



AUSTRALIAN STROKE CLINICAL REGISTRY

FACILITATING QUALITY

Revised minimum dataset - Overview and next steps

The Australian Stroke Clinical Registry (AuSCR) has updated its minimum dataset. These are the core variables required to be collected in the registry, and may vary depending on the type of health service.

The revised dataset will be implemented in the new Adaptive Health Data Platform (AHDaPt), with anticipated collection commencing **July 2026**.

Revised variable list

The revised variable list is shown on the following tab '**AuSCR dataset**'.

- Each variable has been assigned a new **Primary Data List** (PDL) reference number, replacing the previous Master Data List (MDL) reference.
- The Master Data List corresponds to the variable identification code that were used in the previous platform known as the Australian Stroke Data Tool (AuSDaT).
- The PDL represents all variables that can be collected across any program in the AHDaPt.
- **New variables** introduced to the AuSCR are highlighted in green.
- Variables that have changed in name or answer option are shown in red text.
- Some new variables will be pre-populated by the system or only enabled depending on the response to previous questions - these are noted in the notes column.

Please note that AuSCR dataset list is **provisional** and minor updates may be made before the final dataset is released in May.

Variables being removed

Variables no longer being collected as part of the AuSCR minimum dataset are listed in the 'Discontinued_adapted' tab, along with a brief reason for their removal.

Why has the AuSCR dataset been revised?

The AuSCR dataset has been revised to ensure the data collected are relevant and useful to stroke clinicians and people with lived experience of stroke.

The data collection aligns with current clinical guidelines and standards.

The data collection burden on hospital staff is minimised.

It is also considered best practice for clinical registries to periodically review their datasets to ensure their continued relevance and value.

How was the dataset revised?

The revision processes involved extensive consultation including:

- AuSCR governance committees
- Focus groups including subject matter experts and data analysts
- Relevant of relevant guidelines and standards
- Consideration of feedback collected by the AuSCR team over time

Based on this input, decisions were made regarding the addition, modification or removal of variables and answer options.

What are the main changes?

Main changes to the dataset include:

- Addition of intracerebral haemorrhage specific variables including anticoagulant reversal and blood pressure monitoring.
- Addition of optional allied health assessment variables including physiotherapy, occupational therapy and speech pathology
- New variables to capture rehabilitation assessment and referral
- New variables to capture the reason patients were not treated in a stroke unit, and whether patients were provided palliative care, supporting more complete interpretation of results.
- Updates to answer options for several variables to improve accuracy and consistency.

Please refer to the 'AuSCR dataset' tab for additions and changes and the 'Removals' tab for removed variables and brief explanations.

Are there still Red and Black Programs?

No, there will no longer Red and Black Programs - there will only be one dataset for admitted episodes.

The variables displayed will depend on your stroke service type - for example only Comprehensive Centres will see the variables related to Endovascular Therapy.

The Fever Sugar Swallow (FeSS) variables are incorporated into this admitted dataset as optional variables.

What should I do with this variable list?

We recommend you review this variable list, particularly the new variables to confirm whether these data are recorded locally and determine the best way to capture them in your workflows.

If you currently extract data from your patient management system or electronic medical records, we recommend providing this variable list to the teams responsible for this extraction so they can begin to consider the extraction of new variables.

Upcoming dates

~ Final variable list and import template: May

~ Data Dictionary: June

~ Variables available in AHDaPt: July

~ Minor refinements may occur: January 2027

Will I need to collect new variables for all 2026 episodes?

No. There is no expectation that hospital staff will retrospectively update episodes already entered in 2026. However, AHDaPt will allow retrospective completion of new variables if your site chooses to do so.

What if a removed variable is important to us?

One of the benefits of AHDaPt is that hospitals can add additional variables of local interest.

After the new platform goes live, hospitals can apply to have additional variables added, and these will go live from January 2027.

Any other questions?

If you have any questions, please contact your state coordinator, or AuSCR Program Manager, Julie Morrison, julie.morrison@florey.edu.au.

For assistance with API integration, please contact AuSCR Senior Database Engineer, Mya Thandar, mya.thandar@florey.edu.au.

Provisional revised minimum dataset

Key	
Red text	change
	pre-populated
	new to AuSCR

Primary Data List (PDL) ref	PDL variable name	PDL import/export codes	Notes
USER INFORMATION			
1.000	Site name	Free text (max 50 chars)	Pre-populated
1.010	Type of organisation	CSC = Comprehensive stroke centre PSC = Primary stroke centre SCRGH = Stroke capable regional general hospital TTC = Telestroke thrombolysis centre REHAB = Rehabilitation service SPEC = Specialised hospital AMB = Ambulance service CPCS = Community-based/Primary Care service RCI = Research centre/ Institute NA = NA	Pre-populated
1.030	Site ID	Numerical in export NOT INCLUDED IN IMPORT TEMPLATE	Pre-populated
1.050	User name	Free text (max 50 chars)	Pre-populated
PATIENT IDENTIFIERS (This section to be removed with personal opt outs)			
Patient details			

2.000	Title	MR = Mister MS = Ms MRS = Mrs MISS = Miss MX = Mx DR = Doctor SR = Sister MSTR = MASTER FR = Father REV = Reverend PROF = Professor	
2.010	First name	Free text (max 20 char)	
2.020	Last name	Free text (max 20 chars)	
2.060	Date of birth	DD/MM/YYYY	
2.070	Medical Record Number	Free text, (alpha numerical, max 16 chars)	
2.080	Individual Healthcare Identifier (IHI)	Free text, (alpha numerical, max 16 chars)	
Contact information			
2.090	Preferred phone number	Free text Numerical, Area code and 8 digit space (max 10 char) (XX) XXXX XXXX	
2.100	Additional phone number	Free text Numerical (max char 10) (XX) XXXX XXXX	Optional
2.110	Email	Free text (max 50 chars) xxxx@xxx.com	Optional
2.130	Street address	Free text, alpha numerical, max 50 char	
2.140	Suburb	Free text, max 20 char	
2.150	Postcode	Free text, numerical, max 4 char	
2.160	State	8 ACT = Australian Capital Territory 1 NSW = New South Wales 7 NT = Northern Territory 3 QLD = Queensland 4 SA = South Australia 6 TAS = Tasmania 2 VIC = Victoria 5 WA = Western Australia 9 OTH = Other OS = Overseas	
2.170	Country	List (from website)	

Emergency contact details		
2.190	First name	Free text (max 20 char)
2.200	Last name	Free text (max 20 char)
2.210	Same as patient address	TRUE/FALSE
2.230	Street address	Free text, alpha numerical, max 50 char
2.240	Suburb	Free text, max 20 char
2.250	Postcode	Free text numerical, max 4 char
2.260	State	8 ACT = Australian Capital Territory 1 NSW = New South Wales 7 NT = Northern Territory 3 QLD = Queensland 4 SA = South Australia 6 TAS = Tasmania 2 VIC = Victoria 5 WA = Western Australia 9 OTH = Other OS = Overseas
2.270	Country	List (from website)
2.280	Preferred phone number	Free text Numerical, Area code and 8 digit space (max 10 char) (XX) XXXX XXXX
2.290	Additional phone number	Free text Numerical (max char 10) (XX) XXXX XXXX
2.310	Relationship to patient	SP = Spouse/Partner CH = Child SIB = Sibling PAR = Parent FA = Friend/Associate GC = Grandchild OR = Other Relative PC = Professional Carer NS = Not stated/inadequately described
PATIENT DEMOGRAPHICS		
Patient characteristics (to be kept even for personal opt outs)		
3.010	AHDaPt ID number	Numerical in export NOT INCLUDED IN IMPORT TEMPLATE
		Pre-populated. Site-level patient ID number.

3.060	Episode ID number	Numerical in export NOT INCLUDED IN IMPORT TEMPLATE	Pre-populated. An episode ID equivalent to the current AuSDaT ID number. Migrate old to new episode number: Patient Record ID: 264561 => Episode ID number => 20264561 New Episode in New Platform will start from: 20300001
3.070	Event ID number	Numerical in export NOT INCLUDED IN IMPORT TEMPLATE	Pre-populated. A unique number used to track the same event for different episodes.
3.080	Visit number	Free text (alpha numerical, max 16 chars)	A visit number generated by the admitting hospital, also known as encounter ID. Optional field.
3.090	Statistical linkage key	Alphanumerical in export NOT INCLUDED IN IMPORT TEMPLATE	Pre-populated
3.100	Age on admission	Free text (numerical) in export	Pre-populated
3.110	Paediatric patient (0-17)	TRUE/FALSE	Pre-populated
3.130	Sex at birth	1 = Male 2 = Female 3 = Another term 9 = Not stated/inadequately described	
3.160	Country of birth	List (from website)	
3.170	Language spoken	List (from website)	
3.180	Interpreter needed	1 = Yes, 2 = No	
3.190	Indigenous status	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 9 = Missing / not stated	
ADMISSION AND TRANSFER INFORMATION			
Admission details			

5.000	Onset time accuracy	KWN = Known time of onset UNC = If uncertain time of stroke, then time last seen well WAK = If wake up stroke, then time last seen well TU = Time unknown	
5.010	Onset date	DD/MM/YYYY	Onset time includes last seen well time
5.020	Unknown	TRUE/FALSE	
5.040	Onset time	hh:mm	
5.050	Date of symptom discovery	DD/MM/YYYY	Enable if 'onset time accuracy' = uncertain, wake up or time unknown. Can be used for in-hospital stroke discovery time.
5.060	Time of symptom discovery	hh:mm	Enable if uncertain, wake up or unknown time onset.
5.070	Unknown	TRUE/FALSE	Enable if uncertain, wake up or unknown time onset.
5.080	Did the stroke occur while the patient was in hospital?	1A = Yes, during admission 1B = Yes, in ED 1C = Yes, at another site 2 = No 9 = Unknown	
5.150	Date of arrival to site	DD/MM/YYYY	
5.160	Time of arrival to site	hh:mm	
5.170	Unknown	True/False	
5.460	Did the patient arrive via emergency services transport?	1 = Yes, 2 = No, 9 = Unknown	
5.470	If yes, mode of transport used	AMB = Standard ambulance MSU = Mobile stroke unit/stroke capable ambulance PLA = Plane HELI = Helicopter	
5.520	Was the patient transferred from another site?	1 = Yes, 2 = No, 9 = Unknown	
5.930	Date of admission to site	DD/MM/YYYY	
5.950	Time of admission to site	hh:mm	
5.960	Unknown	TRUE/FALSE	

5.970	Index date	DD/MM/YYYY	Pre-populated
6.030	Were palliative goals of care/end of life care provided?	1 = Yes, 2 = No, 9 = Unknown	
6.040	Commencement date	DD/MM/YYYY	Enable if yes to 6.030
6.050	Was the patient treated in a stroke unit at any time during their stay?	1 = Yes, 2 = No, 9 = Unknown	
6.060	Date of admission to stroke unit	DD/MM/YYYY	Enable if yes to 6.050
6.070	Time of admission to stroke unit	hh:mm (24 hr)	Consider optional
6.080	Not documented	TRUE/FALSE	
6.090	Reason patient was not treated in a stroke unit	1 = Managed in ICU/HDU/Critical care 2 = Managed in neurosurgical unit 3 = No stroke unit 4 = Stroke unit bed unavailable 5 = Treated in short stay unit 6 = Other co-morbidities 9 = Unknown	Enable if 'no' or 'unknown' to 6.050. Drop down list.
PRE STROKE HISTORY			
History of known risk factors			
7.970	Previous stroke	1 = Yes, 2 = No, 9 = Not documented	
ACUTE CLINICAL DATA			
First 24 hours			
9.440	National Institute of Stroke Scale (NIHSS) at baseline	0-42 99 = Unknown	
Diagnostic tests and imaging			
10.090	Brain scan after onset of stroke symptoms	1A = Yes, performed at this site 1B = Yes, performed prior to arrival at this site 2 = No	
10.120	Date of first brain scan after the stroke	DD/MM/YYYY	Enable if 10.090=1A
10.130	Time of first brain scan after the stroke	hh:mm	Enable if 10.090=1A
10.140	Not documented	TRUE/FALSE	
10.410	Type of stroke	ISCHAEMIC = Ischaemic HAEMORRHAGE = Haemorrhage	
Anticoagulant reversal for intracranial haemorrhage			Enabled if type of stroke 10.410=haemorrhage
11.04	Anticoagulant reversal	1 = Yes, 2 = No, 3=Not Applicable 9 = Unknown	

11.07	Date reversal agent given	DD/MM/YYYY	Calendar
11.08	Time reversal agent given	hh:mm	Clock
Blood pressure management for intracranial haemorrhage			
11.16	Systolic BP at baseline (mmHg)	Free text (numerical, max 3 chars)	
11.17	Diastolic BP at baseline (mmHg)	Free text (numerical, max 3 chars)	Optional
11.22	Antihypertensive administered	1 = Yes, 2 = No	
11.27	Date of commencement of acute blood pressure lowering treatment	DD/MM/YYYY	Enable if 11.22=yes
11.28	Time of commencement of acute blood pressure lowering treatment	hh:mm	Enable if 11.22=yes
TELEMEDICINE AND TIME CRITICAL THERAPY FOR REPERFUSION			
12.000	Was a stroke telemedicine consultation conducted?	1 = Yes, 2 = No, 9 = Unknown	Disabled for Comprehensive centres
12.010	Date	DD/MM/YYYY	Enable if 'yes' to 12.000
12.020	Time	hh:mm	
12.030	Unknown	TRUE/FALSE	
Reperfusion			
12.290	Intravenous thrombolytic provided	1A = Yes, at this site 1B = Yes, prior to arrival at this site 2 = No 9 = Unknown	
12.340	Date of delivery	DD/MM/YYYY	Enabled when "Yes" for "Did the patient receive intravenous
12.350	Time of delivery	hh:mm	
Endovascular intervention			
12.690	Endovascular thrombectomy treatment provided	1 = Yes, 2 = No	Enabled only for comprehensive centres
NO NUMBER REQUIRED	Acute occlusion sites		
12.700	Left	TRUE/FALSE	
12.710	Right	TRUE/FALSE	
12.730	Internal carotid artery- extracranial	TRUE/FALSE	
12.740	Internal carotid artery - intracranial	TRUE/FALSE	
12.750	Middle cerebral artery M1 segment	TRUE/FALSE	

12.760	Middle cerebral artery M2 segment	TRUE/FALSE	
12.770	Middle cerebral artery M3 segment	TRUE/FALSE	
12.780	Anterior cerebral artery	TRUE/FALSE	
12.790	Posterior cerebral artery	TRUE/FALSE	
12.800	Basilar artery	TRUE/FALSE	
12.810	Vertebral artery	TRUE/FALSE	
12.820	Other	Free text	
12.830	No occlusion	TRUE/FALSE	
12.840	Not documented	TRUE/FALSE	
13.080	NIHSS before endovascular treatment (if different from NIHSS on admission)	0-42 99 = Unknown	
13.100	Date of arterial access	DD/MM/YYYY	
13.110	Time of arterial access	hh:mm	
13.120	Date of final reperfusion	DD/MM/YYYY	
13.130	Time of final reperfusion	hh:mm	
13.260	Final eTICI	0 = 0 1 = 1 2a = 2a 2b = 2b 2c = 2c 3 = 3	
13.270	Serious adverse event following reperfusion therapy	1A = Yes, symptomatic ICH 1B = Yes, other 2 = No	Enabled if intravenous thrombolytic or endovascular thrombectomy provided.
13.280	Serious adverse event following reperfusion therapy (other)	Free text	
OTHER CLINICAL INFORMATION			
Swallowing			
16.160	Was a formal swallowing screen performed (i.e. not a test of gag reflex)?	1 = Yes 2 = No 3 = Patient unable to participate 4 = Provided at transferring site 5 = Intent to immediately transfer out 9 = Not documented	
16.170	Date	DD/MM/YYYY	

16.180	Time	hh:mm	
16.190	Unknown	True / False	
16.210	Did the patient pass the screening?	1 = Yes, 2 = No, 9 = Not documented	
16.220	Was a swallowing assessment by a speech pathologist recorded?	1 = Yes, 2 = No, 3 = Not required, 9 = Not documented	
16.230	Date	DD/MM/YYYY	
16.240	Time	hh:mm	
16.250	Unknown	True / False	
NO NUMBER REQUIRED	Was the swallowing screen or swallowing assessment performed before the patient was given	NA	
16.260	Oral medications	1 = Yes, 2 = No, 9 = Not documented	
16.270	Oral food or fluids	1 = Yes, 2 = No, 9 = Not documented	
Mobility			
16.450	Was the patient able to walk independently on admission? (i.e. may include walking aid, but without assistance from another person)	1 = Yes, 2 = No, 9 = Unknown	
Assessment and management of fever			
17.430	Was temperature recorded at least four times on day one of ward admission?	1 = Yes, 2 = No, 9 = Not documented	Optional
17.460	In the first 72 hours following admission did the patient develop a fever $\geq 37.5^{\circ}\text{C}$?	1 = Yes, 2 = No, 9 = Not documented	Optional
17.520	Was paracetamol for the first elevated temperature administered within 1 hour?	1 = Yes 2 = No 3 = Already received regular paracetamol 4 = Contraindicated 9 = Not documented	Optional
Assessment and management of hyperglycaemia			
17.560	Was finger-prick blood glucose level recorded at least four times on day one of ward admission?	1 = Yes, 2 = No, 9 = Not documented	Optional
17.590	In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal 10 mmols/L?	1 = Yes, 2 = No, 9 = Not documented	Optional
17.600	If yes, was insulin administered within 1 hour of the <u>first elevated</u> finger-prick glucose (≥ 10 mmols/L)?	1 = Yes, 2 = No, 9 = Not documented	Optional
ALLIED HEALTH MANAGEMENT			
Physiotherapy			

18.000	Was the patient seen by a physiotherapist?	Yes No Not required Patient declined Therapist not on staff	Optional
18.010	Date first occasion of service	DD/MM/YYYY	Optional
18.030	Time first occasion of service	hh:mm (24 hr)	Optional
Occupational therapy			
18.110	Was the patient seen by an occupational therapist?	Yes No Not required Patient declined Therapist not on staff	Optional
18.120	Date first occasion of service	DD/MM/YYYY	Optional
18.140	Time first occasion of service	hh:mm (24 hr)	Optional
Speech pathology			
18.220	Was the patient seen by a speech pathologist?	Yes No Not required Patient declined Therapist not on staff	Optional. Consider pre-populating this with 16.220 Was a swallowing assessment by a speech pathologist recorded?
18.230	Date first occasion of service	DD/MM/YYYY	Optional
18.250	Time first occasion of service	hh:mm (24 hr)	Optional
EARLY ASSESSMENT FOR REHABILITATION			
21.000	Was an assessment for rehabilitation performed?	1 = Yes, 2 = No, 9 = Unknown	
21.010	If yes, date	DD/MM/YYYY	
DISCHARGE INFORMATION			
Patient discharge			
22.000	Patient deceased during site care?	1 = Yes, 2 = No	
22.010	Date of death	DD/MM/YYYY	
22.080	Separation date	DD/MM/YYYY	Previously date of discharge
22.090	Separation time	hh:mm	Required for event ID in platform, optional
22.100	Separation time (not documented)	TRUE/FALSE	

22.220	Principal diagnosis ICD-10-AM code	I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.7, I61.8, I61.9, I62.9, I63.0, I63.1, I63.2, I63.3, I63.4, I63.5, I63.6, I63.8, I63.9, I64.0, G45.9; OTH = Other	
22.230	Other (specify)	Free text (max 6 chars)	
22.240	ICD-10-AM codes for additional diagnoses present on admission	Free text (max 500 chars)	E.g. comorbidities.
22.250	ICD-10-AM codes for additional diagnoses arising during admission	Free text (max 500 chars)	Complications.
22.260	ACHI Intervention and procedure codes	Free text (max 500 chars)	
22.270	What is the discharge destination/mode?	10 = Discharge/transfer to (an)other acute hospital 21 = Discharge/transfer to a residential aged care service, which is not the usual place of residence 22 = Discharge/transfer to a residential aged care service, which is the usual place of residence 40 = Discharge/transfer to other health care accommodation (includes rehabilitation hospitals) 50 = Statistical discharge - type change 60 = Left against medical advice/discharge at own risk 80 = Died 90 = Home or community dwelling/other	
22.280	Was the patient referred for rehabilitation services on separation from acute care?	INPR = Inpatient rehabilitation RITH = Rehabilitation in the home (including bed substitution and ESD services) DAYR = Day rehabilitation CRP = Community rehabilitation program/outpatient rehabilitation appointments NR = Not required DEC = Declined NA = Not available NO = No - other reason	
Medication prescribed at discharge			
22.500	On discharge, was the patient with ischaemic stroke and atrial fibrillation prescribed oral anticoagulation therapy?	1 = Yes 2 = No 3 = Contraindicated 5 = Not applicable 9 = Unknown	Not applicable if patient didn't have AF. Disabled if stroke type=haemorrhage

22.510	On discharge was the patient prescribed antihypertensives?	1 = Yes 2 = No 3 = Contraindicated 4 = Not indicated 9 = Unknown	
22.600	On discharge was the patient prescribed lipid-lowering treatment?	1 = Yes 2 = No 3 = Contraindicated 4 = Not indicated 9 = Unknown	
Care planning and community referrals			
22.740	Is there evidence that an individualised, comprehensive care plan outlining post discharge care in the community was developed with the team and the patient (or family alone if patient has severe aphasia or cognitive impairments)?	1 = Yes 2 = No 3 = Not applicable (remains in hospital e.g. inpatient rehabilitation or other acute care) 9 = Unknown	
COMMENTS			
25.190	Comments	Free text	

Discontinued or adapted variables

Master Data List (MDL) ref	MDL variable name	MDL import/export codes	Reason for discontinuation or adaption
Patient details			
2.210	Address type	HOME, BUSINESS, OTHER	Not required.
2.110	Medicare number	Free text (numerical, must be 10 chars)	Not frequently used, has been replaced with Individual Health Identifier.
2.320	Other relative (specify)	Free text	Not required.
Alternative contact details			
2.400	First name	Free text (max 20 char)	Alternative contacts are no longer contacted during the follow-up process.
2.410	Last name	Free text (max 20 char)	
2.420	Address type	HOME, BUSINESS, OTHER	
2.430	Street address	Free text, alpha numerical, max 50 char	
2.440	Suburb	Free text, max 20 char	
2.450	Postcode	Free text numerical, max 4 char	
2.460	State	ACT, NSW, NT, QLD, SA, TAS, VIC, WA, OTH = Other, OVERSEAS	
2.470	Country	See sheet 3	
2.480	Phone number	Free text Numerical, Area code and 8 digit space (max 10 char) (XX) XXXX XXXX	
2.490	Mobile number	Free text Numerical (max char 10) (XX) XXXX XXXX	
2.510	Alternative contact person relationship to participant	SP = Spouse/Partner SD = Son/Daughter SIB = Sibling PAR = Parent FA = Friend/Associate OR = Other Relative PC = Professional Carer NS = Not stated/inadequately described	

The Master Data List corresponds to the variable identification code that were used in the previous platform known as the Australian Stroke Data Tool (AuSDaT)

2.511	Other relative (specify)	Free text	
Admission details			
All date accu	Date accuracy	AAA = Accurate EAA = Estimate	Accurate and estimate fields were not used in analysis.
4.190	Direct admission to hospital (bypass ED)	1 = Yes, 2 = No	Not required.
4.300	Not admitted	TRUE/FALSE	Not required- only admitted patients in the core dataset.
Care provided at transferring hospital			
L5.04	What was the reason for transfer?		Reason for transfer out will be included in the ED dataset, but reason for transfer in will not be captured as not used in a anlysis.
5.040	Need for IV tPA	1 = Yes, 2 = No	
5.050	Need for stroke unit care	1 = Yes, 2 = No	
5.060	Need for rehabilitation	1 = Yes, 2 = No	
5.070	Need for BRAIN IMAGING only	1 = Yes, 2 = No	
5.080	Need for ICU	1 = Yes, 2 = No	
5.090	Need for specialist medical assessments	1 = Yes, 2 = No	
5.100	Need for surgical interventions	1 = Yes, 2 = No	
5.110	Need for diagnostic tests	1 = Yes, 2 = No	
5.120	Need for coordinated care by a Stroke Service	1 = Yes, 2 = No	
5.121	Need for endovascular therapy	1 = Yes, 2 = No	
5.130	Unknown	1 = Yes, 2 = No	
5.140	Other (specify)	Free text	
7.480	Date of subsequent brain scan after the stroke	DDMMYYYY	Subsequent brain scan will no longer be captured for Comprehensive Centres.
7.490	Not applicable (no further scans)	True/False	

7.500	Time of subsequent brain scan after the stroke	hh:mm	
7.510	Not documented	True / False	
7.580	Cause of stroke	KNOWN, UNKNOWN	Generally not used.
Mobility			
9.370	Was the patient mobilised in this admission?	1 = Yes, 2 = No, 9 = Unknown	Mobilisation difficult to find and interpret. Updated with physio assessment.
9.380	Date of first documented mobilisation	DDMMYYYY	
9.390	Accuracy	AAA, EAA	
9.400	Method of mobilisation documented	SITTING, STANDING, WALKING	
Antithrombotic therapy			
10.020	Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA)?	1 = Yes 2 = No O = No, but anticoagulant agent provided U = Unknown CI = Contraindicated	Removed as less clinically relevant compared to other indicators.
10.030	Date	DDMMYYYY	
10.040	Date accuracy	AAA = Accurate EAA = Estimate	
10.050	Time	hh:mm	
10.051	Unknown	True / False	
10.060	Time accuracy	AAA = Accurate EAA = Estimate	
14.161	Please specify (if discharged/transferred to residential aged care service)	LLRC = Low level residential care HLRC = High level residential care	No longer relevant.
Medication prescribed at discharge			

13.020	On discharge was the patient prescribed antithrombotics?	1 = Yes, 2 = No, 9 = Unknown, 3 = Contraindicated	Retired as excellent adherence. Replaced with 'On discharge, was the patient with ischaemic stroke and atrial fibrillation prescribed oral anticoagulation therapy?'
14.070	Is the discharge date known?	1 = Yes, 2 = No	Expect discharge date is known in most instances.