

Stroke Patient Management Tool: Stroke, Coverdell

Patient ID:			Bold Question = Required
Date of Birth:	___/___/___		
DEMOGRAPHICS <i>Demographics Tab</i>			
Gender:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Date of Birth:	___/___/___	Age:	___
Race:	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> White <input type="checkbox"/> UTD <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <div style="margin-left: 20px;">[if Asian selected]</div> <div style="margin-left: 40px;"> <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Vietnamese <input type="radio"/> Other Asian </div> </div> <div style="width: 48%;"> <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <div style="margin-left: 20px;">[if native Hawaiian or pacific islander selected]</div> <div style="margin-left: 40px;"> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander </div> </div> </div>		
Zip Code:	_____ - _____		<input type="checkbox"/> Homeless
Health Insurance Status:	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/VA/Champus/Other Insurance <input type="checkbox"/> Self Pay/No Insurance <input type="checkbox"/> ND		
RACE AND ETHNICITY			
Hispanic Ethnicity:	<input type="radio"/> Yes <input type="radio"/> No/UTD		
If Yes,	<input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino or Spanish Origin		
ADMIN <i>Admin Tab</i>			
Final clinical diagnosis related to stroke	<input type="radio"/> Ischemic Stroke <input type="radio"/> Intracerebral Hemorrhage <input type="radio"/> Transient Ischemic Attack (< 24 hours) <input type="radio"/> Subarachnoid Hemorrhage <input type="radio"/> Stroke not otherwise specified <input type="radio"/> <input type="radio"/> No stroke related diagnosis <input type="radio"/> <input type="radio"/> Elective Carotid Intervention only		
If No Stroke Related Diagnosis:	<input type="radio"/> Migraine <input type="radio"/> Electrolyte or metabolic imbalance <input type="radio"/> Seizure <input type="radio"/> Functional disorder <input type="radio"/> Delirium <input type="radio"/> Other <input type="radio"/> <input type="radio"/> Uncertain		
Was the Stroke etiology documented in the patient medical record:		<input type="radio"/> Yes <input type="radio"/> No	
Select documented stroke etiology (select all that apply):	O1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis) O2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI) O3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm) O4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders. <input type="radio"/> Dissection <input type="radio"/> Hypercoagulability <input type="radio"/> Other O5: Cryptogenic stroke (stroke of undetermined etiology) <input type="radio"/> Multiple potential etiologies identified <input type="radio"/> Stroke of undetermined etiology <input type="radio"/> Unspecified		
When is the earliest documentation of comfort measures only?	<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented/UTD		
Arrival Date/Time:	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	Admit Date: ___/___/___
Not Admitted:	<input type="radio"/> Yes, not admitted <input type="radio"/> No, patient admitted as inpatient	Reason Not Admitted:	<input type="radio"/> Transferred from your ED to another acute care hospital <input type="radio"/> Discharged directly from ED to home or other location that is not an acute care hospital <input type="radio"/> Left from ED AMA

Additional Fields:

Stroke Band ID No.

EMS Agency Name Transporting Patient from Referring Hospital

EMS Agency Name Transporting Patient Receiving Hospital

Hospital name if patient transferred from your ED to another hospital

Hospital name if patient transferred from another hospital

			<input type="radio"/> Died in ED <input type="radio"/> Discharged from observation status without an inpatient admission <input type="radio"/> Other
If patient transferred from your ED to another hospital, specify hospital name	<i>Select hospital name from picker list</i> <input type="checkbox"/> Hospital not on the list <input type="checkbox"/> Hospital not documented		
Select reason(s) for why patient transferred	<input type="checkbox"/> Evaluation for IV tPA up to 4.5 hours <input type="checkbox"/> Post Management of IV tPA (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented		
Discharge Date/Time:	___/___/___ : ___ <input type="checkbox"/> MM/DD/YYYY only		
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	1 – Home 2 – Hospice – Home 3 – Hospice – Health Care facility 4 – Acute Care Facility 5 – Other Health Care facility 6 – Expired 7 – Left Against Medical Advice/AMA 8 – Not Documented or Unable to Determine (UTD)		
If Other Health Care Facility	<input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Other <input type="radio"/> Long Term Care Hospital (LTCH)		

DIAGNOSIS CODE		Clinical Codes Tab
ICD-9-CM or ICD-10-CM Principal Diagnosis Code		
ICD-9-CM or ICD-10-CM Other Diagnosis Codes		
ICD-9-CM or ICD-10-PCS Principal Procedure Code		
ICD-9-CM or ICD-10-PCS Other Procedure Codes		
ICD-9-CM Discharge Diagnosis Related to Stroke:		
ICD-10-CM Discharge Diagnosis Related to Stroke:		
No Stroke or TIA Related ICD-9-CM Code Present:	<input type="checkbox"/>	
No Stroke or TIA Related ICD-10-CM Code Present:	<input type="checkbox"/>	
ARRIVAL AND ADMISSION INFORMATION		Admission Tab
During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. STK,VTE)?		<input type="radio"/> Yes <input type="radio"/> No
Was this patient admitted for the sole purpose of performance of elective carotid intervention?		<input type="radio"/> Yes <input type="radio"/> No
Patient location when stroke symptoms discovered	<input type="radio"/> Not in a healthcare setting <input type="radio"/> Outpatient healthcare setting <input type="radio"/> Another acute care facility <input type="radio"/> Stroke occurred after hospital arrival (in ED/Obs/inpatient) <input type="radio"/> Chronic health care facility <input type="radio"/> ND or Cannot be determined	
How patient arrived at your hospital	<input type="radio"/> EMS from home/scene <input type="radio"/> Mobile Stroke Unit <input type="radio"/> Private transportation/taxi/other from home/scene <input type="radio"/> Transfer from another hospital <input type="radio"/> ND or Unknown	
Referring hospital discharge Date/ Time	___/___/___ : ___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	
If transferred from another hospital, specify hospital name	< Select hospital name from dropdown menu> <input type="checkbox"/> Hospital not on the list <input type="checkbox"/> Hospital not documented	
Referring hospital arrival date/ time	___/___/___ : ___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	

If patient transferred to your hospital, select transfer reason(s)	<input type="checkbox"/> Evaluation for IV tPA up to 4.5 hours <input type="checkbox"/> Post Management of IV tPA (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented			
Where patient first received care at your hospital	<input type="radio"/> Emergency Department/ Urgent Care	<input type="radio"/> Direct Admit, not through ED	<input type="radio"/> Imaging suite	<input type="radio"/> ND or Cannot be determined
Advanced Notification by EMS (Traditional Responder or Mobile Stroke Unit)?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> N/A			
Where was the patient cared for and by whom? Check all that apply.	<input type="checkbox"/> Neuro Admit <input type="checkbox"/> Stroke Consult <input type="checkbox"/> In Stroke Unit		<input type="checkbox"/> Other Service Admission <input type="checkbox"/> No Stroke Consult <input type="checkbox"/> Not in Stroke Unit	
Physician/Provider NPI:				

MEDICAL HISTORY

Previously known medical hx of:	<input type="checkbox"/> None <input type="checkbox"/> Atrial Fib/Flutter <input type="checkbox"/> CAD/Prior MI Carotid Stenosis <input type="checkbox"/> Current Pregnancy (or up to 6 weeks post partum) <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Drugs/Alcohol Abuse <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Family History of Stroke <input type="checkbox"/> HF <input type="checkbox"/> HRT <input type="checkbox"/> Hypertension <input type="checkbox"/> Migraine <input type="checkbox"/> Obesity/Overweight	<input type="checkbox"/> Previous Stroke <input type="checkbox"/> Previous TIA <input type="checkbox"/> Prosthetic Heart Valve <input type="checkbox"/> PVD <input type="checkbox"/> Renal insufficiency – chronic <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Smoker
Ambulatory status prior to current event	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND		

DIAGNOSIS & EVALUATION

Symptom Duration if diagnosis of Transient Ischemic Attack (< 24 hours)	<input type="radio"/> Less than 10 minutes <input type="radio"/> 10-59 minutes <input type="radio"/> ≥ 60 minutes <input type="radio"/> ND
Had stroke symptoms resolved at time of presentation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND
Initial NIH Stroke Scale	<input type="radio"/> Yes <input type="radio"/> No/ND
If Yes:	<input type="radio"/> Actual <input type="radio"/> Estimated from the record <input type="radio"/> ND
Total Score	_____ (refer to web program for questions)

NIHSS score obtained from transferring facility:	_____ <input type="checkbox"/> ND
Initial exam findings (Select all that apply)	<input type="checkbox"/> Weakness/Paresis <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Disturbance Aphasia/Language <input type="checkbox"/> Other neurological signs/symptoms <input type="checkbox"/> No neurological signs/symptoms <input type="checkbox"/> ND
Ambulatory status on admission	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND

MEDICATIONS PRIOR TO ADMISSION

<input type="checkbox"/> No medications prior to admission	
Antiplatelet or Anticoagulant Medication(s):	<input type="radio"/> Yes <input type="radio"/> No/ND
<input type="checkbox"/> Class: Antiplatelet	<input type="checkbox"/> Class: Anticoagulant

<input type="checkbox"/> aspirin <input type="checkbox"/> aspirin/dipyridamole (Aggrenox) <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> prasugrel (Effient) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid) <input type="checkbox"/> Other Antiplatelet		<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> argatroban <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> desirudin (Iprivask) <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> fondaparinux (Arixtra) <input type="checkbox"/> full dose LMW heparin <input type="checkbox"/> lepirudin (Refludan) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> warfarin (Coumadin) <input type="checkbox"/> other Anticoagulant	
Antihypertensive	<input type="radio"/> Yes <input type="radio"/> No/ND		
Cholesterol-Reducer	<input type="radio"/> Yes <input type="radio"/> No/ND		
Diabetic medication	<input type="radio"/> Yes <input type="radio"/> No/ND		
Antidepressant medication	<input type="radio"/> Yes <input type="radio"/> No/ND		
SYMPTOM TIMELINE		Hospitalization Tab	
Date/Time patient last known to be well?		<input type="checkbox"/> Time of Discovery same as Last known well	Date/Time of discovery of stroke symptoms?
____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown			____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Comments			
BRAIN IMAGING			
Brain imaging completed at your hospital for this episode of care?		Date/Time Brain Imaging Initiated	____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Interpretation of first brain image after symptom onset, done at any facility:		<input type="radio"/> Hemorrhage <input type="radio"/> No Hemorrhage <input type="radio"/> Not Available	
ADDITIONAL TIME TRACKER			
Date/Time Stroke Team Activated:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Date/Time Stroke Team Arrived	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown
Date/Time of ED Physician Assessment:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Date/Time Neurosurgical Services Consulted:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
Date/Time Brain Imaging Ordered:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Date/Time Brain Imaging Interpreted:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown
Date/Time IV t-PA Ordered:		Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
Date/Time Lab Tests Ordered:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Date/Time Lab Tests Completed:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown
Date/Time Chest X-ray Ordered:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Date/Time Chest X-ray Completed:	Select one option <input type="checkbox"/> MM/DD/YYYY HH:MI ____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY ____/____/____ <input type="checkbox"/> Unknown
Additional comments:			

IV THROMBOLYTIC THERAPY			
IV t-PA initiated at this hospital?	O Yes O No	Date/Time IV tPA initiated: ____/____/____ : ____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?		O Yes O No	
Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window?		O Yes O No	
SHOW ALL			
If yes, documented exclusions for 0 -3-hour treatment window or 3 – 4.5 treatment window, select reason for exclusion.			
For discharges on or after 1 April 2016			
Exclusion Criteria (contraindications) 0-3 hr treatment window. Select all that apply:			
<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Acute bleeding diathesis (low platelet count, increased PTT, INR \geq 1.7 or use of NOAC) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrates multi-lobe infarction (hypodensity >1/3 cerebral hemisphere) <input type="checkbox"/> C8: Arterial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L)			
Relative Exclusion Criteria (Warnings) 0-3 hr treatment window. Select all that apply:			
<input type="checkbox"/> W1: Care-team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Patient/family refusal <input type="checkbox"/> W6: Rapid improvement <input type="checkbox"/> W7: Stroke severity too mild <input type="checkbox"/> W8: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W9: Seizure at onset with postictal residual neurological impairments <input type="checkbox"/> W10: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)			
Exclusion Criteria (contraindications) 3-4.5 hr treatment window. Select all that apply:			
<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Acute bleeding diathesis (low platelet count, increased PTT, INR \geq 1.7 or use of NOAC) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrates multi-lobe infarction (hypodensity >1/3 cerebral hemisphere) <input type="checkbox"/> C8: Arterial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L)			
Relative Exclusion Criteria (Warnings) 3-4.5 hr treatment window. Select all that apply:			
<input type="checkbox"/> W1: Care-team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Patient/family refusal <input type="checkbox"/> W6: Rapid improvement <input type="checkbox"/> W7: Stroke severity too mild <input type="checkbox"/> W8: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W9: Seizure at onset with postictal residual neurological impairments			

<input type="checkbox"/> W10: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days) Additional Relative Exclusion Criteria 3-4.5 hr treatment window. Select all that apply: <input type="checkbox"/> AW1: Age > 80 <input type="checkbox"/> AW2: History of both diabetes and prior ischemic stroke <input type="checkbox"/> AW3: Taking an oral anticoagulant regardless of INR <input type="checkbox"/> AW4: Severe Stroke (NIHSS > 25)	
Other Reasons (Hospital-related or other factors) 0-3-hour treatment window. <input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> In-hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Advanced Age <input type="checkbox"/> Stroke too severe <input type="checkbox"/> Other – requires specific reason to be entered in the PMT when this option is selected.	
Other Reasons (Hospital-related or other factors) 3-4.5-hour treatment window. <input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> In-hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Other – requires specific reason to be entered in the PMT when this option is selected	
If IV tPA was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	
Eligibility Reason(s):	<input type="checkbox"/> Social/Religious <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care-team unable to determine eligibility <input type="checkbox"/> Specify eligibility reason: _____
Medical Reason(s):	<input type="checkbox"/> Hypertension requiring aggressive control with IV medications <input type="checkbox"/> Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 50), seizures, or major metabolic disorders <input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Investigational or experimental protocol for thrombolysis <input type="checkbox"/> Specify medical reason: _____
Hospital Related or Other Reason(s):	<input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> In-hospital time delay <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> Other _____
IV tPA at an outside hospital or Mobile Stroke Unit?	<input type="radio"/> Yes <input type="radio"/> No
Investigational or experimental protocol for thrombolysis?	<input type="radio"/> Yes If yes, specify _____ <input type="radio"/> No
Additional Comments Related to Thrombolytics	_____
ENDOVASCULAR THERAPY	
Catheter-based stroke treatment at this hospital?	<input type="radio"/> Yes <input type="radio"/> No
IA t-PA or MER Initiation Date/Time:	____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Catheter-based stroke treatment at outside hospital?	<input type="radio"/> Yes <input type="radio"/> No
Note, if your hospital is collecting data for the Comprehensive Stroke Center and/or Mechanical Endovascular Reperfusion measure set, please ensure you complete additional data entry on the Advanced Stroke Care.	
COMPLICATIONS	
Complications of Thrombolytic Therapy	<input type="checkbox"/> Symptomatic intracranial hemorrhage <36 hours <input type="checkbox"/> Other serious complications <input type="checkbox"/> Life threatening, serious systemic hemorrhage <36 hours <input type="checkbox"/> No serious complications <input type="checkbox"/> UTD

If bleeding complications occur in patient transferred after IV tPA:	<input type="radio"/> Symptomatic hemorrhage detected prior to patient transfer <input type="radio"/> Symptomatic hemorrhage detected only after patient transfer	<input type="radio"/> Unable to determine <input type="radio"/> N/A
Other In-hospital Treatments and Screening		
Dysphagia Screening		
Patient NPO throughout the entire hospital stay?	<input type="radio"/> Yes <input type="radio"/> No/ND	
Was patient screened for dysphagia prior to any oral intake including water or medications?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	
If yes, Dysphagia screening results:	<input type="radio"/> Pass <input type="radio"/> Fail <input type="radio"/> ND	
Treatment for Hospital-Acquired Pneumonia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
VTE Interventions	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> 1- Low dose unfractionated heparin (LDUH) <input type="checkbox"/> 2- Low molecular weight heparin (LMWH) <input type="checkbox"/> 3- Intermittent pneumatic compression devices (IPC) <input type="checkbox"/> 4- Graduated compression stockings (GCS) <input type="checkbox"/> 5- Factor Xa Inhibitor <input type="checkbox"/> 6- Warfarin </div> <div> <input type="checkbox"/> 7- Venous foot pumps (VFP) <input type="checkbox"/> 8- Oral Factor Xa Inhibitor <input type="checkbox"/> 9- Aspirin <input type="checkbox"/> A- None of the above or ND </div> </div>	
What date was the initial VTE prophylaxis administered after hospital admission?	____/____/____ <input type="checkbox"/> Unknown	
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?	<input type="radio"/> Yes <input type="radio"/> No	
For discharges on or after 01/01/2013: Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?	<input type="radio"/> Yes <input type="radio"/> No	
Other Therapeutic Anticoagulation	<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> argatroba <input type="checkbox"/> dabigatran (Pradaxa)	<input type="checkbox"/> desirudin (Iprivask) <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> lepirudin (Refludan)
		<input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> other anticoagulant
Was DVT or PE documented?	<input type="radio"/> Yes <input type="radio"/> No/ND	
Was antithrombotic therapy administered by the end of hospital day 2?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	
If yes, select all that apply	<input type="checkbox"/> Antiplatelet <input type="checkbox"/> Anticoagulant	
Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?		<input type="radio"/> Yes <input type="radio"/> No
Was patient treated for a urinary tract infection (UTI) during this admission?	<input type="radio"/> Yes <input type="radio"/> No/ND	
If patient was treated for a UTI, did the patient have a Foley catheter during this admission?	<input type="radio"/> Yes, patient had catheter in place on arrival <input type="radio"/> Yes, but only after admission <input type="radio"/> No <input type="radio"/> Unable to Determine	

MEASUREMENTS

Total Chol:	_____ mg/dL	Triglycerides:	_____ mg/dL	HDL:	_____ mg/dL	LDL:	_____ mg/dL	<input type="checkbox"/> Lipids: NC <input type="checkbox"/> Lipids: ND
A ₁ C:	_____ % A ₁ C: ND <input type="checkbox"/>	Blood Glucose (required if patient received IV tPA):		_____ <input type="checkbox"/> ND <input type="checkbox"/> Too Low <input type="checkbox"/> Too High mg/dL				
Serum Creatinine:	_____ <input type="checkbox"/> ND							
INR:	_____ <input type="checkbox"/> ND <input type="checkbox"/> NC							
Vital Signs:	Heart Rate (beats per minute): _____ Blood Pressure (required if patient received IV tPA): _____/_____ mmHg <input type="checkbox"/> ND (Systolic/Diastolic)							
Height:	_____ <input type="radio"/> in <input type="radio"/> cm <input type="checkbox"/> ND							
Weight:	_____ <input type="radio"/> lbs <input type="radio"/> kg <input type="checkbox"/> ND							
Waist Circumference:	_____ <input type="radio"/> in <input type="radio"/> cm <input type="checkbox"/> ND							

BMI:	_____ <input type="checkbox"/> ND		
DISCHARGE INFORMATION <i>Discharge Tab</i>			
GWTG Ischemic Stroke-Only Estimated Mortality Rate			[Calculated in the PMT]
GWTG Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke NOS)			[Calculated in the PMT]
Modified Rankin Scale at Discharge		<input type="radio"/> Yes <input type="radio"/> No/ND	
If Yes:	<input type="radio"/> Actual <input type="radio"/> Estimated from the record <input type="radio"/> ND		
Total Score	_____ (refer to web program for questions)		
Ambulatory status at discharge		<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND	
Discharge Blood Pressure (Measurement closest to discharge)		_____/____ mmHg(Systolic/Diastolic) <input type="checkbox"/> ND	
DISCHARGE TREATMENTS			
Antithrombotic Therapy approved in stroke	Prescribed?		<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC
	If yes,		
	<input type="checkbox"/> Antiplatelet		<input type="checkbox"/> Anticoagulant
	<input type="checkbox"/> aspirin <input type="checkbox"/> aspirin/dipyridamole (Aggrenox) <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> ticlopidine (Ticlid)	<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> argatroban <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> fondaparinux (Arixtra)	<input type="checkbox"/> full dose LMW heparin <input type="checkbox"/> lepirudin (Refludan) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> Unfractionated heparin IV <input type="checkbox"/> warfarin (Coumadin)
	Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____	Dosage 1. _____ 2. _____ 3. _____ 4. _____
	If NC, documented contraindications <input type="checkbox"/> Allergy to or complications r/t antithrombotic <input type="checkbox"/> Patient/Family refused Measures Only <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort <input type="checkbox"/> Other		
Other Antithrombotic(s)	Prescribed?		<input type="radio"/> Yes <input type="radio"/> No
	If yes,		
	Medication: <input type="checkbox"/> desirudin (Iprivask) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> prasugrel (Effient)*contraindication in stroke and TIA <input type="checkbox"/> Other	Dosage: 1. _____ 2. _____ 3. _____ 4. _____	Frequency: 1. _____ 2. _____ 3. _____ 4. _____
Persistent or Paroxysmal Atrial Fibrillation/Flutter		<input type="radio"/> Yes <input type="radio"/> No	
If atrial fib/flutter or history of PAF documented, was patient discharged on anticoagulation?			<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC
If NC, documented reasons for no anticoagulation	<input type="checkbox"/> Allergy to or complication r/t warfarin or heparins <input type="checkbox"/> Mental status <input type="checkbox"/> Patient refused <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding <input type="checkbox"/> Risk for falls <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only		
Antihypertensive Tx (Select all that apply)	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> ACE Inhibitors <input type="checkbox"/> Beta Blockers <input type="checkbox"/> Diuretics <input type="checkbox"/> None - contraindicated <input type="checkbox"/> ARB <input type="checkbox"/> Ca++ Channel Blockers <input type="checkbox"/> Other anti-hypertensive med		

Cholesterol-Reducing Tx	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> Statin <input type="checkbox"/> Niacin <input type="checkbox"/> Other med <input type="checkbox"/> None - contraindicated <input type="checkbox"/> Fibrate <input type="checkbox"/> Absorption Inhibitor		
Statin Medications:	<input type="radio"/> Amlodipine + Atorvastatin (Caduet) <input type="radio"/> Atorvastatin (Lipitor) <input type="radio"/> Ezetimibe + Simvastatin (Vytorin) <input type="radio"/> Fluvastatin (Lescol) <input type="radio"/> Fluvastatin XL (Lescol XL) <input type="radio"/> Lovastatin (Altoprev) <input type="radio"/> Lovastatin (Mevacor) <input type="radio"/> Lovastatin + Niacin (Advicor) <input type="radio"/> Pitavastatin (Livalo) <input type="radio"/> Pravastatin (Pravachol) <input type="radio"/> Rosuvastatin (Crestor) <input type="radio"/> Simvastatin (Zocor) <input type="radio"/> Simvastatin + Niacin (Simcor)	Statin Total Daily Dose:	
Documented reason for not prescribing a statin medication at discharge?		<input type="radio"/> Yes <input type="radio"/> No	
Intensive Statin Therapy	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
New Diagnosis of Diabetes?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND		
Basis for Diagnosis (Select all that apply):	<input type="checkbox"/> HbA1c <input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Oral Glucose Tolerance <input type="checkbox"/> Test Other		
Diabetic Tx (Select all that apply):	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> Insulin <input type="checkbox"/> None – contraindicated <input type="checkbox"/> Oral agents <input type="checkbox"/> Other subcutaneous/injectable agents		
Anti-Smoking Tx	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Any antidepressant class of medication at discharge?	<input type="radio"/> Yes, SSRI <input type="radio"/> Yes, any other antidepressant class <input type="radio"/> No/ND		
OTHER LIFESTYLE INTERVENTIONS			
Reducing weight and/or increasing activity recommendations	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
TLC Diet or Equivalent	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Antihypertensive Diet	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Was Diabetes Teaching Provided?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
STROKE EDUCATION			
Patient and/or caregiver received education and/or resource materials regarding all the following:			
Check all as Yes: <input type="checkbox"/>			
Risk Factors for Stroke	<input type="radio"/> Yes <input type="radio"/> No	Stroke Warning Signs and Symptoms	<input type="radio"/> Yes <input type="radio"/> No
How to Activate EMS for Stroke	<input type="radio"/> Yes <input type="radio"/> No	Need for Follow-Up After Discharge	<input type="radio"/> Yes <input type="radio"/> No
Their Prescribed Medications	<input type="radio"/> Yes <input type="radio"/> No		
STROKE REHABILITATION			
Patient assessed for and/or received rehabilitation services during this hospitalization?		<input type="radio"/> Yes <input type="radio"/> No	
Check all rehab services that patient received or was assessed for:	<input type="checkbox"/> Patient received rehabilitation services during hospitalization <input type="checkbox"/> Patient transferred to rehabilitation facility <input type="checkbox"/> Patient referred to rehabilitation services following discharge <input type="checkbox"/> Patient ineligible to receive rehabilitation services because symptoms resolved <input type="checkbox"/> Patient ineligible to receive rehabilitation services due to impairment (i.e. poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)		

Stroke Diagnostic Tests and Interventions

Cardiac ultrasound/echocardiography <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Extended surface cardiac rhythm monitoring > 7 days <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Intracranial Vascular Imaging <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Carotid Imaging <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Extended Implantable Cardiac Rhythm Monitoring <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Short-Term Cardiac Rhythm Monitoring ≤ 7 days <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned
Carotid revascularization <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Hypercoagulability Testing <input type="radio"/> Performed during this admission or prior 3 months <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	

OPTIONAL FIELDS – Please do not enter any patient identifiers in this section**Optional Fields Tab**

Field 1	Field 2	Field 3	Field 4	Field 5
Field 6	Field 7	Field 8	Field 9	Field 10
Field 11		Field 12		
Field 13	__/__/____ __: __ <input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown		Field 14	__/__/____ __: __ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Additional Comments				

Administrative

PMT used concurrently or retrospectively or combination?	<input type="radio"/> Concurrently	<input type="radio"/> Retrospectively	<input type="radio"/> Combination
Was a stroke admission order set used in this patient?	<input type="radio"/> Yes	<input type="radio"/> No	
Was a stroke discharge checklist used in this patient?	<input type="radio"/> Yes	<input type="radio"/> No	
Patient adherence contract/compact used?	<input type="radio"/> Yes	<input type="radio"/> No	