Patient Name: _____ DOB: ___/___/_____ MRN: _____

AuSCR RED PROGRAM ACUTE DATA COLLECTION FORM

AuSCR Australian Stroke Clinical Registry

Please complete the form:
- Neatly and legibly
- Each question must be completed

For any queries contact the AuSCR Office at the Florey Institute of Neuroscience and Mental Health
P: 1800 673 053 **Email**: admin@auscr.com.au

Hospital Name: _____

Auditor Name: _____

AFFIX PATIENT STICKER HERE

PATIENT DEMOGRAPHICS

Patient Details

Title ☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Medicare No ☐☐☐☐☐☐☐☐☐☐ Hospital MRN ☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Intersex or indeterminate ☐ Not stated/inadequately described

Country of birth ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Language spoken ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Interpreter needed ☐ Yes ☐ No

Is the patient of Aboriginal and/or Torres Strait Islander origin?
- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Indigenous not otherwise described
- ☐ Missing/Not stated

Contact Information

Phone number ☐☐☐☐☐☐☐☐☐☐ Mobile number ☐☐☐☐☐☐☐☐☐☐

Address type ☐ Home ☐ Business ☐ Other

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Suburb ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Post Code ☐☐☐☐ State ☐☐☐

Country ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient Name: _____ DOB: ___/___/_____ MRN: _____

Emergency Contact

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Same as patient address? ☐ True ☐ False

Address type ☐ Home ☐ Business ☐ Other

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Suburb ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Post Code ☐☐☐☐ State ☐☐☐

Country ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number ☐☐☐☐☐☐☐☐☐☐ Mobile Number ☐☐☐☐☐☐☐☐☐☐

Relationship to participant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Alternative Contact

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address type ☐ Home ☐ Business ☐ Other

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Suburb ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Post Code ☐☐☐☐ State ☐☐☐

Country ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number ☐☐☐☐☐☐☐☐☐☐ Mobile Number ☐☐☐☐☐☐☐☐☐☐

Relationship to participant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient Name: _____ DOB: ___/___/_____ MRN: _____

ADMISSION AND TRANSFER INFORMATION

Admission Details

Date of stroke onset ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Unknown ☐ Accurate ☐ Estimate

Time of stroke onset ☐☐:☐☐ (24-hour clock)

Time accuracy:

☐ Known time of onset ☐ If uncertain time of stroke, then time last seen well

☐ If wake up stroke, then time last seen well ☐ Time unknown

Did the stroke occur while the patient was in hospital? ☐ Yes ☐ No ☐ Unknown

Date of arrival at Emergency Department ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Time of arrival at Emergency Department ☐☐:☐☐ (24-hour clock) ☐ Accurate ☐ Estimate ☐ Unknown

Did the patient arrive by ambulance? ☐ Yes ☐ No ☐ Unknown

Was the patient transferred from another hospital? ☐ Yes ☐ No ☐ Unknown

Date of admission to hospital ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐Accurate ☐ Estimate ☐ Not admitted (leave field blank)

Time of admission to hospital ☐☐:☐☐ (24-hour clock) ☐ Accurate ☐ Estimate ☐ Unknown

Was the patient treated in a stroke unit at any time during their stay? ☐ Yes ☐ No ☐ Unknown

PRE STROKE HISTORY

History of known risk factors

Documented evidence of a previous stroke?
(i.e. focal neurological signs persisting for more than 24 hours) ☐ Yes ☐ No ☐ Not documented

ACUTE CLINICAL DATA

NIHSS (National Institutes of Health Stroke Scale) at baseline ☐☐ ☐ Unknown (99)
(Paediatric version as appropriate)

Date of first brain scan after the stroke ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Time of first brain scan after the stroke ☐☐:☐☐ (24-hour clock) ☐ Not documented

Type of stroke ☐ TIA ☐ Ischaemic ☐ Haemorrhagic ☐ Undetermined

Cause of stroke ☐ Known ☐ Unknown

Patient Name: _____ DOB: ___/___/_____ MRN: _____

TELEMEDICINE AND REPERFUSION

Was a stroke telemedicine consultation conducted? ☐ Yes ☐ No ☐ Unknown

Telemedicine setting and reason

Did the patient receive intravenous thrombolysis? ☐ Yes ☐ No ☐ Unknown

Date of intravenous thrombolysis delivery ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Time of intravenous thrombolysis delivery ☐☐:☐☐ (24-hour clock)

Was there a serious adverse event related to thrombolysis? ☐ Yes ☐ No

Type of adverse event:

Intracranial haemorrhage	☐ Yes	☐ No
Extracranial haemorrhage	☐ Yes	☐ No
Angioedema	☐ Yes	☐ No
Other	☐ Yes	☐ No

OTHER CLINICAL INFORMATION

Swallowing

Was a formal swallow screen performed (i.e. not a test of gag reflex)? ☐ Yes ☐ No ☐ Not documented

Date of screening ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Time of screening ☐☐:☐☐ (24-hour clock) ☐ Accurate ☐ Estimate ☐ Unknown

Did the patient pass the screening? ☐ Yes ☐ No ☐ Not documented

Was a swallowing assessment by a speech pathologist recorded? ☐ Yes ☐ No ☐ Not documented

Date of assessment ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Time of assessment ☐☐:☐☐ (24-hour clock) ☐ Accurate ☐ Estimate ☐ Unknown

Was the swallow screen or swallowing assessment performed before the patient was given:

Oral medications? ☐ Yes ☐ No ☐ Not documented

Oral food or fluids? ☐ Yes ☐ No ☐ Not documented

Mobilisation

Was the patient able to walk independently on admission? ☐ Yes ☐ No ☐ Unknown
(i.e. may include walking aid, but without assistance from another person)

Was the patient mobilised in this admission? ☐ Yes ☐ No ☐ Unknown

Date of first documented mobilisation ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Method of mobilisation documented
(Assisting the patient upright and out of bed, this includes sitting over the edge of the bed.)
☐Sitting ☐Standing ☐Walking
Please select the one method documented within the medical record.

Antithrombotic therapy

Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA)? ☐ Yes ☐ No ☐ No, but anticoagulant agent provided ☐ Unknown ☐ Contraindicated

Date of commencement ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Time of commencement ☐☐:☐☐ (24-hour clock) ☐ Accurate ☐ Estimate ☐ Unknown

Patient Name: _____ DOB: ___/___/_____ MRN: _____

SECONDARY PREVENTION

Medication prescribed on discharge

On discharge was the patient prescribed antithrombotics?	☐ Yes	☐ No	☐ Unknown	☐ Contraindicated
On discharge was the patient prescribed antihypertensives?	☐ Yes	☐ No	☐ Unknown	☐ Contraindicated
On discharge was the patient prescribed lipid-lowering treatment?	☐ Yes	☐ No	☐ Unknown	☐ Contraindicated

DISCHARGE INFORMATION

Patient deceased during hospital care ☐ No ☐ Yes

Date of death: ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

Is the date of discharge known? ☐ Yes ☐ No

Date of discharge: ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY) ☐ Accurate ☐ Estimate

ICD10 codes

Discharge diagnosis ☐☐☐☐

Medical condition ☐☐☐☐, ☐☐☐☐, ☐☐☐☐

Medical complication ☐☐☐☐, ☐☐☐☐, ☐☐☐☐

Medical procedures ☐☐☐☐, ☐☐☐☐, ☐☐☐☐,☐☐☐☐

What was the discharge destination?

- ☐ Discharge/transfer to (an)other acute hospital
- ☐ Discharge/transfer to a residential aged care service , unless this is the usual place of residence:
  - ☐ Low level residential care
  - ☐ High level residential care
- ☐ Statistical discharge – type change
- ☐ Left against medical advice/discharge at own risk
- ☐ Died
- ☐ Other
- ☐ Usual residence (e.g. home) with supports
- ☐ Usual residence (e.g. home) without supports
- ☐ Inpatient rehabilitation
- ☐ Transitional care services

Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient (or family alone if patient has severe aphasia or cognitive impairments)?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not applicable (remains in hospital e.g. inpatient rehabilitation or other acute hospital)

Opt-Out Request	Refusal of follow-up survey
Place ☑ in appropriate box	Place ☑ in appropriate box
☐ Opt-out personal information (If selected, then patient cannot be contacted for follow-up)	☐ Does not wish to be contacted for follow-up survey at 3-6 months post-stroke

Form completed by: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Contact Number ☐☐☐☐☐☐☐☐☐☐