/> No/ND				
Specific reason for delay documented in transfer patient (check all that apply):	<input type="checkbox"/> Social/religious <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care team unable to determine eligibility <input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Investigational or experimental protocol for reperfusion <input type="checkbox"/> Delay in stroke diagnosis * <input type="checkbox"/> In-hospital time delay * <input type="checkbox"/> Equipment-related delay * <input type="checkbox"/> Need for additional imaging* <input type="checkbox"/> Catheter lab not available* <input type="checkbox"/> Other *				
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	<input type="checkbox"/> 1 – Home <input type="checkbox"/> 2 – Hospice – Home <input type="checkbox"/> 3 – Hospice – Health Care Facility <input type="checkbox"/> 4 – Acute Care Facility <input type="checkbox"/> 5 – Other Health Care Facility <input type="checkbox"/> 6 – Expired <input type="checkbox"/> 7 – Left Against Medical Advice / AMA <input type="checkbox"/> 8 – Not Documented or Unable to Determine (UTD)				

If Other Health Care Facility	<input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Long Term Care Hospital (LTCH)	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Other
DIAGNOSIS CODE		<i>Clinical Codes Tab</i>
ICD-9CM or ICD-10-CM Principal Diagnosis Code	_____	
ICD-9CM or ICD-10-CM Other Diagnosis Codes	_____	
ICD-9-CM or ICD-10-PCS Principal Procedure Code	_____	
ICD-9-CM or ICD-10-PCS Other Procedure Codes	_____	
ICD-9-CM Discharge Diagnosis Related to Stroke	_____	
ICD-10-CM Discharge Diagnosis Related to Stroke	_____	
No Stroke or TIA Related ICD-9-CM Code Present	<input type="checkbox"/>	
No Stroke or TIA Related ICD-10-CM Code Present	<input type="checkbox"/>	
ARRIVAL AND ADMISSION INFORMATION		<i>Admission Tab</i>
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)?		<input type="radio"/> Yes <input type="radio"/> No
Was this patient admitted for the sole purpose of performance of elective carotid intervention?		<input type="radio"/> Yes <input type="radio"/> No
Patient location when stroke symptoms discovered	<input type="radio"/> Not in a healthcare setting <input type="radio"/> Another acute care facility <input type="radio"/> Chronic health care facility	<input type="radio"/> Outpatient healthcare setting <input type="radio"/> Stroke occurred after hospital arrival (in ED/Obs/inpatient) <input type="radio"/> ND or Cannot be determined
How patient arrived at your hospital	<input type="radio"/> EMS from home/scene <input type="radio"/> Mobile Stroke Unit	<input type="radio"/> Private Transportation/Taxi/Other from home/scene <input type="radio"/> Transfer from another hospital <input type="radio"/> ND or Unknown
Referring hospital discharge Date/ Time	____/____/____:____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
If transferred from another hospital, specify hospital name	[Select hospital name from picker list] <input type="checkbox"/> Hospital not on list <input type="checkbox"/> Hospital not documented	
Referring hospital arrival date/ time	____/____/____:____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
If patient transferred to your hospital, select transfer reason(s)	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented	
Where patient first received care at your hospital	<input type="checkbox"/> Emergency Department / Urgent Care	<input type="checkbox"/> Direct Admit, not through ED <input type="checkbox"/> Imaging suite <input type="checkbox"/> ND or Cannot be determined
Advanced Notification by EMS or MSU?	<input type="radio"/> Yes <input type="radio"/> N/ND	
Initial Admitting Service	<input type="radio"/> Neurology <input type="radio"/> Neurosurgery <input type="radio"/> Neurocritical Care	<input type="radio"/> Medicine <input type="radio"/> Surgery <input type="radio"/> Other: _____
In which settings were care delivered? Select all that apply.	<input type="checkbox"/> Neuro/ Neurosurgery ICU <input type="checkbox"/> Other ICU <input type="checkbox"/> Stroke Unit (Non-ICU)	<input type="checkbox"/> General Care Floor <input type="checkbox"/> Observation <input type="checkbox"/> Other: _____
If the patient was not cared for in a dedicated stroke unit, was a formal inpatient consultation from a stroke expert obtained?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND	

Physician / Provider NPI:	
MEDICAL HISTORY	
Previously known medical hx of:	<input type="checkbox"/> None <input type="checkbox"/> Atrial Fib/Flutter <input type="checkbox"/> Current Pregnancy (up to 6 weeks post-partum) <input type="checkbox"/> Diabetes Mellitus <input type="radio"/> Type I <input type="radio"/> Type II <input type="radio"/> ND Duration: <input type="radio"/> < 5 years <input type="radio"/> 5 - < 10 years <input type="radio"/> 10 - < 20 years <input type="radio"/> >= 20 years <input type="radio"/> Unknown <input type="checkbox"/> E-Cigarette Use (Vaping) <input type="checkbox"/> HF <input type="checkbox"/> Hypertension <input type="checkbox"/> Previous Stroke <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> ICH <input type="checkbox"/> SAH <input type="checkbox"/> Not Specified <input type="checkbox"/> PVD <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CAD/ Prior MI <input type="checkbox"/> DVT/ PE <input type="checkbox"/> Drugs/ Alcohol Abuse <input type="checkbox"/> Familial Hypercholesterolemia <input type="checkbox"/> HRT <input type="checkbox"/> Migraine <input type="checkbox"/> Previous TIA <input type="checkbox"/> Renal Insufficiency – Chronic <input type="checkbox"/> Smoker <input type="checkbox"/> Carotid Stenosis <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Family History of Stroke <input type="checkbox"/> Hx of Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other Infectious Respiratory Pathogen <input type="checkbox"/> Obesity Overweight <input type="checkbox"/> Prosthetic Heart Valve <input type="checkbox"/> Sickle Cell
Ambulatory status prior to current event	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND
Pre-stroke Modified Rankin Score	<input type="radio"/> 1 – A pre-stroke mRS of 0, 1, or 2 was documented in the medical record, OR physician/ APN/PA documentation that the patient was able to look after self without daily help prior to this acute stroke episode. <input type="radio"/> 2- A pre-stroke mRS of 3, 4, or 5 was documented in the medical record, OR physician/ APN/ PA documentation that the present could NOT look after self without daily help prior to this acute stroke episode. <input type="radio"/> 3 – A pre-stroke mRS was not documented, OR unable to determine (UTD) from the medical record documentation
DIAGNOSIS & EVALUATION	
Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)	<input type="radio"/> Less than 10 minutes <input type="radio"/> 10 – 59 minutes <input type="radio"/> > = 60 minutes <input type="radio"/> ND
Had stroke symptoms resolved at time of presentation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND
Initial NIH Stroke Scale	<input type="radio"/> Yes <input type="radio"/> No/ND
If yes:	<input type="radio"/> Actual <input type="radio"/> Estimate from record <input type="radio"/> ND
Total Score:	_____ (refer to web program for questions)
NIHSS score obtained from transferring facility:	_____ <input type="radio"/> ND
Initial exam findings (Select all that apply)	<input type="checkbox"/> Weakness/Paresis <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Aphasia/ Language Disturbance <input type="checkbox"/> Other Neurological Signs/ Symptoms <input type="checkbox"/> No Neurological Signs/ Symptoms <input type="checkbox"/> ND

Ambulatory status on admission	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND
MEDICATION PRIOR TO ADMISSION	
No medications prior to admission <input type="checkbox"/>	
Antiplatelet or Anticoagulant Medication(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND
<input type="checkbox"/> Antiplatelet Medication <input type="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> prasugrel (Effient) <input type="radio"/> ticagrelor (Brilinta) <input type="radio"/> ticlopidine (Ticlid) <input type="radio"/> Other Antiplatelet	<input type="checkbox"/> Anticoagulant Medication <input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> desirudin (Iprivask) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra) <input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> unfractionated heparin IV <input type="radio"/> warfarin (Coumadin) <input type="radio"/> other Anticoagulant
Antihypertensive	<input type="radio"/> Yes <input type="radio"/> No/ND
Cholesterol-Reducer	<input type="radio"/> Yes <input type="radio"/> No/ND
Anti-hyperglycemic medications:	<input type="radio"/> Yes <input type="radio"/> No/ND
If yes, select medications (select all that apply)	<input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> SGLT2 inhibitor <input type="checkbox"/> Other injectable/subcutaneous agent <input type="checkbox"/> GLP-1 receptor agonist <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Insulin <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> Metformin <input type="checkbox"/> Other oral agents
Antidepressant medication	<input type="radio"/> Yes <input type="radio"/> No/ND
VACCINATIONS & TESTING	
COVID-19 Vaccination:	<input type="radio"/> COVID-19 vaccine was given during this hospitalization <input type="radio"/> COVID-19 vaccine was received prior to admission, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of COVID-19 vaccine <input type="radio"/> Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD
COVID-19 Vaccination Date:	____/____/____ <input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown
COVID-19 Vaccine Manufacturer:	<input type="radio"/> AstraZeneca <input type="radio"/> Johnson & Johnson's / Janssen <input type="radio"/> Moderna <input type="radio"/> Novavax <input type="radio"/> Pfizer <input type="radio"/> Other <input type="radio"/> Not Documented
Did the patient receive both doses of vaccine? (if applicable)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
Is there documentation that this patient was included in a COVID-19 vaccine trial?	<input type="radio"/> Yes <input type="radio"/> No/ND

Influenza Vaccination:	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/sensitivity to influenza vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD
------------------------	---

SYMPTOM TIMELINE *Hospitalization Tab*

Date/Time Patient last known to be well?	<input type="checkbox"/> Time of Discovery same as Last Known well	Date/Time of discovery of stroke symptoms?
____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown		____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Comments:		

BRAIN IMAGING

Brain imaging completed at your hospital for this episode of care?	<input type="radio"/> Yes <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="radio"/> No/ND <input type="radio"/> NC	Date/Time Brain Imaging First Initiated at your hospital:	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	
Interpretation of first brain image after symptom onset, done at any facility:		<input type="radio"/> Acute Hemorrhage	<input type="radio"/> No Acute Hemorrhage	<input type="radio"/> Not Available
Was acute Vascular or perfusion imaging (e.g. CTA, MRA, DSA) performed at your hospital?	<input type="radio"/> Yes <input type="radio"/> No	Date/Time 1 st vessel or perfusion imaging initiated at your hospital:	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	
If yes, type of vascular imaging (select all that apply)	<input type="checkbox"/> CTA <input type="checkbox"/> CT Perfusion <input type="checkbox"/> MRA	<input type="checkbox"/> MR Perfusion <input type="checkbox"/> DSA (catheter angiography) <input type="checkbox"/> Image type not documented		
Was a target lesion (large vessel occlusion) visualized?	<input type="radio"/> Yes <input type="radio"/> No/ND			
If yes, select site of large vessel occlusion (select all that apply):	<input type="checkbox"/> ICA <input type="checkbox"/> Intracranial ICA <input type="checkbox"/> Cervical ICA <input type="checkbox"/> Other/UTD	<input type="checkbox"/> MCA <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> Other/UTD	<input type="checkbox"/> Basilar <input type="checkbox"/> Other cerebral artery branch <input type="checkbox"/> Vertebral Artery	

ADDITIONAL TIME TRACKER

Date/Time Stroke Team Activated:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Stroke Team Arrived:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
Date/Time of ED Physician Assessment:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Neurosurgical services consult:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
Date/Time Brain Imaging Ordered:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Brain Imaging Interpreted:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
Date/Time IV alteplase Ordered:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A		
Date/Time Lab Tests Ordered:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown	Date/Time lab Tests Completed:	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown

	N/A		
Date/Time ECG Ordered: ____/____/____ :____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time ECG Completed: ____/____/____ :____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
Date/Time Chest X-ray Ordered: ____/____/____ :____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Chest X-ray Completed: ____/____/____ :____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown

Additional Comments:

IV THROMBOLYTIC THERAPY

IV thrombolytic initiated at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Time IV thrombolytic initiated:	____/____/____ :____
Thrombolytic used:	<input type="checkbox"/> Alteplase (Class 1 evidence) Alteplase, total dose: _____(mg) <input type="checkbox"/> Alteplase dose ND	<input type="checkbox"/> Tenecteplase (Class 2b evidence) Tenecteplase, total dose: _____(mg) <input type="checkbox"/> Tenecteplase dose ND	
Reason for selecting tenecteplase instead of alteplase:	<input type="checkbox"/> Large Vessel Occlusion (LVO) with potential thrombectomy <input type="checkbox"/> Mild Stroke <input type="checkbox"/> Other: _____		
If IV thrombolytic administered beyond 4.5-hour, was imaging used to identify eligibility?	<input type="checkbox"/> Yes, Diffusion-FLAIR mismatch <input type="checkbox"/> Yes, Core-Perfusion mismatch <input type="checkbox"/> None <input type="checkbox"/> Other: _____		
Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?	<input type="radio"/> Yes <input type="radio"/> No		
Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window?	<input type="radio"/> Yes <input type="radio"/> 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 thrombolytic was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	<input type="radio"/> Yes	<input type="radio"/> No
If IV thrombolytic was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	<input type="radio"/> Yes	<input type="radio"/> No
If IV thrombolytic was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	<input type="radio"/> Yes	<input type="radio"/> No
Eligibility Reason(s):	<input type="checkbox"/> Social/Religious <input type="checkbox"/> Initial refusal	

	<input type="checkbox"/> Care-team unable to determine eligibility <input type="checkbox"/> Specify eligibility reason: _____
Medical Reason(s):	<input type="checkbox"/> Hypertension requiring aggressive control with IV medications <input type="checkbox"/> Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 50), seizures, or major metabolic disorders <input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Investigational or experimental protocol for thrombolysis <input type="checkbox"/> Need for additional PPE for suspected/ confirmed infectious disease <input type="checkbox"/> Specify medical reason: _____
Hospital Related or Other Reason(s):	<input type="checkbox"/> Need for additional imaging <input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> In-hospital time delay <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> Other _____
IV thrombolytic at an outside hospital or Mobile Stroke Unit?	<input type="radio"/> Yes <input type="radio"/> No
If yes, select thrombolytic administered at outside hospital or Mobile Stroke Unit	<input type="radio"/> Alteplase <input type="radio"/> Tenecteplase
Investigational or experimental protocol for thrombolysis?	<input type="radio"/> Yes If yes, specify _____ <input type="radio"/> No
Additional Comments Related to Thrombolytics:	

ENDOVASCULAR THERAPY

Catheter-based stroke treatment at this hospital?	<input type="radio"/> Yes <input type="radio"/> No
IA alteplase or MER Initiation Date/Time	____ / ____ / ____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
Catheter-based stroke treatment at outside hospital?	<input type="radio"/> Yes <input type="radio"/> 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 Thrombolytic Therapy	<input type="checkbox"/> Symptomatic Intracranial hemorrhage <36 hours <input type="checkbox"/> Life threatening, serious systemic hemorrhage <36 hours <input type="checkbox"/> UTD	<input type="checkbox"/> Other serious complications <input type="checkbox"/> No serious complications
	If bleeding complications occur in patient after IV alteplase: <input type="radio"/> Symptomatic hemorrhage detected prior to patient transfer <input type="radio"/> Symptomatic hemorrhage detected only after patient transfer	<input type="radio"/> Unable to determine <input type="radio"/> N/A

OTHER IN-HOSPITAL TREATMENT AND SCREENING

Dysphagia Screening	
Patient NPO throughout the entire hospital stay?	<input type="radio"/> Yes <input type="radio"/> No/ND
Was patient screened for dysphagia prior to any oral intake including water or medications?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC
If yes, Dysphagia screening results:	<input type="radio"/> Pass <input type="radio"/> Fail <input type="radio"/> ND
Treatment for Hospital-Acquired Pneumonia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
VTE Interventions	<input type="checkbox"/> 1- Low dose unfractionated heparin (LDUH) <input type="checkbox"/> 2- Low molecular weight heparin (LMWH) <input type="checkbox"/> 3- Intermittent pneumatic compression devices (IPC) <input type="checkbox"/> 4- Graduated compression stockings (GCS) <input type="checkbox"/> 5- Factor Xa Inhibitor <input type="checkbox"/> 6- Warfarin <input type="checkbox"/> 7- Venous foot pumps (VFP) <input type="checkbox"/> 8-Oral Factor Xa Inhibitor <input type="checkbox"/> 9- Aspirin <input type="checkbox"/> A- None of the above or ND

What date was the initial VTE prophylaxis administered after hospital admission?		____/____/____		<input type="checkbox"/> Unknown
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?		<input type="radio"/> Yes	<input type="radio"/> 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?		<input type="radio"/> Yes	<input type="radio"/> No	
Other Therapeutic Anticoagulation	<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> argatroban <input type="checkbox"/> dabigatran (Pradaxa)	<input type="checkbox"/> desirrudin (Iprivask) <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> lepirudin (Refludan)	<input type="checkbox"/> rivaroxaban (Xaralto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> other anticoagulant	
Was DVT or PE documented?	<input type="radio"/> Yes <input type="radio"/> No/ND			
Was antithrombotic therapy administered by the end of hospital day 2?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC			
If yes, select all that apply	<input type="checkbox"/> Antiplatelet <input type="checkbox"/> Anticoagulant			
Active bacterial or viral infection at admission or during hospitalization:	<input type="checkbox"/> None <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> MERS <input type="checkbox"/> Other Emerging Infectious Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal Cold <input type="checkbox"/> Other Viral Infection			
MEASUREMENTS (first measurement upon presentation to your hospital)				
Total Chol: _____ mg/dl	Triglycerides: _____ mg/dl	HDL: _____ mg/dl	LDL: _____ mg/dl	<input type="checkbox"/> Lipids: NC <input type="checkbox"/> Lipids: ND
A ₁ C: _____ % A ₁ C <input type="checkbox"/> ND	Blood Glucose (required if patient received IV alteplase): _____ mg/dl	<input type="checkbox"/> ND <input type="checkbox"/> Too Low <input type="checkbox"/> Too High		
Serum Creatine:	_____ <input type="checkbox"/> ND			
INR:	_____ <input type="checkbox"/> ND <input type="checkbox"/> NC			
Vital Signs:	Heart Rate (beats per minute): _____ bpm	_____ / _____ <input type="checkbox"/> Vital signs UTD		
Height: _____	<input type="radio"/> in <input type="radio"/> cm <input type="radio"/> ND			
Weight: _____	<input type="radio"/> lbs <input type="radio"/> kg <input type="radio"/> ND			
Waist Circumference: _____	<input type="radio"/> in	<input type="radio"/> cm	<input type="radio"/> ND	
BMI: _____	<input type="checkbox"/> 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	<input type="radio"/> Yes <input type="radio"/> No/ND			
If Yes:	<input type="radio"/> Actual <input type="radio"/> Estimated from record <input type="radio"/> ND			
Total Score:	_____			

Ambulatory status at discharge	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND			
Discharge Blood Pressure (Measurement closest to discharge)	_____ / _____ mmHg (Systolic/Diastolic)		<input type="checkbox"/> ND	
DISCHARGE TREATMENTS				
Antithrombotic Therapy approved in stroke	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
	If yes,			
	<input type="checkbox"/> Antiplatelet		<input type="checkbox"/> Anticoagulant	
	<input type="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> ticlopidine (Ticlid)		<input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra)	
			<input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> Unfractionated heparin IV <input type="radio"/> warfarin (Coumadin)	
	Dosage		Frequency	
	1. _____		1. _____	
	2. _____		2. _____	
3. _____		3. _____		
4. _____		4. _____		
	If NC, documented contraindications		<input type="checkbox"/> Allergy to or complications r/t antithrombotic <input type="checkbox"/> Patient/Family refused <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding	
			<input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only <input type="checkbox"/> Other	
Other Antithrombotic(s)	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,			
	Medication:		Dosage Frequency	
	<input type="checkbox"/> Desirudin (Iprivask)		1. _____ 1. _____	
	<input type="checkbox"/> Ticagrelor (Brilinta)		2. _____ 2. _____	
	<input type="checkbox"/> Prasugrel (Effient) *contraindicated in stroke and TIA		3. _____ 3. _____	
	<input type="checkbox"/> Other		4. _____ 4. _____	
Persistent or Paroxysmal Atrial Fibrillation/Flutter		<input type="radio"/> Yes <input type="radio"/> No		
If atrial fib/flutter or history of PAF documented, was patient discharged on anticoagulation?			<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	
If NC, documented reasons for no anticoagulation	<input type="checkbox"/> Allergy to or complication r/t warfarin or heparins <input type="checkbox"/> Mental status <input type="checkbox"/> Patient refused <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding			
	<input type="checkbox"/> Risk for falls <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only			
Anti-hypertensive Tx (Select all that apply)	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> Other anti-hypertensive med <input type="checkbox"/> Ace Inhibitors <input type="checkbox"/> Beta Blockers		<input type="checkbox"/> None - Contraindicated <input type="checkbox"/> Diuretics <input type="checkbox"/> ARB <input type="checkbox"/> CA++ Channel Blockers	
Cholesterol-Reducing Tx (Select all that apply)	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> None – contraindicated <input type="checkbox"/> Statin <input type="checkbox"/> Fibrate		<input type="checkbox"/> Niacin <input type="checkbox"/> Absorption Inhibitor <input type="checkbox"/> PCSK 9 inhibitor <input type="checkbox"/> Other med	

Statin Medication:	<input type="checkbox"/> Amlodipine + Atorvastatin (Caduet) <input type="checkbox"/> Atorvastatin (Lipitor) <input type="checkbox"/> Ezetimibe + Simvastatin (Vytorin) <input type="checkbox"/> Fluvastatin (Lescol) <input type="checkbox"/> Fluvastatin XL (Lescol XL) <input type="checkbox"/> Lovastatin (Altoprev) <input type="checkbox"/> Lovastatin (Mevacor) <input type="checkbox"/> Lovastatin + Niacin (Advicor) <input type="checkbox"/> Pitavastatin (Livalo) <input type="checkbox"/> Pravastatin (Pravachol) <input type="checkbox"/> Rosuvastatin (Crestor) <input type="checkbox"/> Simvastatin (Zocor) <input type="checkbox"/> Simvastatin + Niacin (Simcor)			Statin Total Daily Dose:	
	Documented Reason for Not Prescribing Guideline Recommended Dose?		<input type="checkbox"/> Intolerant to moderate (>75yr) or high (<=75yr) intensity statin <input type="checkbox"/> No evidence of atherosclerosis (cerebral, coronary, or peripheral vascular disease)		<input type="checkbox"/> Other documented reason <input type="checkbox"/> Unknown/ND
Documented reason for not prescribing a statin medication at discharge?		<input type="radio"/> Yes <input type="radio"/> No			
New Diagnosis of Diabetes?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND			
Basis for Diagnosis (Select all that apply)		<input type="checkbox"/> HbA1c <input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Oral Glucose Tolerance <input type="checkbox"/> Test Other			
Anti-hyperglycemic medications:	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?		<input type="radio"/> Yes <input type="radio"/> No/ND			
Follow-up appointment scheduled for diabetes management?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
Date of scheduled diabetes follow-up appointment:	____/____/____ <input type="radio"/> Unknown				
Anti-Smoking Tx	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
Smoking Cessation Therapies Prescribed (select all that apply)	<input type="checkbox"/> Counseling <input type="checkbox"/> Over the Counter Nicotine Replacement Therapy <input type="checkbox"/> Prescription Medications <input type="checkbox"/> Other <input type="checkbox"/> Treatment not specified				
Was the patient prescribed any antidepressant class of medication at discharge?	<input type="radio"/> Yes, SSRI <input type="radio"/> Yes, any other antidepressant class <input type="radio"/> No/ND				
OTHER LIFESTYLE INTERVENTIONS					
Reducing weight and/or increasing activity recommendations	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
TLC Diet or Equivalent	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
Antihypertensive Diet	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
Was Diabetic Teaching Provided?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC				
STROKE EDUCATION					
Patient and/or caregiver received education and/or resource materials regarding all the following:					

Check all as Yes: <input type="checkbox"/>	
Risk Factors for Stroke	<input type="radio"/> Yes <input type="radio"/> No
Stroke Warning Signs and Symptoms	<input type="radio"/> Yes <input type="radio"/> No
How to Activate EMS for Stroke	<input type="radio"/> Yes <input type="radio"/> No
Need for Follow-Up After Discharge	<input type="radio"/> Yes <input type="radio"/> No
Their Prescribed medications	<input type="radio"/> Yes <input type="radio"/> No
STROKE REHABILITATION	
Patient assessed for and/or received rehabilitation services during this hospitalization?	
<input type="radio"/> Yes <input type="radio"/> No	
Check all rehab services that patient received or was assessed for:	<input type="checkbox"/> Patient received rehabilitation services during hospitalization <input type="checkbox"/> Patient transferred to rehabilitation facility <input type="checkbox"/> Patient referred to rehabilitation services following discharge <input type="checkbox"/> Patient ineligible to receive rehabilitation services because symptoms resolved <input type="checkbox"/> Patient ineligible to receive rehabilitation services due to impairment (i.e. poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)
HEALTH RELATED SOCIAL NEEDS ASSESSMENT	
During this admission, was a standardized health related social needs form or assessment completed?	
<input type="radio"/> Yes <input type="radio"/> No/ND	
If Yes, identify the areas of unmet social need. Select all that apply.	<input type="checkbox"/> Living Situation/ Housing <input type="checkbox"/> Employment <input type="checkbox"/> Food <input type="checkbox"/> Education <input type="checkbox"/> Utilities <input type="checkbox"/> Mental Health <input type="checkbox"/> None <input type="checkbox"/> Personal Safety <input type="checkbox"/> Substance Use <input type="checkbox"/> Financial Strain <input type="checkbox"/> Transportation Barriers
STROKE DIAGNOSTIC TESTS AND INTERVENTIONS	
Cardiac ultrasound/echocardiography <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Extended implantable cardiac rhythm monitoring <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Hypercoagulability testing <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Carotid revascularization <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Intracranial vascular imaging <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Carotid imaging <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Hypercoagulability testing <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Extended surface cardiac rhythm monitoring > 7 days <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Intracranial vascular imaging <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Short-term cardiac rhythm monitoring <= 7 days <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
OPTIONAL FIELDS – Please do not enter any patient identifiers in this section	
<i>Optional Fields Tab</i>	
Field 1	Field 2
Field 3	Field 4
Field 5	Field 6
Field 7	Field 8
Field 9	Field 10
Field 11	Field 12
Field 13	Field 14
____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown	____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown
Additional Comments:	
ADMINISTRATIVE	
PMT used concurrently or retrospectively or combination?	<input type="radio"/> Concurrently <input type="radio"/> Retrospectively <input type="radio"/> Combination
Was a stroke admission order set used in this patient?	<input type="radio"/> Yes <input type="radio"/> No

Was a stroke discharge checklist used in this patient?	<input type="radio"/> Yes	<input type="radio"/> No
Patient adherence contract/compact used?	<input type="radio"/> Yes	<input type="radio"/> No
END OF FORM		