May 2025
Version 7.2

AuSCR Data Dictionary

Please consider the environment before printing. Number of pages: 158

AuSCR OFFICE

The Florey Institute of Neuroscience and Mental Health
245 Burgundy Street
Heidelberg Victoria 3084

Free Call: 1800 673 053
Email: admin@auscr.com.au
Website: www.auscr.com.au

Executive Director
Prof Dominique Cadilhac
dominique.cadilhac@florey.edu.au

Project Consortium:

The Florey Institute of Neuroscience and Mental Health, Stroke Foundation, Australian and New Zealand Stroke Organisation and Monash University

Updates to Version 7.2 (May 2025) from 7.1 (March 2023)

Variables	Updates in version 7.2	Page number(s)
Introduction	Addition of AuSCR eligibility criteria	10
7.550 Type of stroke	Instruction to select Ischaemic if brain imaging excludes haemorrhage.	71
7.6001 to 7.6014 Acute occlusion site	Simplified help note.	75-76
8.000 Stroke telemedicine consultation	Clarified that this variable refers only to telemedicine consultation in the hyperacute phase of care.	77
8.280 Time groin puncture	Revised to “arterial access” rather than “groin puncture” (note: variable name cannot be updated.)	86
9.100 Time of swallow screen	Simplified help note for entering time of swallow screen.	92
9.160 Time of swallowing assessment	Simplified help note for entering time of swallowing assessment.	96
10.070 to 10.250 Fever and hyperglycaemia management	Inclusion of help notes for timing of fever and hyperglycaemia management for in-hospital stroke.	107-110
14.160 Discharge destination	Instruction to select transitional care where the patient remains in your hospital as Statistical separation.	123-124
Follow-up	Addition of paediatric follow-up variables	136-144

Table of Contents

INTRODUCTION

The Australian Stroke Clinical Registry (AuSCR) Data Dictionary provides variable definitions and codes to assist with data collection and interpretation. Standard definitions and use of uniform codes are fundamental to ensuring data quality and integrity. All people involved in the collection, processing and analysis of AuSCR data should use this dictionary.

AuSCR definitions are aligned with the National Stroke Data Dictionary (NSDD), where relevant. The NSDD provides standardised definitions, codes and recording guidance for all items that can be collected using the Australian Stroke Data Tool (AuSDaT). This is to enhance the usefulness and comparability of the data across programs and hospitals that use the AuSDaT integrated data management system.

The AuSCR Management Committee is responsible for the content of this publication. We continue to welcome comments on this and other relevant publications. All queries and comments should be directed in the first instance to the AuSCR administration email admin@auscr.com.au

Acknowledgements
The AuSCR Management Committee wishes to thank all those who contributed to the content of this dictionary.

Correspondence/Enquiries:

Professor Dominique Cadilhac
AuSCR Executive Director
The Florey Institute of Neuroscience and Mental Health
245 Burgundy St, Heidelberg
Victoria 3084, Australia

Email: admin@auscr.com.au

What does the AuSCR Data Dictionary cover?

The definitions in this dictionary cover all the available AuSCR acute data variables (Appendix 2; AuSCR follow-up variables are detailed in a separate document.) These definitions give users an explanation of the variables and coding and allow for interpretation of the data that can be exported for their AusCR Program from the AuSDaT and also reviewing AuSCR data reports. Of note, hospitals can choose to export their acute AuSCR data and their follow-up data.

Overview of AuSCR variables and programs

The variables collected by each participating hospital will depend on the AuSCR program that each hospital is assigned. There are six AuSCR programs currently in use within the AuSDaT tool. As such, not all participating AusCR hospitals will collect all of the acute variables listed in the dictionary. See Appendix 1 for details of the programs current in the AuSCR as of March 2023, and the data bundles associated with each program.

Using the Dictionary

Page Layout

Each variable heading gives the variable name and Master Data List (MDL) reference number, if applicable. Below the heading is a colour-coded bar indicating which AuSCR program(s) the variable is part of.

Any program the variable is not part of will be greyed out, e.g.:

Each variable entry contains the following details:

MDL Reference	Master Data List reference number.
Common Name	– Lists any alternative common names for the variable i.e. Last Name may be known as person's surname or family name.
Definition	– The METeOR (Metadata Online Registry) definition or other relevant definition of variable being collected. METeOR is Australia's repository for national metadata standards for healthcare. Includes METeOR reference number if applicable.
Format	– Format for acute AuSCR variables in the user interface and in the import template. Note, the import template format requirements directly reflect the format of acute data when exported from AuSDaT into an Excel spreadsheet.
Recording Guidance	– This section provides data entry advice i.e. where to look for the required information (e.g. medical notes) and/or relevant AuSDaT system information for individuals who are entering data using the AuSDaT (e.g. if a data item will be autocompleted based on an earlier response) and outlining dependencies between variables. – When some variables are selected, they may automatically grey out or disable other variables, this means that no data can be entered into these variables.
Codes and Values	– This section shows any codes and values, where applicable.
Help Note	– This section provides guidance for AuSCR hospital staff and AuSCR analysts who are entering and/or interpreting the data item e.g. the circumstances in which a specific answer option is appropriate.
Further Information	– If applicable, shows any further information on the data item. May include context, rationale and/or additional references or links to relevant documents.

General principles of recording episodes in the AuSCR

- An AuSCR **episode of care** is defined as the period of acute patient care for stroke between official hospital admission and a formal or statistical separation. An episode of care ends when:
    - the patient is discharged;
    - episode type changes;
    - patient is transferred to another facility; or
    - the patient dies.

  The definition of admission varies between hospitals, particularly for emergency department admissions and short stay units. Hospitals should liaise with their own Health Information Services to determine appropriate inclusions to match their admitted episode dataset.

- If an AuSCR registrant has another stroke event following discharge and receives acute care within another hospital admitted episode, a new AuSCR record should be created for the event.

- Patients who are admitted for acute stroke management while **visiting Australia** (i.e. temporary visa or on holiday) should be included in the registry, as this is considered part of usual hospital activity. Where available, all patient address and contact details should be completed to include their local address and contact details in Australia.

- If a patient experiences a **subsequent episode** of stroke while in hospital for an admitted episode for stroke, generally all processes of care will relate to the first episode only. The exceptions to this are:
    - If a patient was admitted with a TIA and has a progression of symptoms or subsequent ischaemic stroke, record the details of the ischaemic stroke.
    - If a patient undergoes treatment for the subsequent stroke (e.g. thrombolysis or ECR), these details should be recorded.

- For patients who experience a stroke during an episode of admitted patient care for a different condition (known as an **'in-hospital stroke'**), processes of care variables should be applied to the period following the onset of their stroke symptoms. It is accepted that details such as admission date will precede symptom onset. Some variables for these patients are automatically disabled or greyed out once 'in-hospital stroke' is recorded. An event is not recorded as an 'in-hospital stroke' if onset occurred while at another hospital prior to transfer to your hospital.

- For **inter-hospital transfers**, most processes of care and administrative (e.g. admission time) variables relate to the patients' current admission at YOUR hospital. The exception to this is:
    - Thrombolysis and 'first brain scan' variables. These details should be entered even if they were provided to the patient prior to arrival at your hospital. These inform ongoing acute management at the receiving hospital.

  Some patients who are admitted at both hospitals (either prior to transfer or on return for further acute care) will have thrombolysis and brain scan data recorded at both hospitals.

AuSCR eligibility criteria

Patients eligible for entry into the AuSCR

- Patients admitted with acute stroke as determined by clinical diagnosis
    - Generally, this includes the following stroke ICD-10 codes:
        - I61.0 –I61.9 Intracerebral haemorrhage
        - I62.9 Other non-traumatic intracranial haemorrhage
        - I63.0 – I63.6, I63.8, I63.9 Cerebral infarction
        - I64 Stroke not specified as haemorrhage or infarction
- Eligible patients include:
    - Patients admitted to any ward
    - Patients admitted to a short stay unit, where this is considered an admission to the hospital
    - Patients admitted directly for palliative care (within same hospital)
    - Where stroke is the most likely diagnosis on discharge
    - Patients with intracerebral haemorrhage receiving neurosurgical intervention
    - Patients who experience a stroke while admitted in hospital for another condition, including when the stroke is a lower priority compared to other health concerns
    - Patients who were initially misdiagnosed or received a delayed diagnosis
    - Patients who are transferred to your hospital from another hospital, where the patient is admitted for further acute stroke care
    - Patients discharged within 24 hours of admission
    - Patients without a stroke ICD-10 diagnosis code. Where there is a discrepancy between clinical coding and clinical diagnosis, the clinical diagnosis assigned by a clinician should be used to determine eligibility
    - Non-traumatic intracerebral bleed regardless of cause (excluding cancer).
        - Examples may include but not limited to cranial venous sinus thrombosis, cavernoma, and ruptured AVMs

Patients eligible for the Emergency Department dataset only

- Patients with acute stroke presenting to your hospital and transferred to another acute hospital for ongoing stroke care prior to admission

Patients ineligible for the AuSCR

- Subarachnoid or subdural haemorrhages
- Patients who die or are certified brain dead in the Emergency Department
- Patients discharged home from the Emergency Department
- Incidental findings of stroke on brain scan only
- Sub-acute stroke presentations
- Patients with sub-acute/chronic stroke admitted for rehabilitation (e.g. patients returning from a comprehensive stroke centre following acute treatment and requiring rehabilitation)
- Central retinal artery or central retinal vein occlusions
- Primary brain cancer complicated by haemorrhage
- Intracerebral haemorrhage secondary to trauma
- Transient ischaemic attack (TIA), since May 2023

Sources of variables and definitions

National Stroke Data Dictionary 2015, plus more recent versions

VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3

Stroke Foundation, National Acute Stroke Services Framework 2019

Stroke Foundation, National Stroke Audit Program: Methodology, March 2020
https://informme.org.au/media/u0ajsha3/national-stroke-audit-methodology.pdf

Stroke Foundation, Living Clinical Guidelines for Stroke Management
https://informme.org.au/guidelines/living-clinical-guidelines-for-stroke-management#

Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard
https://www.safetyandquality.gov.au/our-work/clinical-care-standards/acute-stroke-clinical-care-standard

Home and Community Care Program National Minimum Data Set (Victorian modification) User Guide v2.0 2006

Home and Community Care Program National Minimum Data Set Victorian modification User Guide Version 2.0 Vic June 2006

Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2015-2016.

Queensland Health Clinical Practice Improvement Centre: Stroke Assessment Data Collection Form: Data Collection Manual, Jan 2010

INSPIRE clinical data guidance version 9

SITS Registry data forms for IVTP and TBYP – standard 2014

Agency for Clinical Innovation (ACI), Stroke Network Audit Tool – National Stroke Research Institute – Version 1.3 2013

ACI Stroke Procedures for auditing medical records for stroke admissions using New South Wales Stroke Care Audit Tool 2013

Data Elements for Paul Coverdell National Acute Stroke Registry 2008

Thrombolysis Implementation in Stroke (TIPS) Study

Lees, K. *Modified Rankin Scale: A training and certification resource*. University of Glasgow

EuroQoL Group EQ-5D-3L User Guide Version 5.1 2015

Adams, H. P. et al (1993) Classification of Subtype of Acute Ischaemic Stroke: Definitions for use in a multicenter clinical trial. TOAST. Trial of Org 10172 in Acute Stroke Treatment. Stroke, 1993 (24), pp. 35-41

Counsell C, Dennis M, McDowall M, et al. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. Stroke 2002; 33(4):1041-7

Evans, SM, Loff, B, Cameron PA (2013). Clinical registries: the urgent need to address ethical hurdles. Medical Journal of Australia, 198(3), 134-135

Ontario Stroke Registry Acute Data Dictionary 2013

RIKS-Stroke, Acute Phase. Version 8.0 2007

Get With the Guidelines ® – Stroke PMT ® Coding Instructions - Updated July 2014

National Institute of Health, National Institute of Neurological Disorders and Stroke. NIH Stroke Scale

World Health Organization WHO Draft Guidelines for Adverse Event Reporting and Learning Systems, 2005

Standard Australian Classification of Countries (SACC), 2016. Canberra: Australian Bureau of Statistics (for country names and codes)

Australian Standard Classification of Languages (ASCL), 2016. Canberra: Australian Bureau of Statistics (for languages and codes)

Bernard, TJ et al. (2012). Towards a Consensus-based Classification of Childhood Arterial Ischaemic Stroke, Stroke, 43(2): pp 371-377

Lo, W. (2011). Childhood Hemorrhagic Stroke: An Important but Understudied Problem, Journal of Child Neurology, 26(9): pp 1174-1185.

ACUTE AuSCR DATA VARIABLE DEFINITIONS

Auditor information

Hospital name 1.000

Note: This variable is auto-populated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	1.000
Common Name	Name of the hospital
Definition	The name by which an establishment, agency or organisation is known or called, as represented by text. METeOR Identifier: 407430
Format	User interface: Auto-populated. Import Template: Alpha numeric field. Maximum character length: 50.
Recording Guidance	– **Required field.** – This variable is **auto-populated** in the database at the User level, based on the log-in details of the user. – Hospital Users with logins attached to multiple sites must select the intended site for data entry on login. – Systems Administrator and Program Coordinator have authority to assign hospitals to users, choosing from a drop down list.
Codes and Values	Free text. Codes will be agreed and allocated by the AuSDaT Systems Administrator and AuSDaT Coordinator to represent each hospital (organisation).
Help Note	Auto-populated from login.
Further Information	– This variable is not deleted when a patient elects to remove their personal and/or full clinical data (i.e. opt-out) from the AuSDaT, allowing records of the number of admissions to be retained within the database.

Hospital ID

Note: This variable is auto-populated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	N/A
Common Name	Hospital ID number
Definition	A unique identifier by which the dataset for a specific hospital can be identified.
Format	Numeric field. Variable only appears when exporting data.
Recording Guidance	This variable is **auto-populated** in the database
Codes and Values	N/A

Auditor name 1.020

Note: This variable is auto-populated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	1.020
Common Name	User name
Definition	The name by which the user is known and can be identified.
Format	User Interface: Alpha numeric field. Text box. Auto-populated. Import Template: Alpha numeric field. *Maximum character length: 50.*
Recording Guidance	– **Required field.** – This variable is **auto-populated** in the database at the user level, based on the log-in details of the user. If no auditor name is indicated in the import template, the system will default to recording the log-in details of the person importing the data.
Codes and Values	Free text

Patient demographics

Patient Record ID Number 2.000

This variable is auto-generated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.000
Common Name	Patient Record ID Number
Definition	A unique ID by which the dataset for a specific patient episode of care can be identified.
Format	User Interface: Numeric field. Auto-generated. Import template: Not used for the purpose of data importing.
Recording Guidance	This variable is **auto-generated** in the database on creation of a new patient episode.
Codes and Values	N/A
Further information	Each patient record ID is unique for each episode of care. This number is useful to identify records whilst observing confidentiality of patient information.

Statistical linkage key 2.030

Note: This variable is auto-generated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.030
Common Name	SLK
Definition	Derived from patient details to enable links between AuSDaT programs or to other databases without holding patient identifiable information.
Format	Alph numeric field. *Character length: 14.* Variable only appears when exporting data.
Recording Guidance	– This variable **is auto-generated** in the database on creation of a new patient episode. – Derived from patient name, date of birth and gender.
Codes and Values	N/A
Further information	The SLK is an alphanumeric patient identifier that may or may not be available to programs using the AuSDaT. The SLK algorithm is based on a validated method and is used by certain government departments and programs. It is created based on a combination of personal details (i.e. name, gender and date of birth). The SLK is not visible on the AuSDaT user interface. In the case of opt-outs, the SLK will be retained.

Patient details

Title 2.050

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.050
Common Name	Person's name title
Definition	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, phone, or in person. METeOR Identifier: 613313
Format	User Interface: Drop down list. Import template: Alpha numeric field. Case sensitive - use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	MR Mr MRS Mrs MS Ms MISS Miss DR Dr SR Sr MASTER Master FR Fr REV Rev
Help Note	Select an option indicating the person's preferred title. This field does not indicate the person's marital status.

First name 2.060

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.060
Common Name	Person's given name.
Definition	The person's identifying name within the family group or by which the person is socially identified, as represented by text. METeOR Identifier: 613340
Format	User Interface: Alpha numeric field. Text box. Import Template: Alpha numeric field. *Unlimited character length.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Free text.
Help Note	Record the given name as indicated by the person (e.g. written on a form) or printed on an identification card, e.g. Medicare card. **If a patient has different names on different documents***:* record the person's name as written on their Medicare card. **If a patient only has one name:** record it in the 'Last Name' field and place a hyphen in the 'First Name' field.

Last name 2.070

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.070
Common Name	Person's surname or family name.
Definition	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her first or given names, as represented by text. METeOR Identifier: 613331
Format	User Interface: Alpha numeric field. Text box. Import Template: Alpha numeric field. *Unlimited character length.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Free text.
Help Note	Record the full family name as indicated by the person (e.g. written on a form) or printed on an identification card, e.g. Medicare card. **If a patient has different names on different documents***:* record the person's name as written on their Medicare card. **If a patient only has one name:** record it in the 'Last Name' field and place a hyphen in the 'First Name' field.

Date of birth 2.090

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.090
Common Name	Date of birth.
Definition	The date of birth of the person. METeOR Identifier: 287007
Format	User Interface: Calendar field. Import template: Date field.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	DD/MM/YYYY
Help Note	**If the day of birth is unknown**: enter 01/MM/YYYY. **If the day and month of birth are unknown**: enter 01/01/YYYY. **If the day, month and year of birth are unknown:** Estimate the person's age in years to establish an approximate year of birth and enter 01/01/YYYY.

Age 2.100

Note: This variable is auto-populated within the AuSDaT

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.100
Common Name	Age on admission.
Definition	The age in (completed) years at the date of admission. METeOR identifier 303794
Format	Calculated automatically from date of birth and date of admission.
Recording Guidance	No data entry required.
Codes and Values	Calculated in years
Help Note	Auto-calculated from date of birth and date of admission.
Further Information	Age provides important epidemiological information. Age associated with severity of stroke is an important predictive factor for outcomes both in terms of mortality and resulting dependency.

Medicare number 2.110

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.110
Common Name	Number on the person's Medicare Card, used as an Australian Commonwealth Government identifier.
Definition	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme that appears on a Medicare card. METeOR identifier: 270101
Format	User Interface: Numerical field. Text box. No spaces can be added to this field. Representational layout: NNNNNNNNNN. *Required character length: 10.* Import template: Numerical field. Representational layout: NNNNNNNNNN. *Required character length: 10.*
Recording Guidance	**Optional field** Individual patient medical records, admission form or patient administrative system.
Codes and Values	– Free Text.
Help Note	Record the 10 digit Medicare number with no spaces, and without the individual reference number. **If the person does not have a Medicare number:** leave this field blank. **<u>Do not</u>** use Department of Veterans' Affairs (DVA) number in place of Medicare number.
Further Information	Example: John Smith's full Medicare number is 1234567890. 

Hospital Medical Record Number (MRN) 2.120

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.120
Common Name	Medical Record Number (MRN), also known as Unit Record Number (UR) and Patient Record Number.
Definition	Person identifier unique within an establishment or agency. METeOR Identifier: 290046
Format	User Interface: Alpha numeric field. Text box. *Required character length: Minimum 6, Maximum 10.* Import Template: Alpha numeric field. *Required character length: Minimum 6, Maximum 10.*
Recording Guidance	– **Required field.** – Individual patient medical records – the numbering system including the content and format of the medical record number is usually specific to the individual health care service.
Codes and Values	Free text.
Help Note	Record the 6-10 character alpha numeric patient MRN. **If the MRN is shorter than 6 digits:** enter leading zeros so that a 6 digit number is recorded.
Further Information	– The MRN is collected to assist in individual patient identification. – When extracted from the AuSCR, leading zeros will be removed.

Gender 2.130

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.130
Common Name	Sex
Definition	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code. METeOR Identifier 635126.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	1 Male 2 Female 3 Intersex or indeterminate 9 Not stated/Inadequately described
Help Note	Record the gender as documented in the medical record. **If the gender in the medical record is different to self-identified gender:** document the patient self-identified gender. **If 'non-binary'**: select Intersex or indeterminate.
Further Information	Required to stratify data on the basis of gender.

Country of birth 2.150

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.150
Common Name	The person's country of birth
Definition	The country in which the person was born, as represented by a code. METeOR Identifier: 659454
Format	User Interface: Drop down list. Import template: Numerical field. Representational layout: NNNN. *Required character length: 4.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Four digit numerical code (NNNN) Country names are coded in accordance with the Standard Australian Classification of Countries (SACC), 2016. Canberra: Australian Bureau of Statistics.
Help Note	Select the person's country of birth. **If country of birth is unknown:** select Unknown.
Further Information	A full list of country names and codes available in AuSCR is provided in Appendix 4.

Language spoken 2.160

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.160
Common Name	Person's preferred language
Definition	The language (including sign language) most preferred by the person for communication, as represented by a code. METeOR Identifier: 659407
Format	User Interface: Drop down list. Import Template: Numerical field. Representational layout: NNNN. *Required character length: 4.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Four digit numerical code (NNNN) Languages are coded in accordance with the Australian Standard Classification of Languages (ASCL) 2016. Canberra: Australian Bureau of Statistics.
Help Note	Select the person's preferred language of communication, including sign language if applicable. The person's preferred language may be recorded as a language other than English even where the person can speak fluent English. The response to this variable will not determine the necessity of an interpreter.
Further Information	A full list of languages available in AuSCR is provided in Appendix 5.

Interpreter needed 2.170

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.170
Common Name	Need for interpreter service.
Definition	Whether an interpreter service is required by or for the person, as represented by a code. METeOR Identifier: 304294
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records or admission form.
Codes and Values	1 Yes 2 No
Help Note	Select Yes if the person requires an interpreter service for languages other than English or sign language.

Is the patient of Aboriginal/Torres Strait Islander origin? 2.180

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.180
Common Name	Whether a person identifies as being of Australian Indigenous, Aboriginal or Torres Strait Islander origin.
Definition	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. METeOR Identifier: 602543. There are three components to the Commonwealth definition of identification: – descent; – self-identification; and – community acceptance. This variable is defined in terms of self-identification as being of Aboriginal or Torres Strait Islander origin'.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field**. – Individual patient medical records, admission form or patient administrative system.
Codes and Values	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal nor Torres Strait Islander origin 8 Indigenous not otherwise described 9 Missing/not stated
Help Note	Select the person's self-identified Aboriginal and Torres Strait Islander status in preference to other sources if they conflict.
Further Information	Rationale: Indigenous Australians suffer poorer health outcomes than their counterparts. Stroke subtypes and risk factor prevalence also vary by different ethnic status.

Contact information

Phone number 2.190

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.190
Common Name	Contact landline telephone number.
Definition	The person's contact landline telephone number. METeOR Identifier: 270266.
Format	User Interface: Numerical field. Text box. Representational layout: (XX) XXXX XXXX. Note that the AuSDaT prefills the initial 0 of the prefix. *Required character length: 10.* Import Template: Alpha numeric field. Representational layout: (XX) XXXX XXXX. *Required character length: 10.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – The spaces and brackets are automated features within the user interface. These features are required to be entered within the import template, e.g. (01) 2345 6789.
Codes and Values	Free text.
Help Note	Record the full landline telephone number (the initial zero is prefilled). Spaces and brackets are automated in the AuSDaT. Hyphens are not to be used. **For a person living overseas and visiting Australia:** record their local Australian contact number. **If the person only has a mobile phone number:** this should only be recorded in the mobile number variable (2.200); leave this field (2.190) blank or record (00) 0000 0000.
Further Information	This is required for registrant follow-up in the community.

Mobile number 2.200

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.200
Common Name	Contact mobile telephone number.
Definition	The person's contact mobile telephone number. METeOR Identifier: 270266
Format	User Interface: Numerical field. Text box. Representational layout: (XX) XXXX XXXX. Note that the AuSDaT prefills the initial 0 of the prefix, *Required character length: 10.* Import Template: Alpha numeric field. Representational layout: (XX) XXXX XXXX. *Required character length: 10.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – The spaces and brackets are automated features within the user interface. These features are required to be entered within the import template, e.g. (01) 2345 6789.
Codes and Values	Free text.
Help Note	Record the full mobile telephone number (the initial zero is prefilled). Spaces and brackets are automated in the AuSDaT. Hyphens are not to be used. **For a person living overseas and visiting Australia:** record their local Australian contact number. **If the person only has a landline telephone number:** this should only be recorded in the phone number variable (2.190); leave this field (2.200) blank or record (00) 0000 0000.
Further Information	This is required for registrant follow-up in the community.

Address type 2.210

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.210
Common Name	The address type, residential/business/other.
Definition	The role or use of an address in relation to a person. METeOR Identifier: 428930
Format	User Interface: Radio button. Import template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	BUSINESS Business HOME Home OTHER Other
Help Note	Select Home for a residential street or postal address, including PO Box. **For a person living overseas and visiting Australia**: select Other, and enter their local (temporary) Australian address in the address fields.
Further Information	This is required for registrant follow-up in the the community.

Street address 2.220

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.220
Common Name	Person street address.
Definition	A composite of standard address components that describe a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components, forms a complete geographical/physical address of a person. METeOR Identifier: 286620.
Format	User Interface: Alpha numeric field. Text box. *Maximum character length: 180.* Import template: Alpha numeric field. *Maximum character length: 180.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Free Text.
Help Note	Enter the full street address. **Where two addresses are listed in hospital records:** record the mailing/postal address for follow-up. **For a residential aged care facility or retirement village:** include the property name then street address e.g. Heidelberg Aged Care, 123 High Street. **For a person living overseas and visiting Australia:** record their local (temporary) Australian address in this and the following address fields. **If the person has no fixed address, or does not have a local Australian address:** leave blank.
Further information	This is required for registrant follow-up in the community.

Suburb 2.230

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.230
Common Name	Name of suburb, town or locality.
Definition	The name of the locality contained within the specific address of a person, as represented by text. METeOR Identifier: 429889
Format	User Interface: Alpha numeric field. Text box *Maximum character length: 50* Import template: Alpha numeric field. *Maximum character length: 50*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Free text.
Help Note	**If the person has no fixed address, or does not have a local Australian address:** leave blank.
Further Information	This is required for registrant follow-up in the community.

Postcode 2.240

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.240
Common Name	Australian postcode.
Definition	The Australian numeric descriptor for a postal delivery area for an address. METeOR Identifier: 611398
Format	User Interface: Alpha numerical field. Text box. Representational layout: NNNN*. Maximum character length: 4.* Import template: Alpha numerical field. Representational layout: NNNN*. Maximum character length: 4.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Free text.
Help Note	**If the person has no fixed address, or does not have a local Australian address:** leave blank.
Further Information	This is required for registrant follow-up in the community.

State 2.250

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.250
Common Name	Australian state/territory identifier.
Definition	An identifier of the state or territory of an address, as represented by a code. Based on METeOR Identifier: 352480
Format	User Interface: Drop down list. Import template: Alpha numeric field. Case sensitive; use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	ACT Australian Capital Territory NSW New South Wales NT Northern Territory QLD Queensland SA South Australia TAS Tasmania VIC Victoria WA Western Australia Other Other Overseas Overseas
Help Note	Select the relevant state or territory. **For a person living overseas and visiting Australia with no local address:** select Overseas. **Other** refers to Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory.
Further Information	– Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. – This is required for registrant follow-up in the community.

Country 2.260

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.260
Common Name	The country in which the person resides.
Definition	The country component of an address, as represented by a code. METeOR Identifier: 659626.
Format	User Interface: Drop down list. Import Template: Numerical field. Representational layout: NNNN.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	Four digit numerical code (NNNN). Country names are coded in accordance with the Standard Australian Classification of Countries (SACC), 2016. Canberra: Australian Bureau of Statistics.
Help Note	Select the relevant country **For a person living overseas and visiting Australia:** select Australia if a local (temporary) address is available. **If the person has no fixed address, or does not have a local Australian address:** leave blank.
Further Information	– A full list of country names and codes available in the AuSCR in provided in Appendix 4. – This is required for registrant follow-up in the community.

Emergency contact

Emergency contact details 2.280 to 2.370

ED	Green	Red	Black	FeSS	Paeds

MDL References	2.280 First name 2.290 Last name 2.300 Address type 2.310 Street address 2.320 Suburb 2.330 Postcode 2.340 State 2.350 Country 2.360 Phone number 2.370 Mobile number
Common Name	Contact details of the person's next of kin or key contact.
Definition	Name and contact details of a representative who can be contacted in case of an emergency involving the person as per details recorded in the admission notes for this episode of care.
Format	The format of these variables is the same as those for the patient contact details. *Refer to MDL References: 2.06, 2.07, 2.19, 2.20, 2.21, 2.22, 2.23, 2.24, 2.25, 2.26.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system.
Codes and Values	The codes and values for these variables are the same as those for the patient contact details. *Refer to MDL References: 2.06, 2.07, 2.19, 2.20, 2.21, 2.22, 2.23, 2.24, 2.25, 2.26.*
Further Information	– For persons less than 15 years of age the parent or guardian should be listed as the Emergency Contact. – This is required for registrant follow-up in the community.

Same as patient address? 2.291

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	2.291
Common Name	Same as person's address.
Definition	Emergency contact address is the same as the person's address.
Format	User Interface: Tick box. Import Template: Alpha numeric. Case sensitive - use upper case.
Recording Guidance	– **Required field.** – Selecting the tick box on the user interface will shade out and disable all emergency contact address related fields. – If TRUE is indicated on the import template, then all address related fields for the emergency contact must be deleted from the template, or fields will come up as in error.
Codes and Values	TRUE FALSE
Help Note	Select TRUE if the emergency contact person can be contacted at the same address as the patient. This address may be used to seek proxy completion of follow-up if there is no response to the first attempt to registrant.

Emergency contact relationship to participant 2.390 to 2.391

ED	Green	Red	Black	FeSS	Paeds

MDL References	2.390 Emergency contact relationship to participant 2.391 Other (relative specify)
Common Name	Emergency contact relationship to person.
Definition	The affiliation of the contact person, as represented by a code. Bassed on METeOR Identifier: 270012.
Format	User Interface: 2.390 Drop down list 2.391 Alpha numeric field. Text box Import Template: 2.390 Alpha numeric field. Free text. Case sensitive- use upper case. 2.391 Alpha numeric field. Free text. *Unlimited character length.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – User Interface: The 'Other relative' text box is only enabled when you select 'Other Relative' from the drop-down list.
Codes and Values	2.390 SP Spouse/Partner SD Son/Daughter SIB Sibling PAR Parent FA Friend/Associate OR Other Relative (free text) PC Professional Carer NS Not stated/inadequately described 2.391 Free text
Help Note	If Other Relative is selected, specify the type of relative in 2.391, e.g. Cousin, Grandparent, Daughter-in-law, Foster parent. Professional Carer is a person trained and paid to look after people.

Alternative contact details 2.400 to 2.490

ED	Green	Red	Black	FeSS	Paeds

MDL References	2.400 First name 2.410 Last name 2.420 Address type 2.430 Street address 2.440 Suburb 2.450 Postcode 2.460 State 2.470 Country 2.480 Phone number 2.490 Mobile number
Common Name	Contact details of the person who is given as an alternate contact if the emergency contact is unable to be contacted.
Definition	Name and contact details a representative who can be contacted in case of an emergency involving the person if the primary emergency contact can not be reached, as recorded in the admission notes for this episode of care.
Format	– **Required field.** – The format of these variables is the same as those for the patient contact details. Refer to MDL References: *2.06*, *2.07*, *2.19*, *2.20*, *2.21*, *2.22*, *2.23*, *2.24*, *2.25*, *2.26*.
Recording Guidance	Individual patient medical records, admission form or patient administrative system.
Codes and Values	The codes and values for these variables are the same as those for the patient contact details. Refer to MDL References: *2.06*, *2.07*, *2.19*, *2.20*, *2.21*, *2.22*, *2.23*, *2.24*, *2.25*, *2.26*.
Further Information	The alternate contact may be contacted during the third (phone) follow-up attempt if no response from the patient or emergency contact during follow-up.

Alternative contact relationship to participant 2.510 to 2.511

ED	Green	Red	Black	FeSS	Paeds

MDL References	2.510: Alternate contact relationship to person 2.511: Other relative (specify)
Common Name	Alternate contact relationship to person.
Definition	The affiliation of the contact to the person. Based on METeOR Identifier: 270012.
Format	User Interface: 2.510 Drop down list 2.511 Alpha numeric field. Text box Import Template: 2.510 Alpha numeric field. Free text. Case sensitive - use upper case. 2.511 Alpha numeric field. Free text. *Unlimited character length.*
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – User Interface: The 'Other relative' text box is only enabled when you select 'Other Relative' from the drop-down list.
Codes and Values	2.510 SP Spouse/Partner SD Son/Daughter SIB Sibling PAR Parent FA Friend/Associate OR Other Relative (free text) PC Professional Carer NS Not stated/inadequately described 2.511 Free text
Help Note	If Other Relative is selected, specify the type of relative in 2.511, e.g. Cousin, Grandparent, Daughter-in-law, Foster parent. Professional Carer is a person trained and paid to look after people.

Admission and transfer information

Admission details

Onset date 4.000 to 4.020

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.000: Onset date 4.010: Unknown (onset date) 4.020: Date accuracy
Common Name	Onset date and accuracy of stroke.
Definition	Date and accuracy of the symptom onset for the current stroke. This is also known as the date the person was last seen, or known to be, well. METeOR Identifier: 338263
Format	User Interface: 4.000 Calendar field. 4.010 Tick box. 4.020 Radio buttons. Import Template: 4.000 Date field. 4.010 Alpha numeric field. Case sensitive – use upper case. 4.020 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical record, nursing notes, medical notes and ambulance report. – User Interface: Stroke date and time fields will be greyed out and disabled if onset date 'unknown' is selected.
Codes and Values	4.000 DD/MM/YYYY 4.010 TRUE FALSE 4.020 AAA Accurate EAA Estimate
Help Note	Record the date stated by admitting or stroke physician in preference to other sources. When onset date is known, record the date and select **Accurate** for Date accuracy. If the day is unknown, format as 01/MM/YYYY and select **Estimate** for Date accuracy. If the day and month is unknown, format as 01/01/YYYY and select **Estimate** for Date accuracy. If the person woke with symptoms of stroke (wake-up stroke), record the date that the person was last seen, or known to be well, i.e. unaffected by clinical features related to stroke. Leave blank and select **Unknown** (4.010) if no estimated onset date can be found.

Onset time 4.030 to 4.040

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.030 Onset (stroke) time 4.040 Time accuracy
Common Name	Stroke onset time.
Definition	Time of the current stroke, this is also known as the time the person was last seen, or known to be, well (i.e. if the patient awoke with symptoms of stroke the onset time is designated as the last time the patient was seen, or known to be, well). Based on METeOR Identifier: 270080
Format	User Interface: 4.030 Time field. 4.040 Drop down list. Import Template: 4.030 Time field. 4.040 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical record - Allied health records, Nursing notes and Medical notes or ambulance report. – Stroke onset time will be greyed out and disabled if 'time unknown' for stroke time selected. – Stroke date and time fields will be greyed out and disabled if onset date 'unknown' is selected.
Codes and Values	4.030 hh:mm 4.040 KWN Known time of onset UNC If uncertain time of stroke, time last seen well WAK If wake up stroke, time last seen well TU Time unknown
Help Note	Onset time is recorded to the nearest minute, but time to within 15 minutes of exact time is acceptable to be recorded as '**Known time of onset'**. If person woke with symptoms of stroke, record the time the person was last known to be well, and select '**If wake up stroke, time last seen well'.** If stroke onset time is unclear, then record the time last seen well, and select '**If uncertain time of stroke, then time last seen well'**. If time given is indicative (e.g. Early afternoon), record the specified time from the list in the Data Dictionary under Further Information, and select '**If uncertain time of stroke, then time last seen well'**. Select **Time Unknown** for 4.040 Time accuracy, if stroke onset time is unknown or no estimated stroke onset time can be found. Record the time stated by admitting or stroke physician in preference to other sources if there is a conflict.
Further Information	If only an approximate onset time is available, select an approximate time from the list below:

Description of Time	Record Time as:
Middle of the night	03:00
Breakfast/Early morning	08:00
Morning	09:00

		Late morning	10:00	
		Lunch/Midday/Noon	12:00	
		Early afternoon	14:00	
		Afternoon/Mid-afternoon	15:00	
		Late afternoon	16:00	
		Dinner/Supper	18:00	
		Early evening	19:00	
		Evening	21:00	
		Late evening	22:00	
		Midnight	23:59	

Date of discovery 4.090 to 4.101

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.090 Date of discovery 4.100 Date accuracy 4.101 Unknown (date of discovery)
Common Name	Date patient discovered with stroke.
Definition	The date that the patient was discovered with most recent stroke symptoms (e.g., when the patient was found by family member, hospital staff with symptoms). Date of discovery of patient with the current acute stroke symptoms.
Format	User Interface: 4.090 Calendar field 4.100 Radio buttons 4.101 Tick box Import Template: 4.090 Date field. 4.100 Alpha numeric field. Case sensitive –use upper case. 4.101 Alpha numeric field. Case sensitive –use upper case.
Recording Guidance	– **Required field.** – Individual patient medical record - Admission form, discharge summary, ED nurse's notes, history and medical /nursing notes and ambulance report. – User Interface: Date of discovery (Ref 4.090) and Date accuracy (Ref 4.100) fields will be greyed out disabled if discovery date "Unknown" is selected.
Codes and Values	4.090 DD/MM/YYYY 4.100 AAA Accurate EAA Estimate 4.101 TRUE FALSE
Help Note	- If there are conflicting onset times, please use the following hierarchy: 1. Stroke team/Neurologist 2. Admitting physician 3. Emergency Department physician 4. ED nursing notes 5. Emergency medical staff/Ambulance reports - If date of onset is reported as accurate, this variable will be auto-populated with the same date. - If date of onset is reported as estimated, this variable will be auto-populated but it will be possible to change. - Date of discovery should be the earliest time that patient was known to have symptoms. - If the event was witnessed, then the date/time stroke onset and the date/time discovery will be identical. - If the exact day is not clear, enter closest known date and select "Estimate". - If a date is unknown (i.e. discovery date cannot be determined) or not documented, select "Unknown". - If date unknown is chosen, tool will automatically select "Estimate".

Time of discovery 4.120 to 4.131

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.120 Time of discovery 4.130 Time accuracy 4.131 Unknown
Common Name	Time patient discovered with stroke.
Definition	The time that the patient was discovered with most recent stroke symptoms (e.g., by family member, hospital staff). Time of discovery of patient with the current acute stroke symptoms.
Format	User Interface: 4.120 Time field 4.130 Radio buttons 4.131 Tick box Import Template: 4.120 Time field. 4.130 Alpha numeric field. Case sensitive – use upper case. 4.131 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – The most logical and reliable time from all evidence is to be used. – Individual patient medical record – allied health records, nursing notes, and medical notes, or ambulance report. – Time of discovery (Ref 4.120) and time accuracy (Ref 4.130) fields will be greyed out and disabled if time of discovery “Unknown” selected.
Codes and Values	4.120 hh:mm 4.130 AAA Accurate EAA Estimate 4.131 TRUE FALSE
Help Note	– If there are conflicting dates, please use the following hierarchy: 1. Stroke team/Neurologist 2. Admitting physician 3. Emergency Department physician 4. ED nursing notes 5. Emergency medical staff/Ambulance reports – This variable will be auto-populated from “onset time” responses if “onset time” was reported as accurate. – Time is recorded to the nearest minute; however time to within 15 minutes of exact time of stroke onset is acceptable to be coded as “Accurate”. – Descriptions of time such as two hours prior to arrival, about 1 hour ago or approximately 2 and a half hours ago are specific enough to perform a calculation or express a time as accurate. – If a range of hours is documented (e.g. between 4-6 hours), enter the latest time and select “Estimate”. – If a time cannot be clearly determined from the notes or is documented to be an estimate select “Estimate”. – If a discovery time is not known (i.e. discovery time cannot be determined) or not documented, select “Unknown”.

Did the stroke occur while the patient was in hospital? 4.140

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	4.140
Common Name	In-hospital stroke
Definition	Stroke with onset during an episode of admitted patient care at your hospital for another condition.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical record: admission form, discharge summary, patient history and medical/nursing notes. – When 'YES' or 'UNKNOWN' is selected, all variables 4.15, 4.16, 4.17, 4.18, 4.181, 4.19 and 4.20 are greyed out and disabled. – Note that this refers to onset of symptoms at your hospital only; if stroke onset occurred at another hospital, record as 'No'.
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Select **Yes** when stroke occurred at this hospital during the current episode of admitted care for a condition other than stroke. Select **No** if admitted with a stroke and has a subsequent stroke during the same admission, or if stroke occurred at another hospital, or if stroke occurred in the Emergency Department before admission for acute care.

Date of arrival to Emergency Department 4.150 to 4.160

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.150 Date of arrival to Emergency Department 4.160 Date accuracy
Common Name	Date of arrival to the Emergency Department, otherwise known as Accident & Emergency (A&E) Department or Casualty Department.
Definition	The date of patient presentation at the Emergency Department is the first recorded contact with an emergency department staff member. METeOR Identifier: 746093
Format	User Interface: 4.150 Calendar field. 4.160 Radio buttons. Import Template: 4.150 Date field. 4.160 Alpha numeric field. Case sensitive- use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – This variable is greyed out and disabled if 'Yes' or 'Unknown' is selected for in hospital stroke variable.
Codes and Values	4.150 DD/MM/YYYY 4.160 AAA Accurate EAA Estimate
Help Note	If the day is unknown, format as 01/MM/YYYY and select **Estimate** for Date accuracy. If a patient bypasses ED (either transferred from another hospital or admitted directly), record the date the patient entered the hospital as the ED arrival date, and select **Estimate**.

Time of arrival to Emergency Department 4.170 to 4.181

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.170 Time of arrival to Emergency Department 4.180 Time accuracy 4.181 Unknown (time)
Common Name	Arrival time to the Emergency Department (ED), otherwise known as Accident & Emergency (A&E) Department or Casualty Department.
Definition	The time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first. METeOR Identifier: 746098
Format	User Interface: 4.170 Time field. 4.180 Radio buttons. 4.181 Tick box. Import Template 4.170 Time field. 4.180 Alpha numeric field. Case sensitive – use upper case. 4.181 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – This variable is greyed out and disabled if 'Yes' or 'Unknown' is selected for in hospital stroke variable. – Time of Emergency Department arrival and accuracy is greyed out and disabled if 'Unknown' ED arrival time selected.
Codes and Values	4.170 hh:mm 4.180 AAA Accurate EAA Estimate 4.181 TRUE FALSE
Help Note	If time is unclear, enter an approximate time, and select **Estimate**. If a patient bypasses ED (either transferred from another hospital or admitted directly), record the time the patient entered the hospital or ambulance 'At destination' time as the ED arrival time, and select **Estimate**.

Direct admission to hospital (bypass ED) 4.190

ED	Green	Red	**Black**	FeSS	Paeds

MDL Reference	4.190
Common Name	Direct admission to hospital (bypass ED)
Definition	The patient was directly admitted to hospital without presentation to the hospital's own Emergency Department. This includes patients admitted via the Emergency Department of another hospital or health service.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records, admission form or patient administrative system. – This variable is greyed out and disabled if 'Yes' or 'Unknown' is selected for in hospital stroke variable.
Codes and Values	1 Yes 2 No

Did the patient arrive by ambulance? 4.200

ED	**Green**	**Red**	**Black**	FeSS	**Paeds**

MDL Reference	4.200
Common Name	Arrival by ambulance.
Definition	Person arrived at hospital via ambulance. Based on METeOR Identifier: 651879
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Ambulance report or patient medical records (Admission form, Medical Notes). – This variable is greyed out and disabled if 'Yes' or 'Unknown' is selected for in hospital stroke variable (4.140).
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Select **Yes** if person arrived by road ambulance, Mobile Stroke Unit, air ambulance or helicopter rescue service. Select **Unknown** if mode of arrival is not documented or unclear.

Pre-hospital notification by paramedics 4.210

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	4.210
Common Name	Pre-hospital notification
Definition	Health service pre-notified of the impending arrival of the patient with stroke diagnosed by paramedics.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Ambulance report or patient medical records (Admission form, Medical Notes). – Variable enabled if “Yes” answered for “Did the patient arrive by ambulance?” (Ref 4.200)
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Select **Yes** if there is documentation in the ambulance patient care record that a hospital was notified by the paramedics in the field. If documented evidence is not found, select **No**.
Further Information	Hospital pre-notification can reduce delays between arrival and interventions.

Was the patient transferred from another hospital? 4.220

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	4.220
Common Name	Inter-hospital transfer.
Definition	Patient transported directly from one hospital (or Mobile Stroke Unit) to another, for admission and/or acute stroke management.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Ambulance report or patient medical records (admission form, medical notes)
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Transfer includes from other hospitals within the same state, interstate or overseas for acute care only; this does not apply to a person being admitted for non-acute care. Select **Unknown** if not documented or if there is conflicting information.

Date of transfer 4.240 to 4.250

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.240 Date of transfer 4.250 Not documented
Definition	Date of transfer to another hospital for further acute care.
Format	User Interface: 4.240 Calendar field 4.250 Tick box for “Not documented” Import Template: 4.240 Calendar field 4.250 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records – Discharge summary, Medical/nursing notes.
Codes and Values	4.240 DD/MM/YYYY 4.250 TRUE FALSE
Help Note	– Variable enabled if “Yes” answered to “Was the patient transferred to another hospital for acute care after admission to your hospital?” (Ref 4.230) – If date is unknown (i.e. transfer time cannot be determined) or not documented, select “Not documented”.

Time of transfer 4.260 to 4.270

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.260 Time of transfer 4.270 Not documented
Definition	Time of transfer to another hospital for further acute care
Format	User Interface: 4.260 Time field 4.270 Tick box for “Not documented” Import Template: 4.260 time field 4.270 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records – Discharge summary, Medical/nursing notes.
Codes and Values	4.260 hh:mm 4.270 TRUE FALSE
Help Note	– Variable enabled if “Yes” answered to “Was the patient transferred to another hospital for acute care after admission to your hospital?” (Ref 4.230) – If time is unknown (i.e. transfer time cannot be determined) or not documented, select “Not documented”.

Date of admission to hospital 4.290 to 4.310

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.290 Date of admission to hospital 4.300 Not admitted 4.310 Date accuracy
Common Name	Hospital admission date
Definition	Date on which an admitted patient commences an episode of care. Based on METeOR Identifier: 269967
Format	User Interface: 4.290 Calendar field. 4.300 Tick box. 4.310 Radio buttons. Import Template: 4.290 Date field. 4.300 Alpha numeric field. Case sensitive – use upper case. 4.310 Radio buttons.
Recording Guidance	– **Required field.** – Individual patient medical records (admission form and or patient administrative system). – If patient not admitted then hospital admission date and time fields are greyed out and disabled.
Codes and Values	4.290 DD/MM/YYYY 4.300 TRUE FALSE 4.310 AAA Accurate EAA Estimate
Help Note	If the day is unknown, format as 01/MM/YYYY and select **Estimate** for Date accuracy. AuSCR records for all programs except the ED dataset must be admitted episodes of stroke care; variable 4.300 Not admitted should not be selected, as this disables admission date fields.

Time of admission to hospital 4.320 to 4.331

ED	Green	Red	Black	FeSS	Paeds

MDL References	4.320 Time of admission to hospital 4.330 Time accuracy 4.331 Unknown
Common Name	Hospital admission time.
Definition	Time at which an admitted patient commences an episode of care. Based on METeOR Identifier: 682942
Format	User Interface: 4.320 Time field. 4.330 Radio buttons. 4.331 Tick box. Import Template: 4.320 Time field. 4.330 Alpha numeric field. Case sensitive – use upper case. 4.331 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Individual patient medical records (admission form and or patient administrative system). – If patient not admitted to hospital (i.e. 'Not admitted' selected) then admission date and time fields are greyed out and disabled.
Codes and Values	4.320 hh:mm 4.330 AAA Accurate EAA Estimate 4.331 TRUE FALSE
Help Note	Enter the time admitted to acute care or inpatient unit; not the time of arrival to ED. If time is unclear, enter an approximate time, and select **Estimate** for Time accuracy.
Further Information	Time of admission is required to identify the time of commencement of the episode of care and to calculate length of stay. It will assist to accurately calculate waiting time, such as delay in time between admission and brain imaging.

Was the patient treated in a Stroke Unit at any time during their stay? 4.380

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	4.380
Common Name	Patient admitted to a Stroke Unit.
Definition	Indicator of whether a patient was admitted to a Stroke Unit during their episode of acute care. – The minimum criteria for a stroke unit is defined as: 1. Co-located beds within a geographically defined unit. 2. Dedicated, interprofessional team with members who have expertise in stroke and/or rehabilitation. The minimum team would consist of dedicated medical (stroke) lead, nursing and allied health (including occupational therapy, physiotherapy, speech pathology, social work and dietitian) and stroke coordinator. 3. Interprofessional team meet at least once per week to discuss patient care. 4. Regular programs of staff education and training relating to stroke (e.g. dedicated stroke inservice program and/or access to annual national or regional stroke conferences/educational webinars).
Format	User Interface: Radio buttons. Import template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission form, ward admission list)
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Select **Yes** if the person was admitted at any time during their episode of care to an acute care stroke unit, as defined by the National Acute Stroke Services Framework 2019; see Data Dictionary for further details. AuSCR records: definition excludes rehabilitation only stroke units. Stroke Foundation Rehabilitation Audit: includes rehabilitation only stroke units as per National Rehabilitation Stroke Services Framework 2022. Queensland Health: includes hospital wards/units with beds listed as having dedicated STKU codes on HBCIS.
Further Information	Stroke unit care is specified as one element of the Acute Stroke Clinical Care Standard (Australian Commission on Safety and Quality in Health Care, 2019).

Care provided at transferring hospital

What was the reason for transfer? 5.040 to 5.140

ED	Green	Red	Black	FeSS	Paeds

MDL References	5.040 Need for IV thrombolysis 5.050 Need for stroke unit care 5.060 Need for rehabilitation 5.070 Need for brain imaging only 5.080 Need for ICU 5.090 Need for specialist medical assessment 5.100 Need for surgical interventions 5.110 Need for diagnostic tests 5.120 Need for coordinated care by a stroke service 5.121 Need for endovascular therapy 5.130 Unknown 5.140 Other (specify)
Common Name	Reason for transfer from another hospital.
Definition	Reason for patient being transferred from one hospital to another, categorised as one or more of the following options: Need for IV tPA; Need for stroke unit care; Need for rehabilitation; Need for brain imaging; Need for ICU; Need for specialist medical assessment; Need for surgical interventions; Need for diagnostic tests; Need for Coordinated Care by a Stroke Service; Need for endovascular therapy; or Other.
Format	User Interface: 5.040- 5.130 Radio buttons. 5.140 Alpha numeric field. Text box. *Unlimited character length.* Import template: L5.04 5.040- 5.130 Numeric field. 5.140 Alpha numeric field. Text box. *Unlimited character length*.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, medical or nursing notes and Inter-hospital discharge summary)
Codes and Values	L5.04 No value required for this field. Leave blank in import template 5.040-5.130 1 Yes 2 No 5.140 Free Text.
Help Note	– Multiple reasons for hospital transfer can be selected if applicable. – If a reason for transfer is unable to be categorised within the variable options provided (5.04.-5.130), enter reason in text box 5.140 - Other.

Pre Stroke History

History of known risk factors

Previous stroke 6.020

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	6.020
Common Name	Previous history of stroke.
Definition	A history of stroke prior to this current episode, excluding TIAs. Based on METeOR Identifier: 356777
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, medical notes, correspondence from GP)
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	– Select 'Yes' if there is a history of stroke, probable stroke, or history consistent with stroke PRIOR to this admission. This may be described verbally by the patient, or documented in previous medical notes or confirmed on brain imaging (Computerised tomography or Magnetic Resonance Imaging). – This variable does not include evidence of previous TIA(s).

Cardiac disease 6.211

ED	Green	Red	Black	FeSS	**Paeds**

MDL Reference	6.211
Common Name	Previous history of cardiac disease.
Definition	Congenital or acquired heart disease: congenital heart disease relates to one or more heart defects present at birth; acquired heart disease is a problem that occurs after birth.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, medical notes, correspondence from GP)
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	Answer 'Yes' if there is any documented evidence of congenital or acquired heart disease. Examples of congenital heart disease include: Tetralogy of fallot; Hypoplastic left heart syndrome; Total anomalous pulmonary venous connection; Transposition of great arteries; Coarctation of the aorta. Examples of paediatric acquired heart disease include: Infective endocarditis; Cardiomyopathy Dilated; Hypertrophic; Restrictive); Arrhythmia (Atrial fibrillation); Myocarditis; Intracardiac tumour (Atrial myxoma; Rhabdomyoma; Cardiac papillary; Fibroblastoma)

Anaemia 6.212

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	6.212
Common Name	Previous history of anaemia.
Definition	Anaemia is defined as Haemoglobin (Hb) less than the lower limit of the reference range for age. Sickle cell anaemia can also fall into the anaemia category.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, medical notes, correspondence from GP)
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	Select Yes if there is any documented evidence of anaemia.
Further information	Suspected anaemia requires a full blood examination including blood film (FBC), ferritin and reticulocyte count. Anaemia classification is based on the Mean Corpuscular Volume (MCV): • Microcytic anaemia is consistent with a decreased MCV • Normocytic anaemia is consistent with a normal MCV • Macrocytic anaemia is consistent with an increased MCV. Iron deficiency is the largest factor contributing to anaemia in all paediatric age groups. Reduced serum ferritin (<20µg/L) indicates borderline/low iron stores, which is consistent with iron deficiency anaemia. Sickle cell disease is caused by a structurally abnormal haemoglobin (Hb S) that polymerises with shape change when deoxygenated, resulting in obstruction of blood flow and increasing the risk of stroke. There are 3 common types causing sickle disease, all of which require the same treatment: • Sickle cell anaemia (SS disease) is the most common • Sickle β Thalassemia • Sickle haemoglobin C disease

Infection 6.213

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	6.213
Definition	Major or minor infections
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, medical notes, correspondence from GP)
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	For paediatric patients, answer "Yes" if there is any documented evidence of a major or minor infection in the two weeks prior to the stroke. Major infections include: encephalitis, sepsis/septicaemia, acidosis, meningitis. Minor infections include: varicella, gastroenteritis, otitis media, upper respiratory tract infections (URTI), urinary tract infections (UTI).

Other (specify) 6.221

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	6.221
Definition	History of other known risk factors prior to stroke.
Format	User Interface: Text box. Import Template: Alpha-numeric field. Free text.
Recording Guidance	**Required field.** Individual patient medical records (admission notes, medical notes, correspondence from GP)
Codes and Values	Free text.
Help Note	Other risk factors for paediatric strokes include: • Prothrombotic disorders • Underlying chronic disorders • Associated acute systemic illnesses • Underlying chronic head & neck disorders • Acute head & neck disorders • Post-surgical
Further Information	Dowling, MM, Hynan, LS, Lo, W, Licht, DJ, McClure, C, Yager, JY, Dlamini, N, Kirkham, FJ, de Veber, G, Pavlakis, S, and for the International Paediatric Stroke Study Group. *International Paediatric Stroke Study: stroke associated with cardiac disorders.* International Journal of Stroke. 2013 Oct. 8 (Suppl A100): 39-44

Dependency prior to admission

Functional status prior to stroke (mRS) 6.470 to 6.530

ED	Green	Red	Black	FeSS	Paeds

MDL References	6.470 Functional status prior to stroke (mRS) 6.480 Unknown/derive 6.490 Can the patient walk on their own? 6.500 If the patient can't walk on their own, can they walk with help? 6.510 Does the patient need help with simple activities? 6.520 Does the patient need help with more complex activities? 6.530 If the patient has no disability, do they have any symptoms?
Common Name	Prestroke functional status
Definition	Patient's premorbid modified Rankin score.
Format	User Interface: 6.470 Drop down list 6.480 Tick box 6.490-6.530 Radio buttons
Recording Guidance	**6.470 – Required field.** If not documented, this can be calculated using the algorithm from the questions listed in the Help Note section. All patient history from the medical record needs to be considered or direct contact with the patient about how they were prior to the stroke.
Codes and Values	6.470 Numerical 0-5 6.480 TRUE FALSE 6.490-6.530 1 = Yes 2 = No
Help Note	If mRS is known, enter 0-5 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent, and requiring constant nursing care and attention If unknown, select "Unknown/derive" and calculate using following algorithm: a) Can the patient walk on their own? • If No go to question b • If Yes go to question c b) If the patient can't walk on their own can they walk if someone is helping them? • If Yes score 4 • If No score 5

	c) If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)? • If Yes score 3 • If No go to question d d) If he can perform simple personal activities does he need help with more complex usual activities (driving, golf, finances, household bills, work tasks)? • If Yes score 2, • If No go to question e e) If he has no disability does he have any symptoms? • If Yes score 1 • If No score 0 If two options appear equally valid and if further questions are considered unlikely to clarify choice, then the more severe category should be selected
Further Information	The modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke, and it has become the most widely used clinical outcome measure for stroke clinical trials. Independence= 0-2, dependence >=3, death = 6. The variable is used as a measure of stroke severity at time of hospital admission (e.g. first few hours of presentation). The variable can be used, in statistical models, to make corrections for differences in patient case mix to ensure comparisons of quality of care and/or health outcomes between patient sub-groups are valid. This variable is not used as a functional outcome measure. Further information and training can be found at http://rankin-english.trainingcampus.net/uas/modules/trees/windex.aspx Ref: Lees, K. Modified Rankin Scale: A training and certification resource. University of Glasgow.

Triage category 7.000 to 7.010

ED	Green	Red	Black	FeSS	Paeds

MDL References	7.000 What was the triage category (Australasian Triage Scale; ATS) for this patient in ED? 7.010 Not admitted through ED
Common Name	Clinical urgency
Definition	The urgency of the patient's need for medical and/or nursing care as assessed at triage, represented by a code. METeOR Identifier 684872
Format	User Interface: 7.000 Drop down list 7.010 Tick box
Recording Guidance	Individual patient medical records – ED notes
Codes and Values	7.000 ATS 1-5 7.010 TRUE FALSE
Help Note	ATS Category 1 - Resuscitation: immediate (within seconds) ATS Category 2 - Emergency: within 10 minutes ATS Category 3 - Urgent: within 30 minutes ATS Category 4 - Semi-urgent: within 60 minutes ATS Category 5 - within 120 minutes

NIHSS at baseline 7.250

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.250
Common Name	National Institutes of Health Stroke Scale (NIHSS) on hospital admission.
Definition	Patient's NIHSS on admission to hospital. The NIHSS is a 15 item examination tool used to assess neurological status in acute stroke patients. The stroke scale is a valid measure of stroke severity, and can be used to determine appropriate treatment and predict patient outcome.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (admission notes, physical examination, discharge summary, medical or nursing notes).
Codes and Values	0 to 42 99 Unknown
Help Note	Where there are multiple NIHSS scores, enter the score (0-42) that guides the clinician's treatment decision. Select **99** if unknown or there is no record of a baseline NIHSS being conducted at your hospital. Do not record a NIHSS score assessed prior to arrival at your hospital.

Did the patient have a brain scan after this stroke? 7.410

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.410
Common Name	Brain scan following this stroke.
Definition	Performance of brain imaging (Computerised Tomography - CT or Magnetic Resonance Imaging - MRI) after this episode of stroke. This includes brain imaging conducted at your hospital or at another facility prior to arrival at your hospital.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient administrative system and patient medical record (radiology report). – Date and time variables for both first and subsequent brain scans after the stroke will be greyed out and disabled if 'No' is selected for 'Did the patient have a brain scan after this stroke'.
Codes and Values	1 Yes 2 No
Help Note	Select Yes if there is documented evidence that the patient had a brain scan (CT/MRI) for this current episode for stroke, either at your hospital or elsewhere before arrival at your hospital.
Further Information	Includes computed tomography (CT) or magnetic resonance imaging (MRI) at this hospital or elsewhere for the current episode.

Date of first brain scan after the stroke 7.430

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.430
Common Name	Date of initial brain scan following this stroke.
Definition	The date of the initial brain scan (Computerised Tomography - CT or Magnetic Resonance Imaging – MRI) after this episode of stroke. The initial brain scan includes brain imaging conducted at your hospital or at another facility prior to arrival at your hospital.
Format	User Interface: Calendar field. Import Template: Date field.
Recording Guidance	– **Required field.** – Patient administrative system and patient medical record (radiology report). – Date and time variables for both first and subsequent brain scans after the stroke will be greyed out and disabled if 'no' is selected for 'did the patient have a brain scan after the stroke'.
Codes and Values	DD/MM/YYYY
Help Note	Record date of first brain scan following this stroke, whether conducted at your hospital or elsewhere. For the AuSCR Red program, if no scan was performed, leave this variable blank.

Time of first brain scan after stroke 7.440 to 7.450

ED	Green	Red	Black	FeSS	Paeds

MDL References	7.440 Time of first brain scan after stroke 7.450 Not documented
Common Name	Time of brain scan following this stroke
Definition	The time that the initial brain scan (Computerised Tomography - CT or Magnetic Resonance Imaging – MRI) was conducted after this episode of stroke. The initial brain scan includes brain imaging conducted at your hospital or at another facility prior to arrival at your hospital.
Format	User Interface: 7.440 Time field. 7.450 Tick box. Import Template: 7.440 Time field. 7.450 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient administrative system and patient medical record (radiology report). – If 'not documented' is selected, the time field will be greyed out and disabled. – Date and time variables for both first and subsequent brain scans after the stroke will be greyed out and disabled if 'no' is selected for 'did the patient have a brain scan after the stroke'.
Codes and Values	7.440 hh:mm 7.450 TRUE FALSE
Help Note	Where possible, record exact time of brain scan from radiology records. If brain imaging was performed prior to admittance to this hospital (e.g. inter-hospital transfer), record this time. For the AuSCR Red program, select Not documented if time is unknown, or if no brain scan was performed.
Further information	Where patients arriving by ambulance are transferred directly to imaging before Emergency Department (ED) triage, record time of brain scan as usual, and record time of arrival to ED (4.170) as the ambulance "at destination" time, to avoid negative door-to-scan times.

Was this brain scan diagnostic? 7.451

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.451
Common Name	
Definition	Whether the first brain scan conducted post stroke onset was diagnostic.
Format	User Interface: Radio buttons Import Template: Numeric field.
Recording Guidance	Patient medical record – medical imaging reports. This variable is greyed out and disabled if “No” is selected for 7.410 (Did the patient have a brain scan after this stroke?).
Codes and Values	1 = Yes 2 = No
Help Note	If the patient had computerised tomography (CT) as their first line of imaging and this showed no evidence of acute infarction, select “No”.

What type of brain scan was performed? 7.460

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.460
Common Name	Diagnostic imaging
Definition	Type of brain imaging technique used (either at your hospital or at another facility prior to arrival at your hospital).
Format	Radio buttons
Recording Guidance	– **Optional field.** – Patient administration system and patient medical record (radiology report). – If scan was carried out at another facility, this information will need to be obtained from that facility.
Codes and Values	C = CT M = MRI CM = Both CT & MRI
Help Note	Select CT if Non-Contrast, CT-Angiography or CT-Perfusion. Select MRI if MRI or fMRI

Was advanced imaging performed? 7.471 to 7.476

ED	Green	Red	Black	FeSS	Paeds

MDL References	7.471 CT angiography 7.472 CT perfusion 7.473 Diffusion weighted imaging 7.474 MR angiography 7.475 Perfusion weighted imaging 7.476 No
Common Name	Advanced brain scan
Definition	Performance of advanced brain imaging after stroke. Advanced imaging refers to CTA angiography +/- CTP perfusion OR MRI (including diffusion weighted-MR, MR angiography, +/- perfusion-weighted MR). Scan is undertaken to determine infarct volume and can guide further interventions (e.g. endovascular therapy).
Format	Tick boxes
Recording Guidance	– Patient medical record - Admission notes, physical examination, discharge summary, ED doctor's notes and medical or nursing notes. Type of scan may also be recorded in relevant imaging report.
Codes and Values	TRUE/FALSE
Help Note	– If advanced imaging was performed, select all imaging techniques that apply. – If 7.476 is selected, 7.471-7.475 will be greyed out and disabled.
Further Information	Advanced MRI and CT imaging techniques may be used to identify ischaemic but potentially viable brain tissue and thus guide intervention decisions in the hyper-acute phase (Australian Clinical Guidelines for Stroke Management 2010)

Date of subsequent brain scan after the stroke 7.480 to 7.490

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL References	7.480 Date of subsequent brain scan after the stroke 7.490 Not applicable (no further scans)
Common Name	Date of subsequent brain scan following this stroke
Definition	The date the subsequent brain scan (Computerised Tomography - CT or Magnetic Resonance Imaging – MRI) was conducted after this episode of stroke. The brain scan includes brain imaging conducted at your hospital or at another facility.
Format	User Interface: 7.480 Calendar field. 7.490 Tick box. Import Template: 7.480 Date field. 7.490 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient administrative system and patient medical record (radiology report). – Date and time variables for both first and subsequent brain scans after the stroke, will be greyed out and disabled if 'no' is selected for 'did the patient have a brain scan after the stroke'.
Codes and Values	7.480 DD/MM/YYYY 7.490 TRUE FALSE
Help Note	– If the patient did not require subsequent brain imaging (CT or MRI) select 'not applicable (no further scans)'.

Time of subsequent brain scan after the stroke 7.500 to 7.510

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL References	7.500 Time of subsequent brain scan after stroke 7.510 Not documented
Common Name	Time of follow-up brain scan
Definition	The time that the subsequent brain scan (Computerised Tomography – CT or Magnetic Resonance Imaging – MRI) was conducted after this episode of stroke. This subsequent brain scan includes brain imaging conducted at your hospital or at another facility.
Format	User Interface: 7.500 Time field. 7.510 Tick box. Import Template: 7.500 Time field. 7.510 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient administrative system and patient medical record (radiology report). – Date and time variables for both, first and subsequent brain scans after the stroke, will be greyed out and disabled if 'no' is selected for 'did the patient have a brain scan after the stroke'. – There is no logic check for this i.e. date and time fields for subsequent brain scan will not be greyed out or disabled even if 'not applicable (no further scans)' selected. – There is also no logic check applied for this variable when 'not documented' for 'time of subsequent brain scan after the stroke' is selected i.e time field not greyed out or disabled.
Codes and Values	7.500 hh:mm 7.510 TRUE FALSE
Help Note	– When the time of subsequent brain scan is known record the time and leave the 'not document' field unticked (user interface) or record 'FALSE' (import template). – If time of subsequent brain scan is unknown, select 'Not documented'

What type of brain scan was performed? 7.520

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.520
Common Name	Diagnostic imaging
Definition	Type of brain imaging technique used (either at your hospital or at another facility prior to arrival at your hospital).
Format	Radio buttons
Recording Guidance	– **Optional field.** – Patient administration system and patient medical record (radiology report). – If scan was carried out at another facility, this information will need to be obtained from that facility.
Codes and Values	C = CT M = MRI CM = Both CT & MRI
Help Note	Select CT if Non-Contrast, CT-Angiography or CT-Perfusion. Select MRI if MRI or fMRI

Was advanced imaging performed during subsequent scan? 7.531 to 7.536

ED	Green	Red	Black	FeSS	Paeds

MDL References	7.531 CT angiography 7.532 CT perfusion 7.533 Diffusion weighted imaging 7.534 MR angiography 7.535 Perfusion weighted imaging 7.536 No
Common Name	Advanced brain scan
Definition	Performance of advanced brain imaging after stroke. Advanced imaging refers to CTA angiography +/- CTP perfusion OR MRI (including diffusion weighted-MR, MR angiography, +/- perfusion-weighted MR). Scan is undertaken to determine infarct volume and can guide further interventions (e.g. endovascular therapy).
Format	Tick boxes
Recording Guidance	– **Optional field.** – Patient medical record - Admission notes, physical examination, discharge summary, ED doctor's notes and medical or nursing notes. Type of scan may also be recorded in relevant imaging report.
Codes and Values	TRUE/FALSE
Help Note	– If advanced imaging was performed, select all imaging techniques that apply. – If 7.536 is selected, 7.531- 7.535 will be greyed out and disabled.
Further Information	Advanced MRI and CT imaging techniques may be used to identify ischaemic but potentially viable brain tissue and thus guide intervention decisions in the hyper-acute phase (Australian Clinical Guidelines for Stroke Management 2010)

Type of stroke 7.550

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.550
Common Name	Stroke type.
Definition	The clinical diagnosis of stroke type.
Format	User Interface: Drop down list. Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical record (Radiology report- CTor MRI, admission notes, discharge summary and medical or nursing notes)
Codes and Values	TIA Transient ischaemic attack ISCHAEMIC Ischaemic HAEMORRHAGE Haemorrhage UNDETERMINED Undetermined
Help Note	– This is not the ICD-10-AM code, but rather the clinical diagnosis. – Note that TIAs are currently not collected in the AuSCR, so this option should not be selected. – Ischaemic stroke type should be selected if the brain imaging is consistent with cortical, sub-cortical, brainstem or cerebellar infarction. – Haemorrhage stroke type should be selected if the brain imaging is consistent with intraventricular, intracerebral haemorrhage (ICH) or other non-traumatic intracerebral haemorrhage. – Undetermined stroke type should be selected if no brain imaging has been undertaken and the stroke type cannot be confirmed through other diagnostic assessments. If brain imaging excludes haemorrhage, select Ischaemic.

Cause of stroke 7.580

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	7.580
Common Name	Cause of stroke known.
Definition	Stroke cause determined based on TOAST classification system
Format	User Interface: Radio buttons. Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (Radiology report- CTor MRI, admission notes, discharge summary and medical or nursing notes).
Codes and Values	KNOWN Known UNKNOWN Unknown
Help Note	– 'Known' is selected if there is documented evidence of a structural, radiological, haematological, genetic or drug-related cause of stroke. Specifically, these causes as per the TOAST classification include: 1: large artery atherosclerosis 2: cardio-embolism 3: small artery occlusion (lacune) 4: stroke of other determined etiology such as illicit drug use, a diagnosed metabolic disorder, or intervention/post-operative. – 'Unknown' is selected if the cause can not be defined as per the above guidance.
Further Information	Aetiology of stroke affects prognosis, outcome and management. Understanding the cause of stroke is important for making treatment decisions including secondary prevention management.

Mechanism (ischaemic) 7.591 to 7.592

ED	Green	Red	Black	FeSS	Paeds

MDL References	7.591 Mechanism (ischaemic) 7.592 Other
Common Name	Mechanism (aetiology) of ischaemic stroke
Definition	The cause or mechanism of the current ischaemic stroke episode.
Format	User Interface: 7.591 Drop down list 7.592 Alpha numeric field. Text box Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical record, medical notes, CT/MRI scan results
Codes and Values	7.591 SVA = Small vessel arteriopathy FCA = Focal cerebral arteriopathy BCA = Bilateral cerebral arteriopathy AOCA = Aortic/cervical arteriopathy CE = Cardioembolic MF = Multifactorial OTH = Other UNK = Unknown 7.592 Free text
Further Information	7.592 will be enabled if 7.591 = Other. The CASCADE is an anatomically based classification system which offers the specific diagnostic interventions and suggests the unified terminology. So, it can be used both in clinical practice and in any research in childhood arterial ischaemic stroke. (Bernard, TJ et al. Stroke. 2012:43(2):371-377)

Mechanism (haemorrhage) 7.593 to 7.594

ED	Green	Red	Black	FeSS	**Paeds**

MDL Reference	7.593 Mechanism (haemorrhage) 7.594 Other
Common Name	Mechanism (aetiology) of haemorrhagic stroke
Definition	
Format	User Interface: 7.593 Drop down list 7.594 Alpha numeric field. Text box Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical record, medical notes, CT/MRI scan results
Codes and Values	7.593 AVM = AVM AN = Aneurysm CAV = Cavernoma TBL = Tumour bleed OTH = Other UNK = Unknown 7.594 Free text
Help Note	
Further Information	7.594 will be enabled if 7.593 = Other. There are no validated classification systems for paediatric haemorrhagic stroke, but these mechanisms are selected based on a review article by Lo, W et al, summarising the published literature.

Acute occlusion site 7.6001 to 7.6014

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL References	7.6001 Left 7.6002 Right 7.6003 ICA-EC 7.6004 ICA-IC 7.6005 MCA-M1 7.6006 MCA-M2 7.6007 MCA-M3 7.6008 ACA 7.6009 PCA 7.6010 BA 7.6011 VA 7.6012 No occlusion 7.6013 Not documented 7.6014 Other
Common Name	Origin and site(s) of occlusion
Definition	Origin and site(s) of occlusion of any cervical or cranial artery in acute ischaemic stroke.
Format	User Interface: 7.601-7.6014 Tick box. Import Template: 7.601-7.6014 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical record (Radiology report- CT/MRI or surgical notes).
Codes and Values	7.6001-7.6014 TRUE FALSE
Help Note	– This variable is only relevant for patients who receive endovascular clot retrieval following an ischaemic stroke. For patients who did not receive endovascular therapy, leave all occlusion sites blank. – If the patient has a known ischaemic event, select originating hemisphere and identified occlusion site. – For occlusion sites at the vertebral artery or basilar artery levels, select 'VA' and 'BA' respectively and leave the brain hemisphere blank. – If the patient has a multi-territory ischaemic stroke, record all known occlusion sites and hemispheres involved. – Select 'No occlusion' if the patient has a clinical diagnosis of ischaemic stroke but no occlusion site identified on brain imaging, or when ECR performed (e.g. thrombosis dissolved prior to ECR). – Select 'Not documented' if unable to locate brain imaging report to confirm the site(s) of occlusion. – If the patient was transported to the angio suite and arterial puncture was attempted then abandoned, record the occlusion site(s) for the presenting ischaemic stroke. – Key to acute occlusion site: – Left Left hemisphere involvement – Right Right hemisphere involvement – ICA-EC Internal carotid artery extracranial – ICA-IC Internal carotid artery – intracranial – MCA-M1 Middle cerebral artery M1 segment – MCA-M2 Middle cerebral artery M2 segment – MCA M3 Middle cerebral artery M3 segment – ACA Anterior cerebral artery

	– PCA Posterior cerebral artery – BA Basilar artery – VA Vertebral artery

Telemedicine and Reperfusion

Telemedicine setting and reason

Was a stroke telemedicine consultation conducted? 8.000

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.000
Common Name	Telestroke
Definition	A stroke telemedicine consultation includes a comprehensive consultation (wherever possible audio-visual) and review of imaging, with a written treatment plan provided to treating clinician or hospital.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical record (admission notes, medical or nursing notes).
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	Select 'Yes' if there is documented evidence of this patient receiving a telemedicine consultation including review of imaging and a written treatment plan (also known as Telestroke) during their hyperacute phase of care. If a patient received an in-patient neurological consultation via telemedicine outside the hyperacute phase of care, select 'No'. If a patient received a telemedicine consultation prior to arriving at your hospital, select 'No'.

Date stroke telemedicine consultation conducted 8.010

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.010
Common Name	Date of stroke telemedicine consultation
Definition	The date a telemedicine consultation with the remote clinician commenced. Based on METeOR Identifier: 400713
Format	User Interface: Calendar field Import Template: DD/MM/YYYY
Recording Guidance	– **Required field.** – Patient medical record – medical/nursing notes, ED record. – Telemedicine consultation record or hospital report form.
Codes and Values	DD/MM/YYYY
Help Note	– Variable enabled if 'Yes' selected for Was a stroke telemedicine consultation conducted? (Ref 8.000) – If conflicting dates, record the earliest.

Time stroke telemedicine consultation conducted 8.020 to 8.021

ED	Green	Red	Black	FeSS	Paeds

MDL References	8.020 Time of stroke telemedicine consultation 8.021 Unknown
Common Name	Time of stroke telemedicine consultation
Definition	The time a telemedicine consultation with the remote clinician commenced. Based on METeOR Identifier: 400713
Format	User Interface: 8.020 Time field 8.021 Tick box Import Template: 8.020 Time field 8.021 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical record – medical/nursing notes, ED record. – Telemedicine consultation record or hospital report form.
Codes and Values	8.020 hh:mm 8.021 TRUE/FALSE
Help Note	– Variable enabled if 'Yes' selected for Was a stroke telemedicine consultation conducted? (Ref 8.000) – If conflicting times, record the earliest. – If start or end time unknown, select 'Unknown'.

Did the patient receive intravenous thrombolysis? 8.130

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.130
Common Name	Provision of intravenous thrombolysis.
Definition	Administration of intravenous thrombolysis for those patients admitted with an ischaemic stroke. The administration of thrombolysis includes the provision of thrombolysis at your hospital or at another hospital prior to arrival at your hospital. Based on METeOR identifier: 285087
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** Relevant for ischaemic strokes only. – There should be documented evidence that intravenous or intra-arterial thrombolysis, using tissue plasminogen activator (tPA) such as alteplase, is prescribed and recorded as administered on the patient's medication chart. – If there is not documentation of thrombolytic therapy in the physician's or nurse's notes, check the ED medication order documentation, medication ordering system, acute stroke pathway documentation or admission notes. – If 'No' or 'Unknown' was selected for 'did the patient receive intravenous thrombolysis' then date, time and adverse events variables related to thrombolysis is greyed out and disabled.
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	– Select 'Yes' if there is documentation that the patient, admitted with an ischaemic stroke, received thrombolytic therapy. This is regardless of whether they receive intravenous or intra-arterial thrombolysis. – Select 'No' if there is no documentation that the patient, admitted with an ischaemic stroke, received thrombolytic therapy. – Select 'Unknown' if it cannot be determined whether thrombolytic therapy was provided, e.g. unable to locate relevant medication chart. – Record thrombolytic therapy whether administered before admission to your hospital (e.g. transfer from another hospital) or within your hospital (either emergency department or inpatient unit/ward). – Do not include thrombolytic therapy for indications other than ischaemic stroke. That is, do not include intra-cerebral venous infusion for cerebral venous thrombosis, intraventricular infusion for intraventricular haemorrhage, intraparenchymal infusion for percutaneous aspiration of intracerebral haematoma, myocardial infarction, pulmonary embolism, or peripheral clot.

Date of delivery 8.140

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.140
Common Name	Date thrombolysis administered to a patient.
Definition	The date thrombolysis was first administered to the patient with an ischaemic stroke. The administration of thrombolysis includes the provision of thrombolysis at your hospital or at another hospital prior to arrival at your hospital. Based on METeOR Identifier: 356921
Format	User Interface: Calendar field. Import Template: Date field.
Recording Guidance	– **Required field.** Relevant to ischæmic strokes only. – There should be documented evidence that intravenous or intra-arterial thrombolysis was prescribed, and date administered recorded on the patient's medication chart. – This variable, along with time, drug used and adverse events related to thrombolysis, is only enabled when 'Yes' for 'did the patient receive intravenous thrombolysis' is selected.
Codes and Values	DD/MM/YYYY
Help Note	– The date that thrombolysis was administered to the patient should reflect the date recorded on the patient's medication chart. – If the date that thrombolysis was administered is known then record the date. – If the date that thrombolysis was administered to the patient is not known, then leave this variable blank. – If the patient was thrombolysed prior to arriving at YOUR hospital for ongoing acute stroke management (i.e. inter-hospital transfer), the date the initial bolus was administered (i.e. date administered at referring site) should be recorded. This is regardless of whether they received intravenous or intra-arterial thrombolysis.

Time of delivery 8.150

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.150
Common Name	Time thrombolysis administered to a patient.
Definition	The time thrombolysis therapy was first administered to the patient with an ischaemic stroke. The administration of thrombolysis includes the provision of thrombolysis at your hospital or at another hospital prior to arrival at your hospital. Based on METeOR Identifier: 360949
Format	User Interface: Time field (24 hour time). Import Template: Time field (24 hour time).
Recording Guidance	– **Required field.** Relevant to ischaemic strokes only. – There should be documented evidence that intravenous or intra-arterial thrombolysis was prescribed, and time administered recorded on the patient's medication chart. – This variable, along with date, drug used and adverse events related to thrombolysis, is only enabled when 'Yes' for 'did the patient receive intravenous thrombolysis' (8.130) is selected.
Codes and Values	hh:mm
Help Note	– The time that thrombolysis was administered to the patient should accurately reflect the time recorded on the patient's medication chart. If this is not clear or you are unable to locate the patient's medication chart, then leave this variable blank. – If the patient was thrombolysed prior to arriving at your hospital for ongoing acute stroke management (e.g. inter-hospital transfer), the time the initial bolus was administered (e.g. at referring site) should be recorded. This is regardless of whether they received intravenous or intra-arterial thrombolysis. – Time is recorded to the nearest minute; however time to within 15 minutes of exact time is acceptable.

Drug used 8.160

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.160
Common Name	Name of drug used to thrombolyse the stroke patient.
Definition	Drug used for intravenous thrombolysis
Format	User Interface: Radio buttons
Recording Guidance	– **Required field.** Relevant to ischaemic strokes only. – Patient medical records - ED record/notes, ED physician's medication orders/chart, Emergency nurse's notes, Physician's progress notes; ED medication order documentation, medication ordering system; Acute Stroke Pathway documentation or admission notes.
Codes and Values	8.160 tPA Other
Help Note	– Variable enabled if "Yes" selected for "Did the patient receive intravenous thrombolysis?" (Ref 8.130) – Variable will default to selecting "tPA". Keep this selection if tissue plasminogen activator was used, otherwise select "Other".

Was there a serious adverse event related to thrombolysis? 8.190

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.190
Common Name	Serious adverse event related to thrombolysis.
Definition	Patient experience of a serious adverse event subsequent to being thrombolysed. A serious adverse event is one which is life threatening, incapacitating, or resulted in an extended hospital stay.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** Relevant for ischaemic strokes only. – Patient medical records (ED record/notes, ED physician's medication orders/chart, Emergency nurse's notes, Physician's progress notes; Acute Stroke Pathway documentation or admission notes). – This variable is only enabled when 'Yes' for 'did the patient receive intravenous thrombolysis' is selected.
Codes and Values	1 Yes 2 No
Help Note	– If the patient was thrombolysed prior to arriving at your hospital for ongoing acute stroke management (i.e inter-hospital transfer), any serious adverse event(s) relating to thrombolysis should be recorded, even if these adverse events occurred prior to arrival at YOUR hospital (i.e occurred at referring site). – Examples of adverse events include: Intracranial haemorrhage *(8.201)*, extracranial haemorrhage *(8.202)* and angioedema *(8.203)*.

Type of adverse event 8.201 to 8.204

ED	Green	Red	Black	FeSS	Paeds

MDL References	8.201 Intracranial haemorrhage 8.202 Extracranial haemorrhage 8.203 Angioedema 8.204 Other
Common Name	Type of serious adverse event following thrombolysis
Definition	Type of serious adverse event related to thrombolysis. A serious adverse event is one which is life threatening, incapacitating, or resulted in an extended hospital stay.
Format	User Interface: 8.201-8.204 Radio buttons. Import Template: 8.201-8.204 Numeric field.
Recording Guidance	– **Required field.** Relevant for ischaemic strokes only. – Patient medical records (ED record/notes, medication orders/chart, Physician's progress notes). – These variables are only enabled when 'Yes' is selected for 'Was there a serious adverse event related to thrombolysis'.
Codes and Values	8.201-8.204 1 Yes 2 No
Help Note	– If the patient was thrombolysed prior to arriving at your hospital for ongoing acute stroke management (i.e. inter-hospital transfer), any serious adverse event(s) should be recorded, even if these adverse events occurred prior to arrival at your hospital (i.e. thrombolysed at referring hospital). – If the patient experiences multiple adverse events related to the provision of thrombolysis, record all adverse events encountered. – If the patient experiences an adverse event secondary to thrombolysis that can not be categorised as intracranial haemorrhage, extracranial haemorrhage or angioedema, select 'Other'. – Intracranial haemorrhage is any bleeding within the skull (e.g. intracerebral, subarachnoid, and subdural). – Extracranial haemorrhage is any bleeding outside the skull (e.g. intestinal bleed).

Was other reperfusion (endovascular) treatment provided? 8.250

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL Reference	8.250
Common Name	Medical thrombectomy or clot retrieval.
Definition	Provision of other reperfusion treatment (endovascular).
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** Relevant for ischaemic strokes only. – Patient medical records (ED record/notes, medication orders/chart, Physician's progress notes). – If No is selected, the date and time, NIHSS, and follow-up variables in relation to reperfusion treatment are disabled.
Codes and Values	1 Yes 2 No
Help Note	If the patient was transported to the angio suite and arterial puncture was attempted then abandoned, select Yes. If the procedure was abandoned prior to arterial puncture, select No.

Treatment date for other reperfusion 8.260

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL Reference	8.260
Common Name	Date of reperfusion treatment.
Definition	Date other reperfusion treatment (endovascular) performed for patients admitted with an ischaemic stroke.
Format	User Interface: Calendar field. Import Template: Date field.
Recording Guidance	– **Required field.** Relevant for ischaemic strokes only. – Patient medical records - ED record/notes, medication orders/chart, Physician's progress notes. – This variable will only be enabled when 'Yes' for 'Was other reperfusion (endovascular) treatment provided?' is selected.
Codes and Values	DD/MM/YYYY
Help Note	– When the date for other reperfusion (endovascular) is known record the date. – In the event the patient was transported to the angio suite and arterial puncture was attempted then abandoned, record the date attempted.

NIHSS before endovascular treatment 8.261

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL Reference	8.261
Common Name	National Institutes of Health Stroke Scale (NIHSS) before endovascular treatment.
Definition	Patient's NIHSS before Endovascular Clot Retrieval. The NIHSS is a 15 item examination tool used to assess neurological status in acute stroke patients. The stroke scale is a valid measure of stroke severity, and can be used to determine appropriate treatment and predict patient outcome.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical records (admission notes, physical examination, discharge summary, ED doctor's notes, and medical or nursing notes). – This variable will only be enabled when 'Yes' for 'Was other reperfusion (endovascular) treatment provided?' is selected.
Codes and Values	0 to 42 99 Unknown
Help Note	– If a NIHSS was recorded before reperfusion (endovascular) treatment provided record the score 0-42. – If only a baseline NIHSS was recorded and no additional NIHSS performed prior to endovascular treatment, record as Unknown (99). – In the event the patient was transported to the angio suite and arterial puncture was attempted then abandoned, record the NIHSS before endovascular treatment provided.

Time groin puncture 8.280

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.280
Common Name	Arterial access time.
Definition	Time at which arterial access took place.
Format	User Interface: Time field (24 hour time). Import Template: Time field (24 hour time).
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical records, radiology report, or surgical notes.
Codes and Values	hh:mm
Help Note	– The arterial access signifies the start of the endovascular treatment. This may be recorded as time of 'start of procedure'. – If the patient was transported to the angio suite and arterial puncture was attempted then abandoned, record the arterial puncture time.

Time of completing recanalisation/procedure 8.290

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	8.290
Common Name	Recanalisation procedure time complete.
Definition	The time that eTICI 2b to 3 was achieved or, if that did not occur, the time of the last pass of the stent or retriever or suction.
Format	User Interface: Time field (24 hour time). Import Template: Time field (24 hour time).
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical records, radiology report, or surgical notes.
Codes and Values	hh:mm
Help Note	– Enter the time that eTICI of 2b to 3 was achieved. – If eTICI 2b to 3 not achieved, then enter the time of the last pass of the stent or retriever or suction, or if that did not occur, enter the time of last angio run.

Final eTICI (expanded Thrombolysis In Cerebral Infarction score) 8.420

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL Reference	8.420
Common Name	Final eTICI score.
Definition	Final expanded Treatment in Cerebral Infarction (eTICI) score.
Format	User Interface: Drop down list. Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical records, radiology report, or surgical notes.
Codes and Values	0 Grade 0 1 Grade 1 2A Grade 2a 2B Grade 2b 2C Grade 2c 3 Grade 3
Help Note	– Final eTICI score recorded as: – Grade 0 No reperfusion – Grade 1 Flow beyond occlusion without distal branch reperfusion – Grade 2a Reperfusion of less than half of the downstream target arterial territory – Grade 2b Reperfusion of more than half, yet incomplete, in the downstream target arterial territory – Grade 2c Near-complete reperfusion except for slow flow in a few distal cortical vessels or presence of small distal cortical emboli (estimated >90% reperfusion) – Grade 3 Complete reperfusion of the downstream target arterial territory, including distal branches with slow flow. – If there is no eTICI score recorded, leave field blank. – If the procedure was abandoned after arterial access was attempted, record final eTICI score. – If the procedure was abandoned prior to arterial access, this field should be left blank.
Further Information	The expanded treatment in cerebral infarction (eTICI) score was developed from the original Thrombolysis in Cerebral Infarction (TICI) scale by a consensus group in 2014 to better reflect the increasing use of endovascular therapy for stroke, and expansion of the TICI 2 designation to 2a (less than half), 2b (more than half) and 2c (near complete) reperfusion. Ref: Goyal M., et al. (2014). 2C or not 2C: defining an improved revascularization grading scale and the need for standardization of angiography outcomes in stroke trials. *Journal of NeuroInterventional Surgery*, 6(2): 83-86. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4156591/

24 hour NIHSS 8.430

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL Reference	8.430
Common Name	National Institutes of Health Stroke Scale (NIHSS) at 24 hours post Endovascular Clot Retrieval (ECR).
Definition	Patient's NIHSS at 24 hours post ECR. The NIHSS is a 15 item examination tool used to assess neurological status in acute stroke patients. The stroke scale is a valid measure of stroke severity, and can be used to determine appropriate treatment and predict patient outcome.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Individual patient medical records: medical or nursing notes, post procedure report.
Codes and Values	0 to 42 99 Unknown
Help Note	– Recorded approximately 24 hours post ECR treatment, or as close to this time as possible. – If NIHSS was recorded at 24 hours post ECR record the NIHSS score 0-42. – Select 'Unknown' if there is no record of NIHSS recorded at 24 hours post ECR.

Was there haemorrhage within the infarct on follow-up imaging? 8.470 to 8.480

ED	Green	Red	**Black**	FeSS	**Paeds**

MDL References	8.470 Was there haemorrhage within the infarct on follow-up imaging? 8.480 Details
Common Name	Haemorrhage within the infarct on imaging
Definition	Evidence of haemorrhage (bleed) within the infarct on follow-up brain imaging. Parenchymal haematoma (PH) is a dense blood clot with mass effect. If it occupies more than 30% of the infarcted territory with major mass effect it is classified as PH2. Haemorrhagic Infarction (HI) is petechial bleeding within the infarct, without mass effect. Isolated petechiae are classified as HI1. Confluent petechiae are classified as HI2.
Format	User Interface: 8.470 Radio buttons. 8.480 Drop down list. Import Template: 8.470 Numeric field. 8.480 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This is only relevant to patients who receive endovascular clot retrieval following an ischaemic stroke. – Patient medical records, radiology report, or surgical notes. – The variable 'details' is greyed out and only enabled when 'Yes' for 'Was there haemorrhage within the infarct on follow-up imaging' is selected.
Codes and Values	8.470 1 Yes 2 No 9 Unknown 8.480 HI1 Small petechiae HI2 More confluent petechiae PH1 30% or less of the infarcted area with mild space-occupying effect PH2 More than 30% of the infarcted area with significant space occupying effect
Help Note	– If there was evidence of haemorrhage within the infarct on follow-up imaging, record 'Yes' and select category of haemorrhage. – If the patient was transported to the angio suite and arterial puncture was attempted then abandoned, indicate whether there was a haemorrhage and select category of haemorrhage.

Other Clinical Information

Swallowing

Was a formal swallowing screen performed (i.e. not a test of gag reflex)? 9.070

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.070
Common Name	Formal swallow screen.
Definition	Swallow screen conducted by an appropriately trained health care professional such as a nurse or doctor utilising a formal swallow screen tool.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** This does not include gag reflex testing or assessment. – Individual patient medical records (Allied health records, Nursing notes and Medical notes). – If 'No' or 'Not documented' is selected for was a 'formal screen performed' the variables 9.080 to 9.120 (date, time, and 'Did the patient pass the screening?') are greyed out and disabled.
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	– Select Yes if there is documented evidence of a patient receiving a swallow screen by an appropriately trained healthcare professional during this admission. – If the patient has an impaired level of consciousness (or is unconscious) and is unable to participate in a swallow screen, select Yes only if they are documented as "Nil orally". A swallow screen/assessment should be performed when the patient is able to participate prior to being given any food, drink or oral medications. – The formal swallow screen tool is only performed by non-Speech Pathology Healthcare Professionals. For Speech Pathology assessment data refer to the MDL References 9.130 to 9.170. – Select 'Yes' if the patient had a formal swallow screen regardless of whether a Speech Pathology assessment has also been completed. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether the patient received a formal swallow screen (tool) by an appropriately trained healthcare professional following onset of stroke symptoms.
Further Information	Middleton et al. (2011), 'Implementation of evidence-based treatment protocols to manage fever, hyperglycaemia, and swallowing dysfunction in acute stroke (QASC): a cluster randomised controlled trial', The Lancet, vol 379, Issue 9824: pp. 1389.

Date of swallow screen 9.080 to 9.090

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.080 Date (of swallow screen) 9.090 Accuracy
Common Name	Swallow screen date
Definition	Date and accuracy of date that the formal swallow screen was conducted.
Format	User Interface: 9.080 Calendar field. 9.090 Radio buttons. Import Template: 9.080 Date field. 9.090 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This does not include gag reflex testing or assessment. – Patient medical records (Allied health records, Nursing notes and Medical notes – If 'No' or 'Not documented' is selected for was a 'formal screen performed' the date, time, and 'Did the patient pass the screening' variables are greyed out and disabled.
Codes and Values	9.080 DD/MM/YYYY 9.090 AAA Accurate EAA Estimate
Help Note	– When the formal swallow screen date is known, record the date of swallow screen and select Accurate. – If the day of formal swallow screen is unknown, use 01 for the day (01/MM/YYYY) and select Estimate. – If the day and month of the formal swallow screen is unknown, use 01 for the day and month (01/01/YYYY) and identify as estimate. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record the date and accuracy of the formal swallow screen by an appropriately trained healthcare professional following onset of stroke symptoms.

Time of swallow screen 9.100 to 9.110

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.100 Time (of swallow screen) 9.101 Unknown (time of swallow screen) 9.110 Accuracy
Common Name	Swallow screen time
Definition	Time that the swallow screen was conducted and accuracy.
Format	User Interface: 9.100 Time field (24 hour time). 9.101 Tick box. 9.110 Radio buttons. Import Template: 9.100 Time field (24 hour time). 9.101 Alpha numeric field. Case sensitive – use upper case. 9.110 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This does not include gag reflex testing or assessment. – Patient medical records (Allied Health records, Nursing notes and Medical notes). – If 'No' or 'Not documented' is selected for was a 'formal screen performed' the date, time, and 'Did the patient pass the screening' variables are greyed out and disabled.
Codes and Values	9.100 hh:mm 9.101 TRUE FALSE 9.110 AAA Accurate EAA Estimate
Help Note	– Time accuracy to the nearest 15 minutes is acceptable to be marked as Accurate, otherwise mark as Estimate. – If the time of formal swallow screen is unknown select 'Unknown' field. – The formal swallow screen tool is only performed by non-Speech Pathology Healthcare Professionals. For Speech Pathology assessment data refer to the MDL References 9.180 to 9.190. – For in-hospital stroke, record the time and accuracy of when the patient received a formal swallow screen (tool) by an appropriately trained healthcare professional following onset of stroke symptoms.

Did the patient pass the screening? 9.120

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.120
Common Name	Swallow screen outcome.
Definition	Outcome from formal swallow screen.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** This does not include gag reflex testing or assessment. – Patient medical records (Allied health records, Nursing notes and Medical notes). – If No or Not documented is selected for 'Was a formal screen performed?' the date, time, and 'Did the patient pass the screening' variables are greyed out and disabled.
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	– Select Yes if they passed the formal swallow screen tool that was administered. – For in-hospital strokes this refers to whether they passed the formal swallow screen tool conducted after onset of their stroke symptoms. – Determination of outcome of swallow screen will depend on which formal swallow screen tool is utilised. – The outcome of a gag reflex test or assessment does not constitute whether a patient has passed a swallow test as this is proven to be of little prognostic value for the ability to evaluate effectiveness of swallow.

Was a swallow assessment by a Speech Pathologist recorded? 9.130

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.130
Common Name	Formal speech pathologist swallow assessment.
Definition	Formal swallow assessment conducted by a speech pathologist during the acute phase of the patient's hospital admission.
Format	User Interface: Radio buttons Import Template: Numeric field.
Recording Guidance	– **Required field.** – Individual patient medical records (allied health records, Nursing notes and Medical notes). – If 'No' or 'Not documented' is selected for 'was a swallowing assessment via speech pathologist recorded', related date and time variables are greyed out and disabled.
Codes and Values	1 Yes 2 No 9 Not documented
Help Note	Select Yes if there is documented evidence of a patient receiving a formal swallow assessment by a speech pathologist during this admission. For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether the patient received a formal swallow assessment by a speech pathologist within the first 24 hours of the onset of stroke symptoms.

Date of swallowing assessment 9.140 to 9.150

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.140 Date of swallowing assessment by a speech pathologist 9.150 Accuracy
Common Name	The date of formal swallow assessment by a speech pathologist
Definition	The date and date accuracy that the speech pathologist completed a formal swallow assessment.
Format	User Interface: 9.140 Calendar. 9.150 Radio buttons. Import Template: 9.140 Date field. 9.150 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (allied health records, Nursing notes and Medical notes. – If 'No' or 'Not documented' is selected for 'was a swallowing assessment via speech pathologist recorded', related date and time variables are greyed out and disabled.
Codes and Values	9.140 DD/MM/YYYY 9.150 AAA Accurate EAA Estimate
Help Note	– When the swallow assessment date is known, record the date of swallow assessment and identify as accurate. – If the day of swallow assessment is unknown, use 01 for the day (01/MM/YYYY) and identify as estimate. – If the day and month of the swallow assessment is unknown, use 01 for the day and month (01/01/YYYY) and identify as estimate. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record the date and accuracy of the swallow assessment within the first 24 hours of the onset of stroke symptoms.

Time of swallowing assessment 9.160 to 9.170

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.160 Time of swallow assessment by speech pathologist 9.161 Unknown (time of swallow assessment by speech pathologist) 9.170 Accuracy
Common Name	The time of formal swallow assessment by a speech pathologist
Definition	The time that the speech pathologist completed a formal swallow assessment.
Format	User Interface: 9.160 Time field (24 hour time). 9.161 Tick box. 9.170 Radio buttons. Import Template: 9.160 Time field. 9.161 Alpha numeric field. Case sensitive – use upper case. 9.170 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (e.g. allied health notes). – If 'No' or 'Not documented' is selected for 'was a swallowing assessment via speech pathologist recorded', related date and time variables are greyed out and disabled.
Codes and Values	9.160 hh:mm 9.161 TRUE FALSE 9.170 AAA Accurate EAA Estimate
Help Note	– Time accuracy to within 15 minutes is acceptable to be marked as Accurate, otherwise mark as Estimate. – If the time of formal swallow assessment by speech pathologist is unknown select 'Unknown' field. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, then record the time and accuracy of the swallow assessment within the first 24 hours of the onset of stroke symptoms.

Was the swallow screen/assessment performed before oral medications, food or fluids? 9.180 to 9.190

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.180 Oral medications? 9.190 Oral food or fluids?
Common Name	Swallow screen or assessment performed before oral intake
Definition	Swallow screen by a trained health professional or swallow assessment completed by a speech pathologist conducted prior to patient receiving oral intake, i.e. medications, food or fluids.
Format	User Interface: 9.180 Radio buttons. 9.190 Radio buttons. Import Template: 9.180 Numeric field. 9.190 Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Allied health records, Medication chart, Nursing notes and Medical notes). – A comparison should be made between the medical records and the fluid balance chart and medication chart to ascertain if a swallowing screen or assessment was performed prior to oral intake.
Codes and Values	9.180 1 Yes 2 No 9 Not documented 9.190 1 Yes 2 No 9 Not documented
Help Note	– Select 'yes' if the patient did not receive any form of oral intake (medications, food or fluids) prior to having a formal swallow screen by an appropriately trained health care professional (*Refer to MDL Reference 9.070*) and/or formal swallow assessment by a speech pathologist (*Refer to MDL Reference 9.130*). – Select 'no' if the patient received oral intake (medications, food and fluids) prior to having a formal swallow screen by an appropriately trained healthcare professional and/or formal swallow assessment conducted by a speech pathologist *(Refer to MDL Reference 9.130*). – Select 'Not documented' if there is no documented evidence or it is unclear if a swallow screen or assessment occurred before oral medications or food or fluid intake.
Further Information	Middleton et al. (2012), 'Implementation of evidence-based treatment protocols to manage fever, hyperglycaemia, and swallowing dysfunction in acute stroke (QASC): a cluster randomised controlled trial', The Lancet, vol 379, Issue 9824: pp. 1389.

Was the patient able to walk independently on admission? 9.360

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.360
Common Name	Ability to walk independently on admission.
Definition	Ability to walk unaided or without any form of assistance, at the time of arrival to the hospital. This variable is used as a measure for stroke severity and is a global measure of disability that is normally assessed at the time of admission to hospital. However, for patients who experience a stroke during an episode of admitted patient care for a different condition (i.e. in-hospital stroke), this is assessed within the first 24 hours of onset of their stroke symptoms.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical record (admission notes, ED notes, History and medical /nursing notes).
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	– Select 'yes' if patient able to walk independently or with supervision irrespective of use of gait aid, but without assistance of another person, at time of arrival to hospital. – For in-hospital stroke, i.e. stroke during an acute epidose of admitted care for a different condition, then record their ability to walk within the first 24 hours of the onset of stroke symptoms. – For inter-hospital transfers who were admitted with a stroke, record the patient's ability to walk within the first 24 hours of arrival to YOUR hospital. – In circumstances where the patient is admitted with a stroke and has a subsequent stroke during the same acute episode of care, record their ability to walk independently at the time of arrival to hospital for the initial stroke in relation to the same episode of care. Examples of independent mobility: – Patient walked independently (no equipment, no help from another person) – Patient walked with assistance from an assistive device (e.g. walking stick, walking frame) – Patient walked to and from bathroom – Patient received supervision – Examples of not being able to mobilise independently: – Patient needed assistance from another person/s to walk – Patient used a wheelchair or bed trolley – Patient is only getting out of bed to the bedside commode (or up in chair) – Select 'no' if patient has a Modified Rankin Score of 4 or 5. – Select 'No' if patient has a FIM™ Score of 4 or less. – For children select 'No' in the following scenarios: – For child aged birth-30days: difficulty feeding. – For child aged < 2 years: change/reduction in motor activity including tone/power/movement reported by carers/noted in medical record.

	– For child aged ≥ 2 years: inability to walk and/or use hand to grasp on admission.
Further Information	This variable has been validated for use as a predictor of independence at time of hospital discharge (Cadilhac, 2010). Cadilhac D., Kilkenny M., Churilov L., et al. Identification of a reliable subset of process indicators for clinical audit in stroke care: an example from Australia. Clinical Audit 2010; 2: 67-77. Counsell C, Dennis M, McDowall M, et al. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. Stroke 2002; 33(4):1041-1047

Was the patient mobilised in this admission? 9.370

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.370
Common Name	Patient mobilised during this admission.
Definition	Evidence the patient was mobilised upright and/or out of bed during this admission. This includes sitting on the edge of the bed, sitting in a chair, standing or walking.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Allied health records, nursing notes and medical notes). – If 'No' or 'Unknown' is selected for 'was the patient mobilised in this admission', date and method related variables are greyed out and disabled.
Codes and Values	1 Yes 2 No 9 Unknown
Help Note	– Select 'yes', if any mode of mobilisation has been recorded during this admission. – Select 'no', if there is no record of any mobilisation being undertaken during this admission. This includes patients who have been placed on a palliative care pathway or who die during their acute episode of care. – For in-hospital stroke, i.e. patient has a stroke during an acute episode of admitted care for a different condition, select 'Yes' if the patient was mobilised during their acute admission, after the onset of stroke symptoms. – For inter-hospital transfers record whether the patient mobilised during their acute episode of care at YOUR hospital.
Further Information	The AVERT Trial Collaboration Group. Efficacy and safety of very early mobilisation within 24 h of stroke onset (AVERT): a randomized controlled trial. *The Lancet.* 2015; 386, 46-55.

Date of first documented mobilisation? 9.380 to 9.390

ED	Green	Red	Black	FeSS	Paeds

MDL References	9.380 Date of first documented mobilisation 9.390 Accuracy
Common Name	Date and accuracy of date patient first mobilised
Definition	The date the patient first mobilised during their acute admission, after stroke onset and the accuracy status of the date provided.
Format	User Interface: 9.380 Calendar field. 9.390 Radio buttons. Import Template: 9.380 Date field. 9.390 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (Allied health records, nursing notes and medical notes). – If 'No' or 'Unknown' is selected for 'was the patient mobilised in this admission', date and method related variables are greyed.
Codes and Values	9.380 DD/MM/YYYY 9.390 AAA Accurate EAA Estimate
Help Note	– Mobilisation includes patient sitting on the edge of the bed, sitting out in a chair, standing or walking. – If the date the patient first mobilised during their acute admission is known record the date of mobilisation and identify as accurate. – If the day that the patient first mobilised during their acute admission is unknown, use 01 for the day (01/MM/YYYY) and identify as estimate. – For in-hospital stroke, i.e. patient has a stroke during an acute episode of admitted care for a different condition, record date and accuracy of date documented that the patient first mobilised during their acute episode of care, following onset of stroke symptoms. – For inter-hospital transfers record the date and accuracy of date documented that the patient first mobilised during their acute episode of care at YOUR hospital. – In circumstances where the patient is admitted with a stroke and has a subsequent stroke during the same acute episode of care, record the date and accuracy of date documented that the patient first mobilised following the initial stroke in relation to the same episode of admitted care.
Further Information	The AVERT Trial Collaboration Group. Efficacy and safety of very early mobilisation within 24 h of stroke onset (AVERT): a randomized controlled trial. *The Lancet.* 2015; 386, 46-55.

Method of first mobilisation? 9.400

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	9.400
Common Name	Method of mobilisation.
Definition	Type of first mobilisation made during the patient's acute admission, after stroke onset.
Format	User Interface: Radio buttons. Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (Allied health records, Nursing notes and Medical Notes) – If 'No' or 'Unknown' is selected for 'was the patient mobilised in this admission', date and method related variables are greyed out and disabled.
Codes and Values	SITTING Sitting STANDING Standing WALKING Walking
Help Note	– Mobilisation includes sitting on edge of the bed, sitting out in a chair, standing or walking regardless of level of independence with mobilisation i.e whether they were able to complete type of mobilisation independently or required assistance. – If the patient mobilised during their acute admission, following their stroke, select the type of mobilisation first documented within the patient's notes following arrival at your hospital. If, during their first mobilisation post stroke, they use more than one type of mobilsation, select the following hierarchy applies (walking then standing, then sitting). For instance, if a patient transferred from bed and walked to bathroom select 'Walking'. – If the patient is assisted to sit on the edge of bed, assisted out of bed, patslid out of bed or alternatively hoisted out of bed then select 'sitting' as the type of mobilisation. – For in-hospital stroke, i.e. patient has a stroke during an acute episode of admitted care for a different condition, select the type of mobilisation first documented within the patient's notes, following onset of stroke symptoms. – For inter-hospital transfers select the type of mobilsation first documented in the patient's notes following arrival at YOUR hospital. – In circumstances where the patient is admitted with a stroke and has a subsequent stroke during the same acute episode of care, select the type of mobilisation first documented following the initial stroke in relation to the same episode of admitted care.
Further Information	The AVERT Trial Collaboration Group. Efficacy and safety of very early mobilisation within 24 h of stroke onset (AVERT): a randomized controlled trial. *The Lancet.* 2015; 386, 46-55.

Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA) 10.020

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.020
Common Name	Hyperacute antiplatelets
Definition	Antiplatelet or anticoagulant agent administered as hyperacute therapy for ischaemic stroke, as early as possible in the first 48 hours of their stroke symptoms/stroke onset.
Format	User Interface: Drop down list. Import Template: Alpha numeric field. Case sensitive; use upper case for non-numeric entries.
Recording Guidance	– **Required field.** This field is relevant to ischaemic strokes only, as TIAs are not collected in the AuSCR. – Patient medical records (patient medication sheet, documented in the medical or nursing progress notes or Emergency Department progress notes). – If 'Yes' is selected for 'Antiplatelets given as hyperacute therapy', date and time related variables are enabled.
Codes and Values	1 Yes 2 No O No, but anticoagulant agent provided U Unknown CI Contraindicated
Help Note	**This field is relevant to ischaemic stroke only. Where stroke type is intracerebral haemorrhage (ICH), select Contraindicated.** Select **Yes** if the patient was administered an antiplatelet such as aspirin, clopidogrel, combined aspirin and dipyridamole, or combined aspirin and clopidogrel **within 48 hours of stroke onset** at your hospital during the current episode of care. Select **No** if the person was administered an antiplatelet or anticoagulant **prior to presentation** at your hospital. Select **No, but anticoagulant agent provided** if an anticoagulant agent was provided within 48 hours of stroke onset, such as a direct oral anticoagulant (DOAC) or warfarin. Select **Unknown** if unable to locate medication chart or the date and time on the medication chart is not clear. Select **Contraindicated** if stroke type is ICH, or if antiplatelet therapy is contraindicated for another reason. **Provision of thrombolysis** should not be considered as a contraindication **more than** 24 hours after provision **and** where a subsequent brain scan has excluded haemorrhage.
Further information	– Antiplatelet agents include aspirin, clopidogrel or combined low-dose aspirin and modified release dipyridamole. Patients with minor ischaemic stroke may also be provided combination aspirin and clopidogrel.

	– If a patient is administered antiplatelets during the hyperacute phase of their stroke, select 'Yes'. This **does not** include patients taking a hyperacute dose of aspirin/antiplatelet post onset of stroke symptoms prior to presentation to your hospital. – **If antiplatelets were administered later than 48 hours after stroke onset, select 'No'.** – If a patient is not administered a hyperacute dose of antiplatelets, but another antithrombotic agent was provided with 48 hours of stroke onset, such as a direct oral anticoagulant (DOAC) or warfarin, then select 'No, but anticoagulant agent provided'. – If unable to locate a medication chart, select 'Unknown'. – If the date on the medication chart is not clearly recorded but it appears the patient was administered antiplatelets during their hyperacute phase, select 'Unknown'. – If stroke type is intracerebral haemorrhage (ICH), or antiplatelets are contraindicated for another reason and therefore not provided, select 'Contraindicated'. – Contraindications may include but are not limited to the following: allergy to salicylate, anaphylaxis, asthma, active gastric ulcers, haemophilia, Reye's syndrome, thrombotic thrombocytopenia purpura, acute liver dysfunction, acute kidney disease, pregnancy, lactating/breast feeding women, inadequate vitamin K, anaemia, gout and Von Willebrand's disease. – **Provision of thrombolysis should not be considered as a contraindication more than 24 hours after this treatment has been provided and where a subsequent brain scan excludes haemorrhage.**

Date of commencement of antiplatelets 10.030 to 10.040

ED	Green	Red	Black	FeSS	Paeds

MDL References	10.030 Date of commencement of antiplatelets 10.040 Date accuracy
Common Name	Hyperacute antiplatelets commencement date
Definition	The date (and accuracy) that the antiplatelets were first administered as hyperacute therapy for ischaemic stroke. Hyperacute therapy refers to the provision of medication during the first 48 hours of stroke symptoms/stroke onset.
Format	User Interface: 10.030 Calendar field. 10.040 Radio buttons. Import Template: 10.030 Date field. 10.040 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This field is relevant to ischaemic strokes only. – Patient medical records (Medication chart and Medical Notes). – If 'Yes' is selected for 'Antiplatelets given as hyperacute therapy', date and time related variables are enabled. If any other option for hyperacute antiplatelets is selected, all date and time related variables will be greyed out and disabled. If 'No, but anticoagulant agent provided' is selected, leave date and accuracy variables blank within the import template.
Codes and Values	10.030 DD/MM/YYYY 10.040 AAA Accurate EAA Estimate
Help Note	– The date that hyperacute antiplatelets were given to the patient should reflect the date recorded on the patient's medication chart. – If the date that hyperacute antiplatelets were given to the patient is known, record the date and identify as accurate. – If the date that hyperacute antiplatelets were given to the patient is not known, leave blank and indicate as estimate.

Time of commencement of antiplatelets 10.050 to 10.060

ED	Green	Red	Black	FeSS	Paeds

MDL References	10.050 Time of commencement of antiplatelets 10.051 Time unknown 10.060 Time accuracy
Common Name	Hyperacute antiplatelets commencement time
Definition	The time (and accuracy) that antiplatelets were first administered as hyperacute therapy for ischaemic stroke. Hyperacute therapy refers to the provision of medication during the first 48 hours of their stroke symptoms/stroke onset.
Format	User Interface: 10.050 Time field (24 hour time). 10.051 Tick box. 10.060 Radio buttons. Import Template 10.050 Time field. 10.051 Alpha numeric field. Case sensitive – use upper case. 10.060 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** This field is relevant to ischaemic strokes only. – Patient medical records (medication chart or medical and nursing notes). – If 'Yes' is selected for 'antiplatelets given as hyperacute therapy', date and time related variables are enabled. If any other option for hyperacute antiplatelets is selected, all date and time related variables will be greyed out and disabled. Therefore if 'No, but anticoagulant agent provided' is selected, leave date and accuracy variables blank within the import template. – If you check the 'unknown' variable, this will disable the other time and accuracy fields.
Codes and Values	10.050 hh:mm 10.051 TRUE FALSE 10.060 AAA Accurate EAA Estimate
Help Note	– The time that hyperacute antiplatelets were given to the patient should reflect the time recorded on the patient's medication chart. – If the time that hyperacute antiplatelets were given to the patient is known, then record the time and identify as accurate. – If time that hyperacute antiplatelets were provided to the patient is not known, then record 'Unknown'. This will disable the time and time accuracy fields. – Time is recorded to the nearest minute; however time to within 15 minutes of exact time is acceptable to be coded as 'Accurate'.

Assessment and management of fever

Was temperature recorded at least four times on day one of ward admission? 10.070

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.070
Common Name	Measurement of temperature variation day one
Definition	Evidence that patient's temperature was measured at least 4 times during the first day of admission.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – nursing notes, medical notes, observation chart.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Note	– Day one indicates first 24 hours after admission. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether temperature observations were recorded within the first 24 hours of the onset of stroke symptoms. – Observations should be taken 4 or 6 hourly so there should be at least 4 separate temperate recordings during first 24hrs.

In the first 72 hours following admission did the patient develop a fever ≥ 37.5°C 10.100

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.100
Common Name	Fever within 3 days of admission
Definition	Raised temperature (≥ 37.5°C) recorded within 72 hours of admission.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records- nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Note	– For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether temperature observations were recorded within the first 72 hours of the onset of stroke symptoms.
Further Information	High temperature negatively impacts patient outcomes.

Was paracetamol for the first elevated temperature administered within 1 hour? 10.150

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.150
Common Name	Administration of paracetamol
Definition	Evidence paracetamol was given within 1 hour of elevated temperature.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records- medication chart, nursing notes, medical notes, observation chart.
Codes and Values	1 = Yes 2 = No 3 = Already received regular paracetamol 4 = Contraindicated 9 = Not documented
Help Note	Variable enabled if answered “Yes” to “In the first 72 hours following admission did the patient develop a fever ≥ 37.5°C” (Ref 10.100)
Further Information	Lowering temperature (if raised) improves patient outcomes.

Was a finger-prick blood glucose level recorded at least four times on day one of ward admission? 10.210

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.210
Definition	Evidence of four finger prick tests for blood glucose level (BGL) on first day of admission.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Note	– Day one indicates first 24 hours after admission. – For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether blood glucose levels were recorded within the first 24 hours of the onset of stroke symptoms. – Observations should be taken 4 or 6 hourly so there should be at least 4 separate BGL recordings during first 24hrs. – It is good practice for BGL to be assessed 2 hrs after meals and nocte.

In the first 48 hrs following ward admission did the patient develop a finger-prick glucose level of greater or equal to 10mmol/L? 10.240

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.240
Common Name	Development of hyperglycaemia
Definition	Glucose level equal or exceeding 10mmol/L within 48 hours of admission.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Note	For in-hospital stroke, i.e. stroke during an acute episode of admitted care for a different condition, record whether temperature observations were recorded within the first 48 hours of the onset of stroke symptoms.

Was insulin administered within 1 hour of the first elevated finger-prick glucose (≥10 mmol/L)? 10.250

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	10.250
Common Name	Administration of insulin
Definition	Evidence that insulin was given within 1 hour of the first elevated finger prick glucose (if patient developed finger-prick glucose level of greater or equal to 10mmol/L)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records: medication chart, nursing notes, medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Note	– Variable enabled if “Yes” answered to “In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal to 10mmol/L?” (Ref 10.240) – Ideally, insulin administration should be via infusion but other methods are also acceptable to answer “Yes”.

Secondary prevention

Medication Prescribed at Discharge

On discharge was the patient prescribed antithrombotics? 13.020

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	13.020
Common Name	Prescription of antithrombotic medication at discharge.
Definition	Evidence that antithrombotic medication was prescribed at discharge. Antithrombotic medication includes both antiplatelet and anticoagulant medications.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Medical Notes, Medication Chart and Discharge summary).
Codes and Values	1 Yes 2 No 9 Unknown 3 Contraindicated
Help Note	– Select 'Yes' if the patient was prescribed an antithrombotic agent on discharge from their acute episode of care. This is irrespective of discharge destination. – Select 'No' if the patient did not receive an antithrombotic agent on discharge from their acute episode of care. – Select 'Contraindicated' if: 1) the patient died or were placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing antithrombotic medication because of the potential for harm, e.g. the patient has suffered a recent intracerebral haemorrhage. – If unable to locate a medication chart or details of medications prescribed on discharge, select 'unknown'. – Select Unknown if it is unclear whether an antithrombotic agent was prescribed on discharge.
Further Information	Antiplatelet medications include (but are not limited to) aspirin, clopidogrel, prasugrel, ticagrelor and dipyridamole. Anticoagulants include warfarin, apixaban, digabatran, rivaroxaban, unfractionated heparin, and low molecular weight heparins such as enoxaparin. Refer to MIMS for a full list.

If yes, please specify 13.030 to 13.100

ED	Green	Red	Black	FeSS	Paeds

MDL References	13.030 Aspirin 13.040 Clopidogrel 13.050 Dipyridamole MR 13.055 Other antiplatelet drug 13.060 Warfarin 13.070 Dabigatran 13.080 Rivaroxaban 13.090 Apixaban 13.100 Other anticoagulant
Common Name	Specific antithrombotic prescribed.
Definition	Type of antithrombotic medication prescribed at discharge.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – medical notes, medication chart, and discharge summary.
Codes and Values	1 = Yes 2 = No
Help Note	
Further Information	Dipyridamole MR is the modified released preparation.

On discharge was the patient prescribed antihypertensive agents? 13.120

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	13.120
Common Name	Prescription of antihypertensive medication at discharge.
Definition	Evidence that patient was discharged on antihypertensive medication.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Nursing notes and Medical Notes, Discharge summary).
Codes and Values	1 Yes 2 No 9 Unknown 3 Contraindicated
Help Note	– Select 'Yes' if the patient was prescribed an antihypertensive agent on discharge from their acute episode of care. This is irrespective of discharge destination. – Select 'No' if the patient did not receive an antihypertensive agent on discharge from their acute episode of care. – Select 'Contraindicated' if: 1) the patient died or was placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing antihypertensive medication because of the potential for harm; 3) there is documentation that antihypertensive medication was not required as blood pressure was below the target range. – If unable to locate a medication chart or details of medications prescribed on discharge, select 'unknown'. – If it is unclear whether an antihypertensive agent was prescribed on discharge, select 'unknown'.
Further information	Antihypertensive medications commonly include angiotensin converting enzyme inhibitors (e.g. Perindopril, Ramipril) with or without diuretic, and angiotensin II receptor antagonists (e.g. Telmisartan, Losartin) with or without diuretic. Other medications include alpha blockers (e.g. Prazosin), beta blockers (e.g. Atenolol, Metoprolol), calcium channel blockers (e.g. Amlodipine, Diltiazem hydrochloride) and thiazide diuretics. Refer to MIMs for full list.

On discharge was the patient prescribed lipid lowering treatment? 13.210

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	13.210
Common Name	Prescription of lipid lowering medication at discharge.
Definition	Evidence that lipid lowering medication was prescribed at discharge.
Format	User Interface: Drop down list. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Nursing notes and Medical Notes, Discharge summary).
Codes and Values	1 Yes 2 No 9 Unknown 3 Contraindicated
Help Note	– Select 'Yes' if the patient was prescribed a lipid lowering medication on discharge from their acute episode of care. This is irrespective of discharge destination. – Select 'No' if the patient did not receive a lipid lowering medication on discharge from their acute episode of care. – Select 'Contraindicated' if 1) the patient died or was placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing lipid lowering medication because of potential for harm of because it is clinically inappropriate, e.g. stroke mechanism is unrelated to atherosclerosis, low-density lipoprotein (LDL) already in treated target range, abnormal liver function (x3 above normal range).. – If unable to locate a medication chart or details of medications prescribed on discharge, select 'unknown'. – Select Unknown if it is unclear whether a lipid lowering medication was prescribed on discharge.
Further information	Lipid lowering agents commonly include (but are not limited to) statins (e.g. Atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin, and pitavastatin) and fibrates (e.g. gemfibrozil and fenofibrate). Others include; ezetimibe, colesevelam, torcetrapib, avasimibe, implitapide, and niacin. Refer to MIMS for full list.

Discharge Information

Patient deceased during hospital care? 14.000

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.000
Common Name	In-hospital death.
Definition	Patient died during their acute episode of care at your hospital. This variable does not include those patients who died post discharge from their acute episode of care, e.g. transferred to a sub-acute ward or palliative care. A death post-acute episode of care should be recorded using the Actions button - Record death for patient. Based on METeOR Identifier: 270094
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical record (Physician's and Nursing Progress notes, Discharge Summary, Death certificate in medical record.) – If 'Yes' has been selected for 'deceased during hospital care', subsequent discharge details are greyed out and disabled, excluding discharge diagnoses and procedure codes (Ref. 14.150 to 14.154). Discharge destination (Ref. 14.160) will auto-populate to 'Died'.
Codes and Values	1 Yes 2 No
Help Note	– If the patient died during their acute episode of care for this current stroke episode record 'Yes'. – If the patient died post discharge from their acute episode of care, irrespective of discharge destination record 'No'. – If the patient has not passed away record 'No'. – If the patient represented with another acute stroke and passed away during the subsequent admission, then 'No' should be recorded for this variable for the current stroke episode. However, death date and detail should be recorded via Actions button using 'Record death for patient'.

Date of death (acute care episode) 14.010 to 14.020

ED	Green	Red	Black	FeSS	Paeds

MDL References	14.010 Date of death 14.020 Accuracy (of death date)
Common Name	In-hospital death date.
Definition	The date (and accuracy) the patient died during their acute episode of care for their current episode of stroke. METeOR Identifier: 646025
Format	User Interface: 14.010 Calendar field. 14.020 Radio buttons. Import Template: 14.010 Date field. 14.020 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field if 'Yes' for in hospital death selected.** – Patient medical records (Medical notes, death certificate in medical record) – Telephone contact with family member/s – Telephone or postal follow-up contact with family member/s – If 'Yes' has been selected for 'deceased during hospital care' then subsequent discharge details are greyed out and disabled, excluding discharge diagnosis and procedure codes. Discharge destination (Ref 14.160) will auto-populate to 'Died'. – If patient died subsequent to acute episode of care, enter all discharge details for the current episode, and use the Actions button on patient record view to record death. This includes for patients discharged to palliative care.
Codes and Values	14.010 DD/MM/YYYY 14.020 AAA Accurate EAA Estimate
Help Note	– If the patient died during their acute episode of care for this current stroke episode, record date of death and accuracy. If the date of death has been confirmed (e.g. death certificate) then record date of death and identify as accurate. – If the day of death is unknown use 01 for the day (01/MM/YYYY). – If 'Yes' is selected for 'patient deceased during hospital care' then this date and accuracy details will be enabled. – This date of death (and accuracy) only refers to an in-hospital death during an acute episode of care for current stroke admission.
Further Information	Recording in-hospital patient deaths is important, to avoid the AuSCR Office following up someone who is deceased.

Is the date of discharge known? 14.070

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.070
Definition	Known date of discharge from the acute episode of care i.e. the date on which the patient is transferred from acute care to home, community or inpatient rehabilitation, or when they died while in care.
Format	User Interface: Radio buttons. Import Template: Numeric field.
Recording Guidance	– **Required field.** – Patient medical records (Discharge summary)
Codes and Values	1 Yes 2 No
Help Note	– This variable refers to the date of discharge from the acute episode of care. The patient may have several inpatient separations during a single acute episode of care (e.g. short stay unit to ward to ICU to ward). The final date of discharge from the acute episode of care should be used.

Date of discharge 14.080 to 14.090

ED	Green	Red	Black	FeSS	Paeds

MDL References	14.080 Date of discharge 14.090 Accuracy
Common Name	Date of discharge from acute episode of care
Definition	The date the patient was discharged (and accuracy) from an acute episode of care. METeOR Identifier: 270025
Format	User Interface: 14.080 Calendar field. 14.090 Radio buttons. Import Template: 14.080 Date field. 14.090 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (Discharge summary). – If 'Yes' is selected for 'is the date of discharge known' then these date and accuracy details will be enabled. Conversely, date and accuracy details are greyed out and disabled if 'No' is selected.
Codes and Values	14.080 DD/MM/YYYY 14.090 AAA Accurate EAA Estimate
Help Note	– This variable refers to the date of discharge from the acute episode of care. The patient may have several inpatient separations during a single acute episode of care (e.g. short stay unit to ward to ICU to ward). The final date of discharge from the acute episode of care should be used. – If the date of discharge is unclear, then record an estimated date of discharge and identify as estimate.

What is the discharge diagnosis ICD 10 Classification Code? 14.150 to 14.151

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.150 What is the discharge diagnosis ICD-10-AM classification code? 14.151 Other (specify)
Common Name	Principal diagnosis ICD-10-AM on discharge
Definition	The principal diagnosis is defined as the diagnosis established after investigation to be chiefly responsible for occasioning the patient's episode of care in hospital, as represented by an International Classification of Disease code (ICD-10-AM). Principal diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)*. METeOR Identifier: 699609
Format	User Interface: 14.150 Drop down list. 14.151 Alpha numeric field. Text box. *Maximum character length: 6.* Import Template: 14.150 Alpha numeric field. Case sensitive – use upper case. 14.151 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records; clinical coding documentation.
Codes and Values	14.150 I61.0-I61.6, I61.8-I61.9 I62.9 I63.0-I63.6, I63.8-I63.9 I64 G45.9 OTH Other 14.151 Free text.
Help Note	– See Appendix 7 for full description of codes listed above. – ICD-10-AM diagnosis codes are assigned to patient records after discharge by Health Information staff and should not be coded by those responsible for data collection/entry at your hospital. – The delay in coding by your hospital will influence when the ICD-10AM codes can be entered. – The principal diagnosis on discharge should be entered in this field. The principal diagnosis on discharge will not always be coded as a stroke. If the principal diagnosis is not one of the listed codes, then 'Other' should be recorded. If 'Other' is selected the code should be specified in 14.151. – If you are unable to locate a principal diagnosis on discharge then leave this field blank, until coding is completed by Health Information Services staff.
Further Information	The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and health care planning purposes. Therefore, these codes are important for international, national or state-based comparative analyses of stroke separations.

What is the Medical Condition ICD 10 Classification Code? 14.152

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.152
Common Name	ICD-10-AM Medical Condition.
Definition	A condition or complaint coexisting with the principal diagnosis, as represented by a International Classification of Diseases Code (ICD-10-AM). Based on METeOR Identifier: 699606
Format	User Interface: Alpha numeric field. Text box. Multiple codes should be separated by a comma. *Unlimited character length*. Import Template: Alpha numeric field. Case sensitive – use upper case. Multiple codes should be separated by a comma. *Unlimited character length.*
Recording Guidance	– **Required field.** – Patient medical records; clinical coding documentation.
Codes and Values	Free text.
Help Note	– ICD-10-AM codes are assigned to patient records after discharge by Health Information Services staff and should not be coded by those responsible for data collection/entry at your hospital. – The delay in coding by your hospital will influence when the ICD-10-AM codes can be entered. – Multiple codes should be separated by a comma. – The medical condition represented by an ICD-10-AM code should be recorded in this field. Additional Diagnosis codes with a Condition Onset Flag of 2 (P in Victoria) as provided in the medical record should be recorded in this field. – If you are unable to locate a medical condition code (ICD-10-AM) then this field should be left blank.

What is the Medical Complication ICD 10 Classification Code? 14.153

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.153
Common Name	ICD-10-AM Medical Complication.
Definition	A condition or complaint arising during the episode of admitted patient care, as represented by the International Classification of Diseases code (ICD-10-AM). Based on METeOR Identifier: 699606
Format	User Interface: Alpha numeric field. Text box. Multiple codes should be separated by a comma. *Unlimited character length.* Import Template: Alpha numeric field. Multiple codes should be separated by a comma. *Unlimited character length.*
Recording Guidance	**Required field.** – Patient medical records; clinical coding documentation.
Codes and Values	Free text.
Help Note	– ICD-10-AM codes are assigned to patient records after discharge by Health Information Services staff and should not be coded by those responsible for data collection/entry at your hospital. – The delay in coding by your hospital will influence when the ICD-10-AM codes can be entered. – Multiple codes should be separated by a comma. – All Additional Diagnosis codes with a Condition Onset Flag 1 (C in Victoria) as provided in the medical record should be recorded in this field, separated by commas. – If you are unable to locate a medical complication code (ICD-10-AM) then this field should be left blank.

What is the Medical Procedure ICD 10 Classification Code? 14.154

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.154
Common Name	Australian Classification of Health Interventions (ACHI) code for medical procedures.
Definition	The clinical interventions performed during a hospital admission meeting Australian Classification of Health Interventions (ACHI) criteria for coding, as represented by an ACHI code on the patient discharge summary, casemix summary or Medical Record. METeOR Identifier: 699716
Format	User Interface: Alpha numeric field. Text box. Multiple codes should be separated by a comma. *Unlimited character length.* Import Template: Alpha numeric field. Multiple codes should be separated by a comma. *Unlimited character length.*
Recording Guidance	– **Required field.** – Patient medical records; clinical coding documentation.
Codes and Values	Free text.
Help Note	– ACHI procedure codes are assigned to patient records after discharge by Health Information Services staff and should not be coded by those responsible for data entry collection/entry at your hospital. – The delay in coding by your hospital will influence when the ACHI procedurecodes can be entered. – Multiple codes should be separated by a comma. – All medical procedures as represented by an ACHI code should be recorded in this field. – If you are unable to locate a medical procedural code, then this field should be left blank.

What is the discharge destination/mode? 14.160 to 14.161

ED	Green	Red	Black	FeSS	Paeds

MDL References	14.160 What is the discharge destination/mode? 14.161 Please specify level of care (if discharged/transferred to residential aged care service) – **Not applicable to ED.**
Common Name	Discharge destination
Definition	Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code. METeOR Identifier: 270094
Format	User Interface: 14.160 Drop down list. 14.161 Radio buttons. Import template: 14.160 Numeric field. 14.161 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical record (Physician's notes, Nursing Progress notes and Social Worker notes, discharge summary, discharge care plan) 14.160 – If 'yes' has been selected for 14.000 Patient deceased during hospital care, this variable will be autocompleted with 'Died' and greyed out. 14.161 – If 'Discharge/transfer to a residential aged care service' is selected for 14.160 What is the discharge destination/mode, this field will be enabled. – For the purpose of importing, leave field blank, unless 'Discharge/transfer to a residential aged care service' was selected for 14.160 What is the discharge destination/mode.
Codes and Values	14.160 1 Discharge/transfer to (an)other acute hospital 2 Discharge/transfer to a residential aged care service, unless this is the usual place of residence 5 Statistical discharge - type change 6 Left against medical advice/discharge at own risk 8 Died 9 Other 10 Usual residence (e.g. home) with supports 11 Usual residence (e.g. home) without supports 12 Inpatient rehabilitation 13 Transitional care services 14.161 LLRC Low level residential care HLRC High level residential care
Help Note	14.160 – Select **'Discharge/transfer to (an)other acute hospital'** for admission or transfer to another acute hospital, including transfer to a psychiatric unit or to a palliative care hospital. – Select **'Discharge/transfer to a residential aged care service'** for residential aged care services, special accommodation and aged care hostels, unless this is the usual place of residence. However, if the patient previously resided in residential aged care but the level of residential aged care service has increased, this code is selected. – Select **'Statistical discharge - type change'** for date of discharge from an acute episode to a sub-acute treatment phase but still an inpatient (may also be recorded as SNAP).

	– Select **'Left against medical advice/discharge at own risk'** for self discharge. – The code 'Died' refers to in hospital death; this variable will auto-complete to 'Died' and grey out if 'Yes' has been selected for Patient deceased during hospital care, Ref 14.000). – Select 'Inpatient rehabilitation' for any rehabilitation facility or ward where the patient is undergoing rehabilitation as an inpatient. Note: geriatric assessment units, such as Geriatric Evaluation and Management (GEM) Units, should be coded as Transitional Care Services. – Select 'Usual residence (e.g. home) with supports' for private residences (such as houses, flats, units, units in a retirement village, caravans, mobile homes) in which patients are provided with support in some way by staff or volunteers (including spouse, family members, community care, meals on wheels or other support organisations). This includes discharge back to residential aged care service, when it is a patient's usual residence. – Select 'Other' for discharge to welfare institutions, hostels and group homes providing primarily welfare services, prisons or other destinations than those listed. – Select 'Usual residence (e.g. home) without supports' for private residences (such as houses, flats, units, units in a retirement village, caravans, mobile homes) in which patients will not be provided with care supports. – Select 'Transitional care services' for transition care either at home or in aged care, including hospital-in-the-home, home-based rehabilitation services and transfer to a Geriatric Evaluation and Management (GEM) Unit. For transitional care where the patient remains in your hospital, select 'Statistical separation'. 14.161 – Select 'Low level residential care' for discharge to low level residential services (formerly nursing homes: low level care, special accommodation and aged care hostels) and multipurpose services or multipurpose centres, that are providing low level care. – Select 'High level residential care' for discharge to high level residential services (formerly nursing homes) and multipurpose services or multipurpose centres that are providing high level care.

Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient (or family if patient has severe aphasia or cognitive impairments)? 14.190

ED	Green	Red	Black	FeSS	Paeds

MDL Reference	14.190
Common Name	Post discharge care plan.
Definition	Documented evidence that the patient, or the patient's family, have received an individualised plan that outlines care in the community post discharge (i.e. written specifically for the patient, NOT generic information and NOT a copy of the discharge summary provided to other health professionals. Care plans are developed with input from both the multi-disciplinary team and the patient; or in situations where the patient is no longer able to make decisions, with the family or significant other. The care plan should include the following information: – Rehabilitation goals – Lifestyle modifications and medications required to manage risk factors – Any equipment needed – Follow up appointments – Contact details for ongoing support services in the community
Format	User Interface: Drop down list. Import template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	– **Required field.** – Patient medical records (patient history, discharge summary, discharge care plan). – Compliance with this indicator requires documented evidence of a care plan having been provided to any patient who is going home or to a non-medical private setting. – Select 'Not applicable' for patients who remain in a hospital setting (e.g. transferred to inpatient rehabilitation or other acute hospitals)
Codes and Values	1 Yes 2 No 9 Unknown NA Not applicable (remains in a hospital setting e.g. inpatient rehabilitation or other acute care)
Help Note	Select Yes if there is documented evidence that the patient or their family have received an individualised care plan outlining post discharge care. The plan must meet the criteria outlined in the Acute Stroke Clinical Care Standard. Select Not Applicable if the patient remains in a hospital setting.
Further Information	Consistent with Core data elements 12.12 of the Paul Coverdell National Acute Stroke Registry (January 16, 2008)

References

ACI Stroke Network Audit Tool Version 1.3 2013

Adams, H. P., Bendixen, B. H., Kappelle, L. J., Biller, J., Love, B. B., Gordon, D. L., & Marsh, E. E. (1993). Classification of subtype of acute ischemic stroke. Definitions for use in a multicentre clinical trial. TOAST. Trial of Org 10172 in Acute Stroke Treatment. *Stroke* (Vol. 24). https://doi.org/10.1161/01.STR.24.1.35

Australian Bureau of Statistics (2012). Standard Australian Classification of Countries (SACC), cat. 1269.0, Canberra

Australian Commission on Safety and Quality in Health Care (2014). Framework for Australian clinical quality registries. Sydney, *ACSQHC*, 29

Cadilhac et al. (2015), 'Australian Stroke Clinical Registry: 2014 Annual Report', The Florey Institute of Neuroscience and Mental Health, 6, pp 42.

Cadilhac, D., Kilkenny, M., Churilov, L., et al. (2010). Identification of a reliable subset of process indicators for clinical audit in stroke care: an example from Australia. *Clinical Audit*, 2, 67-77.

Cadilhac, D., Pearce, D. C., Levi, C. R., & Donnan, G. a. (2008). Improvements in the quality of care and health outcomes with new stroke care units following implementation of a clinician-led, health system redesign programme in New South Wales, Australia. *Quality & Safety in Health Care*, *17*(Icd), 329–333. https://doi.org/10.1136/qshc.2007.024604

Counsell, C., Dennis, M., McDowall, M., & Warlow, C. (2002). Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. *Stroke*, *33*(4), 1041–1047. https://doi.org/10.1161/hs0402.105909

Dale, S., Levi, C., Ward, J., Grimshaw, J. M., Jammali-Blasi, A., D'Este, C., Middleton, S. (2015). Barriers and enablers to implementing clinical treatment protocols for fever, hyperglycaemia, and swallowing dysfunction in the quality in acute stroke care (QASC) project-a mixed methods study. *Worldviews on Evidence-Based Nursing*, *12*(1), 41–50. https://doi.org/10.1111/wvn.12078

Evans S. M., Loff B., Cameron P.A. (2013) Clinical registries: the urgent need to address ethical hurdles. *Medical Journal of Australia*, 198(3), 134-135.

Goyal M., et al. (2014). 2C or not 2C: defining an improved revascularization grading scale and the need for standardization of angiography outcomes in stroke trials. *Journal of NeuroInterventional Surgery*, 6(2): 83-86. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4156591/

Home and Community Care (HCC) Program: minimum data set. (2006). Australian Government, V2. Retrieved from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/11_2014/prov_4b1_hacc_mds_user_guide.pdf

INSPIRE clinical data guidance version 9

Intravenous Thrombolysis Protocol. Retrieved from: https://sitsinternational.org/registries/sits-thrombolysis

Kapral, M. K., Hall, R., & Stamplecoski, M. (2011). Report on the 2008/09 Ontario Stroke Audit. *Institute for Clinical Evaluative Sciences, Toronto*.

Karolinska University Hospital. (2014). SITS International Registry Data Form for Paul, C. L. et al. (2014). Thrombolysis ImPlementation in Stroke (TIPS): evaluating the effectiveness of a strategy to increase the adoption of best evidence practice--protocol for a cluster randomised controlled trial in acute stroke care. *Implementation Science : IS*, *9*, 38. https://doi.org/10.1186/1748-5908-9-38

Lees, K. (2008). Modified Rankin Scale: A training and certification resource. *The University of Glasgow*. Retrieved from: http://rankinscale.org/resources.shtml

Middleton, S. et al. (2012). Implementation of evidence-based treatment protocols to manage fever, hyperglycaemia, and swallowing dysfunction in acute stroke (QASC): a cluster randomized controlled trial. *The Lancet*, 379 (9824), 1389.

MIMS Online (2016). Retrieved from: http://www.mims.com.au/index.php/products/mims-online

National Health and Medical Research Council (2007). National statement on ethical conduct in human research (updated May 2015). *NHMRC*, Canberra.

Ontario Stroke Registry Acute Data Dictionary 2013.

Paul, C. L. et al. (2014). Thrombolysis ImPlementation in Stroke (TIPS): evaluating the effectiveness of a strategy to increase the adoption of best evidence practice--protocol for a cluster randomised controlled trial in acute stroke care. *Implementation Science : IS*, *9*, 38. https://doi.org/10.1186/1748-5908-9-38

Queensland Health Data Dictionary. (2013). *Health Statistics Unit, Department of Health*.

Reenan, M. V., Oppe, M. (2015). EQ-5D-3L User Guide: basic information on how to use the eQ-5D-3L instrument. Version 5.1

Reeves, M. J et al. (2006). The Paul Coverdell National Acute Stroke Registry. Initial Results from Four Prototypes. *American Journal of Preventive Medicine*, 31(6 SUPPL. 2), 202–209. https://doi.org/10.1016/j.amepre.2006.08.007

RIKS-Stroke, Acute Phase. (2007). *Swedish national quality register for stroke, 8.*

Stroke Foundation, Living Clinical Guidelines for Stroke Management
https://informme.org.au/guidelines/living-clinical-guidelines-for-stroke-management#

Stroke Foundation, National Stroke Audit Program: Methodology, March 2020
https://informme.org.au/media/u0ajsha3/national-stroke-audit-methodology.pdf

The Avert Trial Collaboration Group. (2015). Efficacy and safety of very early mobilization within 24 hours of stroke onset (AVERT): a randomized controlled trial. *The Lancet*, 386, 46-55.

APPENDICES

Appendix 1: AuSCR programs, at May 2025

AuSCR Program Datasets

Core AuSCR dataset

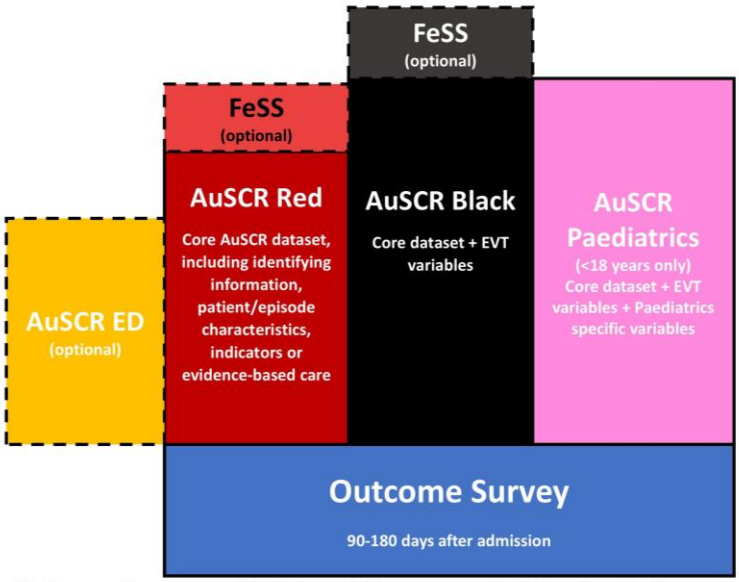
Identifying information
- Name
- Date of birth
- Gender
- Contact details (including next of kin)
- Hospital details

Clinical processes
- Thrombolytic therapy
- Access to a stroke unit
- Swallow screen/assessment
- Mobilisation
- Discharge medications
- Discharge care plan

Timeliness of care delivery
- Arrival by ambulance
- Date/time of stroke onset
- Date/time of ED arrival
- Date/time of admission
- Transfer from other hospital

Risk adjustment
- ICD-10 codes
- Ethnicity
- Ability to walk on admission
- First ever stroke status
- Inpatient stroke
- NIHSS on presentation

Hospital outcomes data
- Date of discharge or death
- Discharge destination



ED: Emergency Department **EVT:** Endovascular Therapy **FeSS:** Fever, Sugar, Swallow

Each colour represents a different amount or type of variables in which AuSCR hospitals choose to collect data based on their quality-of-care objectives. The follow-up survey is collected on behalf of hospitals by AuSCR Office.

Appendix 2: List of AuSCR acute variables collected in each AuSCR program

The list below reflects variables collected in AuSCR programs which were being actively used by hospitals as of March 2023.

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
1.000 Hospital name	✓	✓	✓	✓	✓
1.020 Auditor name	✓	✓	✓	✓	x
2.000 Patient record ID number	✓	✓	✓	✓	✓
2.030 Statistical linkage key	✓	✓	✓	✓	✓
2.050 Title	✓	✓	✓	✓	x
2.060 First name	✓	✓	✓	✓	✓
2.070 Last name	✓	✓	✓	✓	✓
2.090 Date of birth	✓	✓	✓	✓	✓
2.100 Age	x	x	✓	x	✓
2.110 Medicare number	✓	✓	✓	x	x
2.120 Hospital Medical Record Number (MRN)	✓	✓	✓	✓	x
2.130 Gender	✓	✓	✓	✓	✓
2.150 Country of birth	✓	✓	✓	✓	x
2.160 Language spoken	✓	✓	✓	x	x
2.170 Interpreter needed	✓	✓	✓	x	x
2.180 Is the patient of Aboriginal/Torres Strait Islander origin?	✓	✓	✓	✓	x
2.190 Phone number	✓	✓	✓	x	x
2.200 Mobile number	✓	✓	✓	x	x
2.210 Address type	✓	✓	✓	x	x
2.220 Street address	✓	✓	✓	x	x
2.230 Suburb	✓	✓	✓	x	x
2.240 Postcode	✓	✓	✓	✓	x
2.250 State	✓	✓	✓	✓	x
2.260 Country	✓	✓	✓	x	x
2.280 First name	✓	✓	✓	x	x
2.290 Last name	✓	✓	✓	x	x
2.291 Same as patient address?	✓	✓	✓	x	x
2.300 Address type	✓	✓	✓	x	x
2.310 Street address	✓	✓	✓	x	x
2.320 Suburb	✓	✓	✓	x	x
2.330 Postcode	✓	✓	✓	x	x
2.340 State	✓	✓	✓	x	x
2.350 Country	✓	✓	✓	x	x
2.360 Phone number	✓	✓	✓	x	x
2.370 Mobile number	✓	✓	✓	x	x
2.390 Emergency contact relationship to participant	✓	✓	✓	x	x
2.391 Other relative (specify)	✓	✓	✓	x	x
2.400 First name	✓	✓	✓	x	x
2.410 Last name	✓	✓	✓	x	x
2.420 Address type	✓	✓	✓	x	x

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
2.430 Street address	✓	✓	✓	x	x
2.440 Suburb	✓	✓	✓	x	x
2.450 Postcode	✓	✓	✓	x	x
2.460 State	✓	✓	✓	x	x
2.470 Country	✓	✓	✓	x	x
2.480 Phone number	✓	✓	✓	x	x
2.490 Mobile number	✓	✓	✓	x	x
2.510 Alternative contact relationship to participant	✓	✓	✓	x	x
2.511 Other relative (specify)	✓	✓	✓	x	x
3.070 Validated stroke screen performed	x	x	x	x	x
3.080 Type	x	x	x	x	x
4.00 Onset date	✓	✓	✓	✓	✓
4.010 Unknown	✓	✓	✓	✓	✓
4.020 Date accuracy	✓	✓	✓	✓	x
4.030 Onset time	✓	✓	✓	✓	✓
4.040 Time accuracy	✓	✓	✓	✓	✓
4.090 Date of discovery	x	x	x	✓	x
4.100 Date accuracy	x	x	x	✓	x
4.101 Unknown	x	x	x	✓	x
4.120 Time of discovery	x	x	x	✓	x
4.130 Time accuracy	x	x	x	✓	x
4.131 Unknown	x	x	x	✓	x
4.140 Did the stroke occur while the patient was in hospital?	✓	✓	✓	x	✓
4.150 Date of arrival to emergency department	✓	✓	✓	✓	✓
4.160 Date accuracy	✓	✓	✓	✓	x
4.170 Time of arrival to emergency department	✓	✓	✓	✓	✓
4.180 Time accuracy	✓	✓	✓	✓	x
4.181 Unknown	✓	✓	✓	✓	✓
4.190 Direct admission to hospital (bypass ED)	x	✓	✓	x	x
4.200 Did the patient arrive by ambulance?	✓	✓	✓	✓	x
4.210 Prehospital notification by paramedics?	x	x	x	✓	x
4.220 Was the patient transferred from another hospital?	✓	✓	✓	x	✓
4.240 Date of transfer	x	x	x	✓	x
4.250 Not documented	x	x	x	✓	x
4.260 Time of transfer	x	x	x	✓	x
4.270 Not documented	x	x	x	✓	x
4.290 Date of admission to hospital	✓	✓	✓	x	✓
4.300 Not admitted	✓	✓	✓	x	x
4.310 Date accuracy	✓	✓	✓	x	x
4.320 Time of admission to hospital	✓	✓	✓	x	✓
4.330 Time accuracy	✓	✓	✓	x	x
4.331 Unknown	✓	✓	✓	x	✓
4.380 Treated in a stroke unit at any time during their stay?	✓	✓	✓	x	x
5.040 Need for IV thrombolysis	x	✓	✓	✓	x
5.050 Need for stroke unit care	x	✓	✓	✓	x
5.060 Need for rehabilitation	x	✓	✓	x	x
5.070 Need for brain imaging	x	✓	✓	✓	x
5.080 Need for ICU	x	✓	✓	✓	x
5.090 Need for specialist medical assessments	x	✓	✓	✓	x
5.100 Need for surgical interventions	x	✓	✓	✓	x

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
5.110 Need for diagnostic tests	x	✓	✓	✓	x
5.120 Need for coordinated care by a stroke service	x	✓	✓	x	x
5.121 Need for endovascular therapy	x	✓	✓	✓	x
5.130 Unknown	x	✓	✓	✓	x
5.140 Other (specify)	x	✓	✓	✓	x
6.010 History of atrial fibrillation	x	x	x	x	x
6.020 Previous stroke	✓	✓	✓	x	x
6.211 Cardiac disease	x	x	✓	x	x
6.212 Anaemia	x	x	✓	x	x
6.213 Infection	x	x	✓	x	x
6.221 Other (specify)	x	x	✓	x	x
6.470 Functional status prior to stroke (mRS)	x	x	x	✓	x
6.480 Unknown/derive	x	x	x	✓	x
6.490 Can the patient walk on their own (i.e. without the assistance of another person, but may include walking aid)?	x	x	x	✓	x
6.500 If the patient can't walk on their own, can they walk if someone is helping them?	x	x	x	✓	x
6.510 If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)?	x	x	x	✓	x
6.520 If the patient can perform simple personal activities do they need help with more complex usual activities (driving, golf, finances, household bills, work tasks)?	x	x	x	✓	x
6.530 If the patient has no disability, do they have any symptoms?	x	x	x	✓	x
7.000 What was the triage category (Australasian Triage Scale; ATS) for this patient in ED?	x	x	x	✓	x
7.010 Not admitted through ED	x	x	x	✓	x
7.250 NIHSS at baseline	✓	✓	✓	✓	✓
7.410 Did the patient have a brain scan after this stroke?	x	✓	✓	✓	x
7.430 Date of first brain scan after the stroke	✓	✓	✓	✓	x
7.440 Time of first brain scan after the stroke	✓	✓	✓	✓	x
7.450 Not documented	✓	✓	✓	✓	x
7.451 Was this brain scan diagnostic?	x	x	✓	x	x
7.460 What type of brain scan was performed?	x	x	✓	x	x
7.471 CT angiography	x	x	✓	✓	x
7.472 CT perfusion	x	x	✓	✓	x
7.473 Diffusion weighted imaging	x	x	✓	✓	x
7.474 MR angiography	x	x	✓	✓	x
7.475 Perfusion weighted imaging	x	x	✓	✓	x
7.476 No advanced imaging	x	x	✓	✓	x
7.480 Date of subsequent brain scan after the stroke	x	✓	✓	x	x
7.490 Not applicable (no further scans)	x	✓	✓	x	x
7.500 Time of subsequent brain scan after the stroke	x	✓	✓	x	x
7.510 Time of subsequent brain scan - not documented	x	✓	✓	x	x
7.520 What type of brain scan was performed?	x	x	✓	x	x
7.531 CT angiography	x	x	✓	x	x
7.532 CT perfusion	x	x	✓	x	x
7.533 Diffusion weighted imaging	x	x	✓	x	x
7.534 MR angiography	x	x	✓	x	x
7.535 Perfusion weighted imaging	x	x	✓	x	x

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
7.536 No advanced imaging	x	x	✓	x	x
7.550 Type of stroke	✓	✓	✓	✓	✓
7.580 Cause of stroke	✓	✓	x	x	x
7.591 Mechanism (ischaemic)	x	x	✓	x	x
7.592 Other (specify)	x	x	✓	x	x
7.593 Mechanism (haemorrhage)	x	x	✓	x	x
7.594 Other (specify)	x	x	✓	x	x
7.6001 Acute occlusion site - Left	x	✓	✓	x	x
7.6002 Acute occlusion site - Right	x	✓	✓	x	x
7.6003 Acute occlusion site - ICA-EC	x	✓	✓	x	x
7.6004 Acute occlusion site - ICA-IC	x	✓	✓	x	x
7.6005 Acute occlusion site - MCA-M1	x	✓	✓	x	x
7.6006 Acute occlusion site - MCA-M2	x	✓	✓	x	x
7.6007 Acute occlusion site - MCA-M3	x	✓	✓	x	x
7.6008 Acute occlusion site - ACA	x	✓	✓	x	x
7.6009 Acute occlusion site - PCA	x	✓	✓	x	x
7.6010 Acute occlusion site - BA	x	✓	✓	x	x
7.6011 Acute occlusion site - VA	x	✓	✓	x	x
7.6012 Acute occlusion site - No occlusion	x	✓	✓	x	x
7.6013 Acute occlusion site - Not documented	x	✓	✓	x	x
7.6014 Acute occlusion site - Other	x	✓	✓	x	x
8.000 Was a stroke telemedicine consultation conducted?	✓	✓	✓	✓	x
8.010 Date	x	x	x	✓	x
8.020 Time	x	x	x	✓	x
8.021 Unknown	x	x	x	✓	x
8.130 Did the patient receive intravenous thrombolysis	✓	✓	✓	✓	x
8.140 Date of delivery	✓	✓	✓	✓	x
8.150 Time of delivery	✓	✓	✓	✓	x
8.160 Drug	x	x	x	✓	x
8.190 Was there a serious adverse event related to thrombolysis?	✓	✓	✓	✓	x
8.201 Type of adverse event - Intracranial haemorrhage	✓	✓	✓	✓	x
8.202 Type of adverse event - Extracranial haemorrhage	✓	✓	✓	✓	x
8.203 Type of adverse event - Angiodema	✓	✓	✓	✓	x
8.204 Type of adverse event - Other	✓	✓	✓	✓	x
8.250 Was other reperfusion (endovascular) provided?	x	✓	✓	x	x
8.260 Treatment date for other reperfusion	x	✓	✓	x	x
8.261 NIHSS before endovascular treatment	x	✓	✓	x	x
8.280 Time groin puncture	x	✓	✓	x	x
8.290 Time of completing recanalisation/procedure	x	✓	✓	x	x
8.420 Final eTICI	x	✓	✓	x	x
8.430 24 hour NIHSS	x	✓	✓	x	x
8.470 Was there haemorrhage within the infarct on follow-up imaging	x	✓	✓	x	x
8.480 Haemorrhage details	x	✓	✓	x	x
9.070 Was a formal swallowing screen performed (i.e. not a test of gag reflex)?	✓	✓	x	✓	✓
9.080 Date of swallow screen	✓	✓	x	x	✓
9.090 Accuracy	✓	✓	x	x	✓
9.100 Time of swallow screen	✓	✓	x	x	✓
9.101 Unknown	✓	✓	x	x	✓

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
9.110 Accuracy	✓	✓	x	x	✓
9.120 Did the patient pass the screening?	✓	✓	x	x	✓
9.130 Was a swallow assessment by a speech pathologist recorded?	✓	✓	x	x	✓
9.140 Date of swallowing assessment	✓	✓	x	x	✓
9.150 Accuracy	✓	✓	x	x	✓
9.160 Time of swallowing assessment	✓	✓	x	x	✓
9.161 Unknown	✓	✓	x	x	✓
9.170 Accuracy	✓	✓	x	x	✓
9.180 Was the swallow screen or assessment performed before the patient was given oral medications?	✓	✓	x	✓	✓
9.190 Was the swallow screen or assessment performed before the patient was given oral food or fluids?	✓	✓	x	✓	✓
9.360 Was the patient able to walk independently on admission? (i.e. may include walking aid, but without assistance from another person)	✓	✓	✓	✓	x
9.37 Was the patient mobilised in this admission?	✓	✓	✓	x	x
9.38 Date of first documented mobilisation	✓	✓	✓	x	x
9.39 Accuracy	✓	✓	✓	x	x
9.40 Method of mobilisation documented	✓	✓	✓	x	x
10.020 Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA)?	✓	✓	✓	x	x
10.030 Date	✓	✓	✓	x	x
10.040 Accuracy	✓	✓	✓	x	x
10.050 Time	✓	✓	✓	x	x
10.051 Unknown	✓	✓	✓	x	x
10.060 Accuracy	✓	✓	✓	x	x
10.070 Was temperature recorded at least four times on day one of ward admission?	x	x	x	x	✓
10.100 In the first 72 hours following admission did the patient develop a fever ≥ 37.5°C?	x	x	x	x	✓
10.150 Was paracetamol for the first elevated temperature administered within 1 hour?	x	x	x	x	✓
10.210 Was finger-prick blood glucose level recorded at least four times on day one of ward admission?	x	x	x	x	✓
10.240 In the first 48 hours following ward admission did the patient develop a glucose level of 10 mmol/l or more?	x	x	x	x	✓
10.250 Was insulin administered within 1 hour of the first elevated finger-prick glucose (>=10 mmol/L)?	x	x	x	x	✓
13.020 On discharge was the patient prescribed antithrombotics?	✓	✓	✓	x	x
13.030 Aspirin	x	x	✓	x	x
13.040 Clopidogrel	x	x	✓	x	x
13.050 Dipyridamole MR	x	x	✓	x	x
13.055 Other antiplatelet drug	x	x	✓	x	x
13.060 Warfarin	x	x	✓	x	x
13.070 Dabigatran	x	x	✓	x	x
13.080 Rivaroxaban	x	x	✓	x	x
13.090 Apixaban	x	x	✓	x	x
13.100 Other anticoagulant	x	x	✓	x	x
13.12 On discharge was the patient prescribed antihypertensives?	✓	✓	x	x	x
13.21 On discharge was the patient prescribed lipid-lowering treatment?	✓	✓	x	x	x

Master Data List reference and variable name	Red	Black	Paed	ED	FeSS
14.00 Patient deceased during hospital care?	✓	✓	✓	x	x
14.01 Date of death	✓	✓	✓	x	x
14.02 Accuracy	✓	✓	✓	x	x
14.07 Is the date of discharge known?	✓	✓	✓	x	x
14.08 Date of discharge	✓	✓	✓	x	x
14.09 Accuracy	✓	✓	✓	x	x
14.15 What is the discharge diagnosis ICD 10 Classification Code?	✓	✓	✓	x	x
14.151 Other (specify)	✓	✓	✓	x	x
14.152 What is the Medical Condition ICD 10 Classification Code?	✓	✓	✓	x	x
14.153 What is the Medical Complication ICD 10 Classification Code?	✓	✓	✓	x	x
14.154 What is the Medical Procedure ICD 10 Classification Code?	✓	✓	✓	x	x
14.16 What is the discharge destination/mode?	✓	✓	✓	✓	x
14.161 Please specify (if discharged/transferred to residential aged care service)	✓	✓	x	x	x
14.19 Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient (or family if patient has severe aphasia or cognitive impairments)?	✓	✓	x	x	x

Appendix 3: Overview of follow-up AuSCR variables collected in the Australian Stroke Data Tool (AuSDaT)

MDL Ref	Variable, coding used in extracts and description to match codes
15.11	Would you like to receive an information package from the Stroke Foundation about stroke and support services? *1 (Yes)* *2 (No)*
15.12	Would you be willing to be contacted in the future to hear about possible stroke research projects that you may be eligible for? *1 (Yes)* *2 (No)*
15.19	Form completed by *0 (Patient)* *1 (Spouse/Partner)* *2 (Son/Daughter)* *3 (Other relative)* *4 (Friend/associate)* *5 (Professional carer)* *6 (Sibling)* *7 (Not stated)*
15.2	Where are you staying at present? 0 (Missing) *1 (High level residential care)* *2 (Low level residential care)* *3 (Home with supports)* *4 (Home without supports)* *5 (Rehabilitation (inpatient))* *6 (Transitional care services)* *7 (Hospital)* *9 (Other)*
15.21	Do you live on your own? *1 (Yes, I live entirely on my own)* *2 (No, I live with others)* *9 (Missing)*
15.22	Since you were in hospital for your stroke, have you had another stroke? *1 (Yes)* *2 (No)* *9 (Unknown)*
15.23	Since you were in hospital for your stroke, have you been readmitted to hospital? *1 (Yes)* *2 (No)* *9 (Unknown)*
15.24	Date of readmission *DD/MM/YYYY*
15.25	Date of readmission accuracy *AAA (Accurate)* *EAA (Estimate)*
15.26	Reason for readmission *0 (Stroke)* *1 (TIA)* *2 (Acute coronary syndromes or myocardial infarcts* *3 (Coronary heart disease/heart failure and cardiomyopathy/rheumatic heart)* *4 (Peripheral vascular disease)* *5 (Blood and metabolic disorders)* *6 (Cancer and other neoplasms)* *7 (Chronic musculoskeletal disorders)* *8 (Endocrine disorders)* *9 (Gastrointestinal diseases)* *10 (Infections)* *11 (Injuries)* *12 (Kidney and urinary diseases)*

	13 (Mental illnesses and behavioural disorders) *14 (Neurological conditions)* *15 (Respiratory diseases)* *16 (Skin disorders)* *17 (Elective surgery/procedure)* *18 (Unknown)* *19 (Other)*
15.261	Please specify (Enabled is 'Other' is selected for 15.26) *Text field*
15.262	Modified Rankin Score at 3 months post stroke *0 (No Symptoms at all)* *1 (No Significant Disability Despite Symptoms [able to carry out all usual duties and activities])* *2 (Slight Disability [unable to carry out all previous activities, but able to look after own affairs without assistance])* *3 (Moderate Disability [requiring some help, but able to walk without assistance])* *4 (Moderately Severe Disability [unable to walk without assistance, and unable to attend to own bodily needs without assistance])* *5 (Severe Disability [bedridden, incontinent, and requiring constant nursing care and attention])*
15.27	Thinking about your health today, which of the following statements best describes your mobility? *1 (I have no problems in walking about)* *2 (I have some problems in walking about)* *3 (I am confined to bed)*
15.28	Thinking about your health today, which of the following statements best describes your self-care? *1 (I have no problems with self-care)* *2 (I have some problems washing or dressing myself)* *3 (I am unable to wash or dress myself)*
15.29	Thinking about your health today, which of the following statements best describes your usual activities such as work, study, housework, family or leisure activities? *1 (I have no problems with performing my usual activities)* *2 (I have some problems with performing my usual activities)* *3 (I am unable to perform my usual activities)*
15.3	Thinking about your health today, which of the following statements best describes any pain or discomfort you may be experiencing? *1 (I have no pain or discomfort)* *2 (I have moderate pain or discomfort)* *3 (I have extreme pain or discomfort)*
15.31	Thinking about your health today, which of the following statements best describes any anxiety and depression you may be experiencing? *1 (I am not anxious or depressed)* *2 (I am moderately anxious or depressed)* *3 (I am extremely anxious or depressed)*
15.32	What number between 0 and 100 best describes your health today? *0-100* *999 (Unknown)*
15.33	Is this a telephone interview? *1 (Yes)* *2 (No)*
	Additional variables for paediatric registrants
15.34	Which paper form was completed? *0 (Parent Report for Young Child (less than two years))* *1 (Parent Report for Toddlers (2-4years))* *2 (Young Child Parent Report (5-7years))* *3 (Child Parent Report (8-12years))* *4 (Teen Parent Report (13-18years))*
L15.36	PedsQL - who responded to the questionnaire?
15.36	First name
15.361	Last name
15.37	PedsQL - Relationship of person who responded to the questionnaire *0 (Mother)* *1 (Stepmother)* *2 (Foster mother)*

	3 (Father) *4 (Stepfather)* *5 (Foster Father)* *6 (Grandmother)* *7 (Grandfather)* *8 (Guardian)* *9 (Other)*
15.38	Where is your child/teen staying at present? *0 (Hospital)* *2 (Rehabilitation (in patient))* *3 (Hostel Care)* *4 (Nursing home)* *5 (Home with care supports)* *6 (Home without care supports)* *7 (Transitional care services)* *9 (Other)*
15.381	Other (specify)
15.39	Does your child/teen live on their own? *1 (Yes, he/she lives entirely on their own)* *2 (No, he/she lives with others (including parents/guardians and/or siblings))*
15.40	Since your child/teen was in hospital for their stroke, have they had another stroke? *1 (Yes)* *2 (No)*
15.41	Since your child/teen was in hospital for their stroke, have they been readmitted to hospital? *1 (Yes)* *2 (No)*
15.411	How many overnight visits/re-admissions? *0-99*
15.412	Date of first re-admission?
15.413	What was the reason of first re-admission?
15.414	Date of second re-admission?
15.415	What was the reason of second re-admission?
15.416	Date of third re-admission?
15.417	What was the reason of third re-admission?
15.42	In the past 12 months has your child/teen had any Emergency Department/Urgent Care visits? *1 (Yes)* *2 (No)* *9 (Unknown)*
15.421	How many Emergency Department/Urgent Care visits? *0-99*
15.422	What was wrong?
15.43	In the past 6 months, has your child/teen had a chronic health condition? *1 (Yes)* *2 (No)* *9 (Unknown)*
15.431	What is the name of your child's/teen's chronic health condition?
15.44	In the past ONE month, how many days did your child/teen miss school or childcare due to their physical or mental health? *0-30 (0-30)* *32 (Child does not attend)* *99 (Not documented)*
15.45	In the past ONE month, how many days was your child/teen sick in bed or too ill to play? *0-30 (0-30)* *99 (Not documented)*
15.46	In the past ONE month, how many days did your child/teen need someone to care for him/her due to physical or mental health? *0-30 (0-30)* *99 (Not documented)*
15.461	In the past 30 days, how many days have you missed from work due to your child's/teen's physical or mental health? *0-30 (0-30)*

	99 (Not documented)
15.462	Paediatric stroke outcome measure (PSOM) *0 (0)* *0.5 (0.5)* *1.0 (1.0)* *1.5 (1.5)* *2.0 (2.0)* *2.5 (2.5)* *3.0 (3.0)* *3.5 (3.5)* *4.0 (4.0)* *4.5 (4.5)* *5.0 (5.0)* *5.5 (5.5)* *6.0 (6.0)* *6.5 (6.5)* *7.0 (7.0)* *7.5 (7.5)* *8.0 (8.0)* *8.5 (8.5)* *9.0 (9.0)* *9.5 (9.5)* *10.0 (10.0)* *999 (Unknown)*
15.47	In the past ONE month, has your child's/teen's health interfered with your daily routine at work? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.471	In the past ONE month, has your child's/teen's health interfered with your ability to concentrate at work? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.48	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with walking? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.49	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with running? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.5	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with participating in active play, sports activity or exercise? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*

15.51	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with lifting something heavy? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.52	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with bathing or showering *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.53	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with helping to picking up his or her toys or doing chores around the house? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.54	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with hurts, aches or pains? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.55	Physical Functioning - In the last ONE month, how much of a problem has your child/teen had with low energy level? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.56	Emotional Functioning - In the last ONE month, how much of a problem has your child/teen had with feeling afraid or scared? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.57	Emotional Functioning - In the last ONE month, how much of a problem has your child/teen had with feeling sad or blue? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.58	Emotional Functioning - In the last ONE month, how much of a problem has your child/teen had with feeling angry? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*

15.59	Emotional Functioning - In the last ONE month, how much of a problem has your child/teen had with trouble with sleeping? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.60	Emotional Functioning - In the last ONE month, how much of a problem has your child/teen had with worrying? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.61	Social Functioning - In the last ONE month, how much of a problem has your child/teen had with playing/getting along with other children/teens? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.62	Social Functioning - In the last ONE month, how much of a problem has your child/teen had with other children not wanting to play with them or be their friend? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.63	Social Functioning - In the last ONE month, how much of a problem has your child/teen had with getting teased by other children/teens? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.64	Social Functioning - In the last ONE month, how much of a problem has your child/teen had with not being able to do things that other children/teens his or her age can do? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.65	Social Functioning - In the last ONE month, how much of a problem has your child/teen had with keeping up with other children/teens? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.66	Pre-school/School Functioning - In the last ONE month, how much of a problem has your child/teen had doing the same activities as other children/teens and/or paying attention in class? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*

15.67	Pre-school/School Functioning - In the last ONE month, how much of a problem has your child/teen had with forgetting things? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.68	Pre-school/School Functioning - In the last ONE month, how much of a problem has your child/teen had with keeping up with school activities/schoolwork? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.69	Pre-school/School Functioning - In the last ONE month, how much of a problem has your child/teen had with missing preschool/school because of not feeling well? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.70	Pre-school/School Functioning - In the last ONE month, how much of a problem has your child/teen had with missing preschool/school to go to the doctor or hospital? *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
L15.71	About my health and activities (problems with...)
15.71	It is hard for me to walk/walk more than one block *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.72	It is hard for me to run *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.73	It is hard for me to play sport/do sports activity or exercise *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.74	It is hard for me to pick up big things/lift something heavy *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.75	It is hard for me to take a bath or shower/take a bath or shower by myself *0 (Never)* *1 (Almost never)*

	2 (Sometimes) *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.76	It is hard for me to help around the house/do chores around the house *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.77	I get aches and pains/hurt or ache *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.78	Where?
15.79	I feel too tired to play/have low energy *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
L15.80	About my feelings (problems with...)
15.80	I feel afraid or scared *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.81	I feel sad *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.82	I feel angry *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.83	I have trouble sleeping *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.84	I worry about what will happen to me *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
L15.85	How I get along with others (problems with...)

15.85	It is hard/I have trouble getting along with other kids/teens *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.86	Other kids/children/teens say they do not want to play with me/do not want to be my friend *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.87	Other kids/children/teens tease me *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.88	I cannot do things that other kids/children/teens my age can do *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.89	It is hard to keep up when I play with other kids/children/teens *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
L15.90	School/preschool functioning (problems with...)
15.90	It is hard to pay attention at school/preschool *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.91	I forget things *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.92	It is hard/I have trouble keeping up with my work at preschool/schoolwork *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*
15.93	I am away from/miss school because of feeling sick/not feeling well *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*

15.94	I am away from/miss school/preschool to go to the doctor or hospital *0 (Never)* *1 (Almost never)* *2 (Sometimes)* *3 (Often)* *4 (Almost always)* *9 (Not documented)*

Appendix 4: Country Codes

Source: Standard Australian Classification of Countries (SACC), 2016. Canberra: Australian Bureau of Statistics. https://www.abs.gov.au/statistics/classifications/standard-australian-classification-countries-sacc/latest-release

Code	Name
1601	Adelie Land (France)
7201	Afghanistan
0616	Africa
0701	Africa, nec
0918	Africa, nfd
2408	Aland Islands
3201	Albania
4101	Algeria
0702	Americas, nec
8000	Americas, nfd
3101	Andorra
9201	Angola
8401	Anguilla
1600	Antarctica, nfd
8402	Antigua and Barbuda
8201	Argentina
1602	Argentinian Antarctic Territory
7202	Armenia
8403	Aruba
0614	Asia
0703	Asia, nec
0917	Asia, nfd
0001	At Sea
1101	Australia
0746	Australia (includes External Territories, Australian Antarctic Territory and Norfolk Island)
1100	Australia (includes External Territories, nfd)
1603	Australian Antarctic Territory
1199	Australian External Territories, nec
2301	Austria
7203	Azerbaijan
8404	Bahamas
4201	Bahrain
7101	Bangladesh
8405	Barbados
3301	Belarus
2302	Belgium
0704	Belgium and Luxembourg
8301	Belize
9101	Benin
8101	Bermuda
7102	Bhutan
8202	Bolivia, Plurinational State of
8433	Bonaire, Sint Eustatius and Saba
3202	Bosnia and Herzegovina
9202	Botswana
8203	Brazil
1604	British Antarctic Territory
5201	Brunei Darussalam
3203	Bulgaria
9102	Burkina Faso
9203	Burundi
9104	Cabo Verde
5102	Cambodia
9103	Cameroon
8102	Canada
8400	Caribbean, nfd
8406	Cayman Islands

9105	Central African Republic
0705	Central America and the Caribbean (excludes Mexico)
8300	Central America, nfd
9100	Central and West Africa, nfd
7200	Central Asia, nfd
9106	Chad
0922	Channel Islands, nfd
8204	Chile
1605	Chilean Antarctic Territory
6101	China (excludes SARs and Taiwan)
6100	Chinese Asia (includes Mongolia), nfd
0706	Christmas Island
0707	Cocos (Keeling) Islands
8205	Colombia
9204	Comoros
9108	Congo, Democratic Republic of
9107	Congo, Republic of
1501	Cook Islands
8302	Costa Rica
9111	Cote d'Ivoire
3204	Croatia
8407	Cuba
8434	Curacao
3205	Cyprus
3302	Czech Republic
0914	Czechoslovakia, nfd
2401	Denmark
0711	Denmark (includes Greenland and Faroe Islands)
9205	Djibouti
8408	Dominica
8411	Dominican Republic
0615	East Asia
0916	East Asia, nfd
3300	Eastern Europe, nfd
8206	Ecuador
4102	Egypt
8303	El Salvador
2102	England
9112	Equatorial Guinea
9206	Eritrea
3303	Estonia
9207	Ethiopia
0712	Eurodollar Market
0611	Europe
0612	Europe and the former USSR
0713	Europe, nec
0911	Europe, nfd
8207	Falkland Islands
0714	Falkland Islands (includes South Georgia and South Sandwich Islands)
2402	Faroe Islands
1502	Fiji
2403	Finland
0613	Former USSR
0912	Former USSR, nfd
3206	Former Yugoslav Republic of Macedonia (FYROM)
0913	Former Yugoslavia, nfd
2303	France
0715	France (includes Andorra and Monaco)
0716	French Antilles (Guadeloupe and Martinique)
8208	French Guiana
1503	French Polynesia
0717	French Southern Territories
9113	Gabon
9114	Gambia
4202	Gaza Strip and West Bank
7204	Georgia

2304	Germany
9115	Ghana
3102	Gibraltar
3207	Greece
2404	Greenland
8412	Grenada
8413	Guadeloupe
1401	Guam
8304	Guatemala
2107	Guernsey
9116	Guinea
9117	Guinea-Bissau
8211	Guyana
8414	Haiti
3103	Holy See
8305	Honduras
6102	Hong Kong (SAR of China)
3304	Hungary
2405	Iceland
0000	Inadequately Described
7103	India
5202	Indonesia
4203	Iran
4204	Iraq
2201	Ireland
2103	Isle of Man
4205	Israel
3104	Italy
0723	Italy (includes Holy See and San Marino)
8415	Jamaica
6201	Japan
6200	Japan and the Koreas, nfd
2108	Jersey
0724	Johnston and Sand Islands
4206	Jordan
7205	Kazakhstan
9208	Kenya
1402	Kiribati
6202	Korea, Democratic People's Republic of (North)
6203	Korea, Republic of (South)
3216	Kosovo
0915	Kurdistan, nfd
4207	Kuwait
7206	Kyrgyzstan
5103	Laos
3305	Latvia
4208	Lebanon
9211	Lesotho
9118	Liberia
4103	Libya
2305	Liechtenstein
3306	Lithuania
2306	Luxembourg
6103	Macau (SAR of China)
9212	Madagascar
5100	Mainland South-East Asia, nfd
9213	Malawi
5203	Malaysia
7104	Maldives
9121	Mali
3105	Malta
5200	Maritime South-East Asia, nfd
1403	Marshall Islands
8416	Martinique
9122	Mauritania
9214	Mauritius

9215	Mayotte
1300	Melanesia, nfd
8306	Mexico
1404	Micronesia, Federated States of
1400	Micronesia, nfd
4200	Middle East, nfd
0725	Midway Islands
3208	Moldova
2307	Monaco
6104	Mongolia
3214	Montenegro
8417	Montserrat
4104	Morocco
0726	Morocco (includes places under Spanish sovereignty)
9216	Mozambique
5101	Myanmar, The Republic of the Union of
9217	Namibia
1405	Nauru
7105	Nepal
2308	Netherlands
0924	Netherlands Antilles, nfd
1301	New Caledonia
1201	New Zealand
8307	Nicaragua
9123	Niger
9124	Nigeria
1504	Niue
0727	No Country Details
1102	Norfolk Island
4000	North Africa and the Middle East, nfd
4100	North Africa, nfd
6000	North-East Asia, nfd
8100	Northern America, nfd
2400	Northern Europe, nfd
2104	Northern Ireland
1406	Northern Mariana Islands
2000	North-West Europe, nfd
2406	Norway
0003	Not Stated
1000	Oceania and Antarctica, nfd
0728	Oceania, nec
4211	Oman
7106	Pakistan
1407	Palau
8308	Panama
1302	Papua New Guinea
8212	Paraguay
8213	Peru
5204	Philippines
1513	Pitcairn Islands
3307	Poland
1599	Polynesia (excludes Hawaii), nec
1500	Polynesia (excludes Hawaii), nfd
3106	Portugal
8421	Puerto Rico
4212	Qatar
1606	Queen Maud Land (Norway)
9218	Reunion
3211	Romania
1607	Ross Dependency (New Zealand)
3308	Russian Federation
9221	Rwanda
1505	Samoa
1506	Samoa, American
3107	San Marino
9125	Sao Tome and Principe

4213	Saudi Arabia
2105	Scotland
9126	Senegal
3215	Serbia
0921	Serbia and Montenegro, nfd
9223	Seychelles
9127	Sierra Leone
5205	Singapore
8435	Sint Maarten (Dutch part)
3311	Slovakia
3212	Slovenia
1303	Solomon Islands
9224	Somalia
9225	South Africa
8299	South America, nec
8200	South America, nfd
3200	South Eastern Europe, nfd
4111	South Sudan
5000	South-East Asia, nfd
7000	Southern and Central Asia, nfd
9299	Southern and East Africa, nec
9200	Southern and East Africa, nfd
3000	Southern and Eastern Europe, nfd
7100	Southern Asia, nfd
3100	Southern Europe, nfd
3108	Spain
4108	Spanish North Africa
7107	Sri Lanka
8431	St Barthelemy
9222	St Helena
8422	St Kitts and Nevis
8423	St Lucia
8432	St Martin (French part)
8103	St Pierre and Miquelon
8424	St Vincent and the Grenadines
9000	Sub-Saharan Africa, nfd
4105	Sudan
8214	Suriname
9226	Swaziland
2407	Sweden
2311	Switzerland
0743	Switzerland (includes Liechtenstein)
4214	Syria
6105	Taiwan
7207	Tajikistan
9227	Tanzania
5104	Thailand
5206	Timor-Leste
9128	Togo
1507	Tokelau
1508	Tonga
8425	Trinidad and Tobago
4106	Tunisia
4215	Turkey
7208	Turkmenistan
8426	Turks and Caicos Islands
1511	Tuvalu
9228	Uganda
3312	Ukraine
0005	Unidentified
4216	United Arab Emirates
2100	United Kingdom, Channels Islands and Isle of Man, nfd
0744	United States Miscellaneous Islands
8104	United States of America
0004	Unknown
8215	Uruguay

7211	Uzbekistan
1304	Vanuatu
8216	Venezuela, Bolivarian Republic of
5105	Vietnam
8427	Virgin Islands, British
8428	Virgin Islands, United States
0745	Wake Island
2106	Wales
1512	Wallis and Futuna
2300	Western Europe, nfd
4107	Western Sahara
4217	Yemen
9231	Zambia
9232	Zimbabwe

Appendix 5: Language Codes

4-digit numerical code (NNNN) consistent with the Australian Standard Classification of Languages (ASCL) 2011.
ABS cat. No. 1267.0. Australian Standard Classification of Languages (ASCL), 2011. Canberra: Australian Bureau of Statistics.
https://www.abs.gov.au/statistics/classifications/australian-standard-classification-languages-ascl/latest-release

Code	Language
8998	Aboriginal English, so described
6513	Acehnese
9201	Acholi
8901	Adnymathanha
9299	African Languages, nec
1403	Afrikaans
9203	Akan
8121	Alawa
3901	Albanian
8315	Alngith
9101	American Languages
9214	Amharic
8156	Amurdak
8101	Anindilyakwa
8619	Anmatyerr, nec
8703	Antikarinya
9241	Anuak
8902	Arabana
4202	Arabic
4901	Armenian
8199	Arnhem Land and Daly River Region Languages, nec
3903	Aromunian (Macedo-Romanian)
8629	Arrernte, nec
5213	Assamese
4206	Assyrian Neo-Aramaic
9701	Auslan
4302	Azeri
8946	Baanbay
8947	Badimaya
6514	Balinese
4104	Balochi
8903	Bandjalang
8904	Banyjima
8948	Barababaraba
8801	Bardi
9242	Bari
2901	Basque
9243	Bassa
8905	Batjala
3401	Belorussian
9215	Bemba
5201	Bengali
8906	Bidjara
6515	Bikol
8504	Bilinarra
6501	Bisaya
9402	Bislama
3501	Bosnian
3502	Bulgarian
8802	Bunuba
8181	Burarra
8189	Burarran, nec
6101	Burmese
6199	Burmese and Related Languages, nec

7101	Cantonese
8399	Cape York Peninsula Languages, nec
2301	Catalan
6502	Cebuano
1199	Celtic, nec
8611	Central Anmatyerr
4207	Chaldean Neo-Aramaic
6102	Chin Haka
7199	Chinese, nec
3503	Croatian
3601	Czech
3604	Czechoslovakian, so described
8233	Daatiwuy
8951	Dadi Dadi
8122	Dalabon
9244	Dan (Gio-Dan)
1501	Danish
4105	Dari
8221	Dhalwangu
8907	Dhanggatti
8219	Dhangu, nec
8952	Dharawal
8229	Dhay'yi, nec
5214	Dhivehi
8239	Dhuwal, nec
8249	Dhuwala, nec
8291	Dhuwaya
9216	Dinka
8908	Diyari
8305	Djabugay
8953	Djabwurrung
8231	Djambarrpuyngu
8292	Djangu
8232	Djapu
8222	Djarrwark
8259	Djinang, nec
8262	Djinba
8269	Djinba, nec
5199	Dravidian, nec
1401	Dutch
8306	Dyirbal
8612	Eastern Anmatyerr
8621	Eastern Arrernte
1201	English
1601	Estonian
9217	Ewe
9301	Fijian
5217	Fijian Hindustani
6512	Filipino
1602	Finnish
1699	Finnish and Related Languages, nec
2101	French
1402	Frisian
9245	Fulfulde
9218	Ga
1101	Gaelic (Scotland)
8211	Galpu
8813	Gambera
8911	Gamilaraay
8261	Ganalbingu
8157	Garrwa
8913	Garuwali
4902	Georgian
1301	German
9302	Gilbertese
8307	Girramay

8914	Githabul
8212	Golumala
8803	Gooniyandi
2201	Greek
8123	Gudanji
8954	Gudjal
5202	Gujarati
8242	Gumatj
8915	Gumbaynggir
8182	Gun-nartpa
8171	Gundjeihmi
8243	Gupapuyngu
8505	Gurindji
8506	Gurindji Kriol
8183	Gurr-goni
8302	Guugu Yimidhirr
8244	Guyamirrilili
7102	Hakka
9221	Harari
9222	Hausa
9403	Hawaiian English
4107	Hazaraghi
4204	Hebrew
5203	Hindi
6201	Hmong
6299	Hmong-Mien, nec
3301	Hungarian
6503	Ilokano
6516	Iban
2399	Iberian Romance, nec
1502	Icelandic
9223	Igbo
6517	Ilonggo (Hiligaynon)
5299	Indo-Aryan, nec
6504	Indonesian
9601	Invented Languages
4199	Iranic, nec
1102	Irish
2401	Italian
8127	Iwaidja
8128	Jaminjung
7201	Japanese
8507	Jaru
6518	Javanese
8814	Jawi
8131	Jawoyn
8132	Jingulu
8401	Kalaw Kawaw Ya/Kalaw Lagaw Ya
8916	Kanai
5101	Kannada
8917	Karajarri
6103	Karen
8918	Kariyarra
8704	Kartujarra
5215	Kashmiri
8921	Kaurna
8922	Kayardild
8955	Keerray-Woorroong
6301	Khmer
8815	Kija
9224	Kikuyu
8899	Kimberley Area Languages, nec
9246	Kinyarwanda (Rwanda)
9247	Kirundi (Rundi)
9502	Kiwai
8308	Koko-Bera

5204	Konkani
7301	Korean
9248	Kpelle
9251	Krahn
9225	Krio
8924	Kriol
8316	Kugu Muminh
8705	Kukatha
8706	Kukatja
8301	Kuku Yalanji
8133	Kunbarlang
8172	Kune
8173	Kuninjku
8174	Kunwinjku
8179	Kunwinjkuan, nec
4101	Kurdish
8311	Kuuk Thayorre
8303	Kuuku-Ya'u
8158	Kuwema
8956	Ladji Ladji
8312	Lamalama
6401	Lao
8925	Lardil
8136	Larrakiya
2902	Latin
3101	Latvian
1302	Letzeburgish
9252	Liberian (Liberian English)
8508	Light Warlpiri
3102	Lithuanian
8235	Liyagalawumirr
8236	Liyagawumirr
9253	Loma (Lorma)
9226	Luganda
9254	Lumun (Kuku Lumun)
9227	Luo
8707	Luritja
3504	Macedonian
8293	Madarrpa
9255	Madi
9702	Makaton
8137	Malak Malak
6505	Malay
5102	Malayalam
8511	Malngin
2501	Maltese
4208	Mandaean (Mandaic)
7104	Mandarin
9256	Mandinka
8926	Mangala
8138	Mangarrayi
8246	Manggalili
9257	Mann
8263	Manyjalpingu
8708	Manyjilyjarra
9303	Maori (Cook Island)
9304	Maori (New Zealand)
5205	Marathi
8141	Maringarr
8142	Marra
8161	Marramaninyshi
8234	Marrangu
8166	Marridan (Maridan)
8143	Marrithiyel
8711	Martu Wangka
8144	Matngala

8111	Maung
9205	Mauritian Creole
8175	Mayali
8402	Meriam Mir
4299	Middle Eastern Semitic Languages, nec
7107	Min Nan
8804	Miriwoong
8957	Mirning
6303	Mon
6399	Mon-Khmer, nec
7902	Mongolian
9258	Moro (Nuba Moro)
8317	Morrobalama
9503	Motu (HiriMotu)
8512	Mudburra
8146	Murrinh Patha
8927	Muruwari
8147	Na-kara
8928	Narungga
9306	Nauruan
9228	Ndebele
8148	Ndjébbana (Gunavidji)
5206	Nepali
8712	Ngaanyatjarra
8151	Ngalakgan
8152	Ngaliwurru
8113	Ngan'gikurunggurr
8162	Ngandi
8514	Ngardi
8805	Ngarinyin
8515	Ngarinyman
8931	Ngarluma
8932	Ngarrindjeri
8958	Ngatjumaya
8281	Nhangu
8289	Nhangu, nec
9307	Niue
8599	Northern Desert Fringe Area Languages, nec
1503	Norwegian
9231	Nuer
8153	Nungali
8114	Nunggubuyu
8933	Nyamal
8934	Nyangumarta
9232	Nyanja (Chichewa)
8806	Nyikina
8935	Nyungar
9499	Oceanian Pidgins and Creoles, nec
5216	Oriya
9206	Oromo
8999	Other Australian Indigenous Languages, nec
7999	Other Eastern Asian Languages, nec
3999	Other Eastern European Languages, nec
6999	Other Southeast Asian Languages
5999	Other Southern Asian Languages
2999	Other Southern European Languages, nec
4999	Other Southwest and Central Asian Languages, nec
8299	Other Yolngu Matha, nec
8936	Paakantyi
9399	Pacific Austronesian Languages, nec
8937	Palyku/Nyiyaparli
6521	Pampangan
9599	Papua New Guinea Languages, nec
4102	Pashto
4106	Persian (excluding Dari)
8713	Pintupi

9404	Pitcairnese
8714	Pitjantjatjara
3602	Polish
2302	Portuguese
5207	Punjabi
8115	Rembarrnga
8295	Rirratjingu
8271	Ritharrngu
6104	Rohingya
3904	Romanian
3905	Romany
9312	Rotuman
3402	Russian
9308	Samoan
1599	Scandinavian, nec
3505	Serbian
3507	Serbo-Croatian/Yugoslavian, so described
9238	Seychelles Creole
9233	Shilluk
9207	Shona
9799	Sign Languages, nec
5208	Sindhi
5211	Sinhalese
3603	Slovak
3506	Slovene
9405	Solomon Islands Pijin
9208	Somali
6599	Southeast Asian Austronesian Languages, nec
2303	Spanish
9211	Swahili
1504	Swedish
6511	Tagalog
6499	Tai, nec
5103	Tamil
4303	Tatar
5104	Telugu
6507	Tetum
6402	Thai
8318	Thaynakwith
9261	Themne
7901	Tibetan
9235	Tigrinya
9234	Tigré
6508	Timorese
8117	Tiwi
8322	Tjungundji
8722	Tjupany
9504	Tok Pisin (Neomelanesian)
9313	Tokelauan
9311	Tongan
9236	Tswana
5105	Tulu
4399	Turkic, nec
4301	Turkish
4304	Turkmen
9314	Tuvaluan
3403	Ukrainian
5212	Urdu
4305	Uygur
4306	Uzbek
6302	Vietnamese
8163	Waanyi
8272	Wagilak
8164	Wagiman
8938	Wajarri
8516	Walmajarri

8961	Waluwarra
8154	Wambaya
8715	Wangkajunga
8962	Wangkangurru
8716	Wangkatha
8213	Wangurri
8517	Wanyjirra
8155	Wardaman
8963	Wargamay
8518	Warlmanpa
8521	Warlpiri
8717	Warnman
8294	Warramiri
8522	Warumungu
1103	Welsh
8964	Wergaia
8622	Western Arrarnta
8799	Western Desert Language, nec
8304	Wik Mungkan
8314	Wik Ngathan
8941	Wiradjuri
8807	Worla
8808	Worrorra
7106	Wu
8247	Wubulkarra
8811	Wunambal
8251	Wurlaki
9237	Xhosa
8279	Yakuy, nec
8282	Yan-Nhangu
8718	Yankunytjatjara
8165	Yanyuwa
9315	Yapese
8812	Yawuru
1303	Yiddish
8313	Yidiny
8943	Yindjibarndi
8944	Yinhawangka
8945	Yorta Yorta
9212	Yoruba
8721	Yulparija
8403	Yumplatok (Torres Strait Creole)
8321	Yupangathi
9213	Zulu

Appendix 6: International Classification of Diseases (ICD)

Clinical diagnosis	ICD-10 Coding
Codes captured for intracerebral haemorrhage	**I61 Intracerebral haemorrhage** Excludes: sequelae of intracerebral haemorrhage (I69.1) I61.0 Intracerebral haemorrhage in hemisphere, subcortical Deep intracerebral haemorrhage I61.1 Intracerebral haemorrhage in hemisphere, cortical Cerebral lobe haemorrhage Superficial intracerebral haemorrhage I61.2 Intracerebral haemorrhage in hemisphere, unspecified I61.3 Intracerebral haemorrhage in brain stem I61.4 Intracerebral haemorrhage in cerebellum I61.5 Intracerebral haemorrhage, intraventricular I61.6 Intracerebral haemorrhage, multiple localized I61.8 Other intracerebral haemorrhage I61.9 Intracerebral haemorrhage, unspecified
Code captured for intracranial haemorrhage	**I62 Other nontraumatic intracranial haemorrhage** Excludes: sequelae of intracranial haemorrhage (I69.2) I62.9 Intracranial haemorrhage (nontraumatic), unspecified
Codes captured for cerebral infarction	**I63 Cerebral infarction** Includes: occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction Excludes: sequelae of cerebral infarction (I69.3) I63.0 Cerebral infarction due to thrombosis of precerebral arteries I63.1 Cerebral infarction due to embolism of precerebral arteries I63.2 Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries I63.3 Cerebral infarction due to thrombosis of cerebral arteries I63.4 Cerebral infarction due to embolism of cerebral arteries I63.5 Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries I63.6 Cerebral infarction due to cerebral venous thrombosis, nonpyogenic I63.8 Other cerebral infarction I63.9 Cerebral infarction, unspecified
Code captured for unspecified stroke	I64 Stroke, not specified as haemorrhage or infarction
Code captured for TIA	**G45 Transient cerebral ischaemic attacks and related syndromes** Currently not eligible for inclusion in the AuSCR, from May 2023.