Case Record Form
Active Form Groups: Stroke, Diabetes

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

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
○ Transient Ischemic Attack (<24 hours)
○ Subarachnoid Hemorrhage
○ Intracerebral Hemorrhage
○ Stroke not otherwise specified
○ No stroke related diagnosis
○ Elective Carotid Intervention only

If not Stroke Related Diagnosis:
○ Migraine
○ Seizure
○ Delirium
○ Electrolyte or metabolic imbalance
○ Functional disorder
○ 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   ☐ Unknown   **Admit Date:** _____/_____/_____

Not Admitted:	○ Yes, not admitted ○ No, patient admitted as in patient	Reason Not Admitted:	○ Transferred from your ED to another acute care hospital ○ Discharged directly from ED to home or other location that is not an acute care hospital ○ Left from ED AMA ○ Died in ED ○ Discharged from observation status without an inpatient admission ○ other
If patient transferred from your ED to another hospital, specify hospital name	[Select hospital name from picker list] □ Hospital not on list □ Hospital not documented		
Select reason(s) for why patient transferred	□ 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		
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 □ Initial refusal □ Care team unable to determine eligibility □ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) □ Investigational or experimental protocol for reperfusion □ Delay in stroke diagnosis * □ In-hospital time delay * □ Equipment-related delay * □ Need for additional imaging* □ Catheter lab not available* □ Other *		
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	□ 1 – Home □ 2 – Hospice – Home □ 3 – Hospice – Health Care Facility □ 4 – Acute Care Facility □ 5 – Other Health Care Facility □ 6 – Expired □ 7 – Left Against medical Advise / AMA □ 8 – Not Documented or Unable to Determine (UTD)		
If Other Health Care Facility	○ Inpatient Rehabilitation Facility (IRF) ○ Intermediate Care facility (ICF) ○ Long Term Care Hospital (LTCH)	○ Skilled Nursing Facility (SNF) ○ Other	

DIAGNOSIS CODE   *Clinical Codes Tab*

Updated April 2020 - COVID

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 No Stroke or TIA Related ICD-10-CM Code Present	☐ ☐

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

MEDICATION PRIOR TO ADMISSION

No medications prior to admission	☐
Antiplatelet or Anticoagulant Medication(s):	☐ Yes ☐ No/ND

☐ Antiplatelet Medication	**☐ Anticoagulant Medication**
○ aspirin ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ prasugrel (Effient) ○ ticagrelor (Brilinta) ○ ticlopidine (Ticlid) ○ Other Antiplatelet	○ apixaban (Eliquis) ○ argatroban ○ dabigatran (Pradaxa) ○ desirudin (Iprivask) ○ endoxaban (Savaysa) ○ fondaparinux (Arixtra) ○ full dose LMW heparin ○ lepirudin (Refludan) ○ rivaroxaban (Xarelto) ○ unfractionated heparin IV ○ warfarin (Coumadin) ○ 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 ☐ GLP-1 receptor agonist ☐ Insulin ☐ Metformin ☐ Other injectable/ ☐ Sulfonylurea ☐ Thiazolidinedione ☐ Other oral agent subcutaneous 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	Date/Time of discovery of stroke symptoms? ____/____/_____:____ ☐ 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 ☐ MR Perfusion ☐ CT Perfusion ☐ DSA (catheter angiography) ☐ MRA ☐ 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: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Chest X-ray Completed: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Additional Comments:			

IV THROMBOLYTIC THERAPY

IV alteplase initiated at this hospital?	○ Yes ○ No	Date/Time IV alteplase initiated:	____/____/_____ ____:_____

Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?	○ Yes ○ No
Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window?	○ Yes ○ 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 ☐ Initial refusal ☐ Care-team unable to determine eligibility ☐ Specify eligibility reason: _____
Medical Reason(s):	☐ Hypertension requiring aggressive control with IV medications ☐ Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 50), seizures, or major metabolic disorders ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Investigational or experimental protocol for thrombolysis ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Specify medical reason: _____
Hospital Related or Other Reason(s):	☐ Delay in stroke diagnosis ☐ In-hospital time delay ☐ Equipment-related delay ☐ 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 ☐ Life threatening, serious systemic hemorrhage <36 hours ☐ UTD	☐ Other serious complications ☐ No serious complications
If bleeding complications occur in patient after IV alteplase:	○ Symptomatic hemorrhage detected prior to patient transfer ○ Symptomatic hemorrhage detected only after patient transfer	○ Unable to determine ○ 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) ☐ 2- Low molecular weight heparin (LMWH) ☐ 3- Intermittent pneumatic compression devices (IPC) ☐ 4- Graduated compression stockings (GCS) ☐ 5- Factor Xa Inhibitor ☐ 6- Warfarin	☐ 7- Venous foot pumps (VFP) ☐ 8-Oral Factor Xa Inhibator ☐ 9- Aspirin ☐ 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) ☐ argatroba ☐ dabigatran (Pradaxa)	☐ desirrudin (Iprivask) ☐ endoxaban (Savaysa) ☐ lepirudin (Refludan)	☐ rivaroxaban (Xaralto) ☐ unfractionated heparin IV ☐ 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
	☐ Emerging Infectious Disease
	     ☐ SARS-COV-1
	     ☐ SARS-COV-2 (COVID-19) ☐ Bacterial Infection ☐ None/ ND
	     ☐ MERS
	     ☐ Other Infectious Respiratory Pathogen	

MEASUREMENTS (first measurement upon presentation to your hospital)

Total Chol: _____ mg/dl	Triglycerides: _____ mg/dl	HDL: _____ mg/dl	**LDL:** _____ **mg/dl**	☐ Lipids: NC ☐ Lipids: ND

A_1C: _____ % A_1C
☐ ND

Blood Glucose (required if patient received IV alteplase): _____ mg/dl

☐ ND
☐ Too Low
☐ Too High

Serum Creatine:	_____ ☐ ND
INR:	_____ ☐ ND ☐ NC

Vital Signs:

Heart Rate (beats per minute): _____ bpm

^What is the first blood pressure obtained prior to or after hospital arrival? (required if patient received IV alteplase)   _____ / _____

☐ 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
- ○ With assistance (from person)
- ○ Unable to ambulate
- ○ 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 ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ ticlopidine (Ticlid)	○ apixaban (Eliquis) ○ argatroban ○ dabigatran (Pradaxa) ○ endoxaban (Savaysa) ○ fondaparinux (Arixtra)	○ full dose LMW heparin ○ lepirudin (Refludan) ○ rivaroxaban (Xarelto) ○ Unfractionated heparin IV ○ warfarin (Coumadin)
Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____	Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____

	If NC, documented contraindications	☐ Allergy to or complications r/t antithrombotic ☐ Patient/Family refused ☐ Risk for bleeding or discontinued due to bleeding	☐ Serious side effect to medication ☐ Terminal illness/Comfort Measures Only ☐ Other
Other Antithrombotic(s)	Prescribed? ◯ Yes ◯ No		
	If yes,		
	Medication: ☐ Desirudin (Iprivask) ☐ Ticagrelor (Brilinta) ☐ Prasugrel (Effient) *contraindicated in stroke and TIA ☐ Other	Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 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 ☐ Mental status ☐ Patient refused ☐ Risk for bleeding or discontinued due to bleeding	☐ Risk for falls ☐ Serious side effect to medication ☐ Terminal illness/Comfort Measures Only
Anti-hypertensive Tx (Select all that apply)	☐ None prescribed/ND ☐ Other anti-hypertensive med ☐ Ace Inhibitors ☐ Beta Blockers	☐ None - Contraindicated ☐ Diuretics ☐ ARB ☐ CA++ Channel Blockers

Cholesterol-Reducing Tx (Select all that apply)	☐ None prescribed/ND ☐ None – contraindicated ☐ Statin ☐ Fibrate	☐ Niacin ☐ Absorption Inhibitor ☐ PCSK 9 inhibitor ☐ Other med

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

Documented Reason for Not Prescribing Guideline Recommended Dose?	☐ Intolerant to moderate (>75yr) or high (<=75yr) intensity statin ☐ No evidence of atherosclerosis (cerebral, coronary, or peripheral vascular disease)	☐ Other documented reason ☐ 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 ☐ Oral Glucose Tolerance	☐ Fasting Blood Sugar ☐ 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 ☐ Over the Counter Nicotine Replacement Therapy ☐ Prescription Medications ☐ Other ☐ 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 ☐ Patient transferred to rehabilitation facility ☐ Patient referred to rehabilitation services following discharge ☐ Patient ineligible to receive rehabilitation services because symptoms resolved ☐ 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 ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Extended implantable cardiac rhythm monitoring ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Carotid imaging ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned

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