

*Patient ID: _____ (Legend: *Required)

ARRIVAL AND ADMISSION INFORMATION *Admission Tab*

*Patient location when stroke symptoms discovered	<input type="radio"/> Not in a healthcare setting <input type="radio"/> Another acute care facility <input type="radio"/> Chronic health care facility	<input type="radio"/> Outpatient healthcare setting <input type="radio"/> Stroke occurred while patient was an inpatient in your hospital <input type="radio"/> ND or Cannot be determined	
How patient arrived at your hospital	<input type="radio"/> EMS from home/scene	<input type="radio"/> Private transportation/taxi/other from home/scene	<input type="radio"/> Transfer from another hospital <input type="radio"/> ND or Unknown
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
*Arrival Date/Time: ___/___/___ ___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown			

DEMOGRAPHICS

*Age: _____	*Gender: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown
*Hispanic Ethnicity:	<input type="radio"/> Yes <input type="radio"/> No/UTD
*Race:	<input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> UTD

DIAGNOSIS & EVALUATION

*Final clinical diagnosis related to stroke	<input type="radio"/> Ischemic Stroke <input type="radio"/> Transient Ischemic Attack (< 24 hours) <input type="radio"/> Subarachnoid Hemorrhage	<input type="radio"/> Intracerebral Hemorrhage <input type="radio"/> Stroke not otherwise specified <input type="radio"/> No stroke related diagnosis	
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SYMPTOM TIMELINE *Hospitalization Tab*

*Date/Time patient last known to be well? ___/___/___ ___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	*Date/Time of discovery of stroke symptoms? ___/___/___ ___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	<input type="checkbox"/> Time of Discovery same as Last known well
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BRAIN IMAGING

*Brain imaging completed at your hospital for this episode of care?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	*Date/Time Brain Imaging Completed	___/___/___ ___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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IV THROMBOLYTIC THERAPY

*IV thrombolytic therapy initiated at this hospital?	<input type="radio"/> Yes <input type="radio"/> No	*Date/Time IV tPA initiated:	___/___/___ ___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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*Documented Contraindications or Warnings for not initiating IV thrombolytic in the 0-3hr treatment window?	<input type="radio"/> Yes <input type="radio"/> No
Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window?	<input type="radio"/> Yes <input type="radio"/> No

Documented reasons in the medical record for no IV t-PA started at your hospital:
(Check the first box for reasons which apply for the 0-3hr treatment window, check the second box for reasons which apply for the 3-4.5hr treatment window. If the patient arrived within 2 hours, but received treatment beyond 3 hours, select the appropriate contraindications and/or warnings for non-treatment within 3 hours.)

<p>Contraindications 0-3hr 3-4.5hr</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> SBP > 185 or DBP > 110 mmHg despite treatment <input type="checkbox"/> <input type="checkbox"/> Seizure at onset <input type="checkbox"/> <input type="checkbox"/> Recent surgery/trauma (<15 days) <input type="checkbox"/> <input type="checkbox"/> Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.) <input type="checkbox"/> <input type="checkbox"/> History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor <input type="checkbox"/> <input type="checkbox"/> Active internal bleeding (<22 days) <input type="checkbox"/> <input type="checkbox"/> Platelets <100,000, PTT> 40 sec after heparin use, or PT > 15 or INR > 1.7, or known bleeding diathesis <input type="checkbox"/> <input type="checkbox"/> Suspicion of subarachnoid hemorrhage <input type="checkbox"/> <input type="checkbox"/> CT findings (ICH, SAH, or major infarct signs) 	<p>Warnings 0-3hr 3-4.5hr</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Advanced age <input type="checkbox"/> <input type="checkbox"/> Care-team unable to determine eligibility <input type="checkbox"/> <input type="checkbox"/> Glucose < 50 or > 400 mg/dl <input type="checkbox"/> <input type="checkbox"/> Increased risk of bleeding due to comorbid conditions (see coding instructions) <input type="checkbox"/> <input type="checkbox"/> IV or IA tPA given at outside hospital <input type="checkbox"/> <input type="checkbox"/> Left heart thrombus <input type="checkbox"/> <input type="checkbox"/> Life expectancy < 1 year or severe co-morbid illness or CMO on admission <input type="checkbox"/> <input type="checkbox"/> Pregnancy <input type="checkbox"/> <input type="checkbox"/> Pt./Family refused <input type="checkbox"/> <input type="checkbox"/> Rapid improvement <input type="checkbox"/> <input type="checkbox"/> Stroke severity too mild <input type="checkbox"/> <input type="checkbox"/> Stroke severity – Too severe (e.g., NIHSS >22)
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	<p>Additional Warnings for patients treated between 3-4.5 hrs 0-3hr 3-4.5hr</p> <ul style="list-style-type: none"> -- <input type="checkbox"/> Age > 80 -- <input type="checkbox"/> Prior Stroke <u>and</u> Diabetes -- <input type="checkbox"/> Any anticoagulant use prior to admission (even if INR < 1.7) -- <input type="checkbox"/> NIHSS > 25 -- <input type="checkbox"/> CT findings of >1/3 MCA
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Other reasons that may or may not be documented in the medical record for no IV t-PA started at your hospital:
(Check the first box for reasons which apply for the 0-3hr treatment window, check the second box for reasons which apply for the 3-4.5hr treatment window)

<p>Hospital-Related or Other Factors 0-3hr 3-4.5hr</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> <input type="checkbox"/> In-hospital Time Delay <input type="checkbox"/> <input type="checkbox"/> No IV access <input type="checkbox"/> <input type="checkbox"/> Other
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WAS OTHER THROMBOLYTIC/REPERFUSION THERAPY ADMINISTERED?

*IV tPA at an outside hospital?	<input type="radio"/> Yes <input type="radio"/> No		
IA catheter-based reperfusion at this hospital?	<input type="radio"/> Yes <input type="radio"/> No	Date/Time of IA catheter-based reperfusion	___/___/____ __:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
IA catheter-based reperfusion at outside hospital?	<input type="radio"/> Yes <input type="radio"/> No		

IN-HOSPITAL TREATMENT AND COMPLICATIONS

*When is the earliest documentation of comfort measures only?	<input type="radio"/> Day 1 or 2 <input type="radio"/> Day 3 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented/UTD		
*Complications of Thrombolytic Therapy	<input type="checkbox"/> Symptomatic intracranial hemorrhage <36 hours <input type="checkbox"/> Life threatening, serious systemic hemorrhage <36 hours	<input type="checkbox"/> Other serious complications <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	

DISCHARGE INFORMATION *Discharge Tab*

*Discharge Date: ___/___/____

Get With The Guidelines® Ischemic Stroke-Only Estimated Mortality Rate	[Calculated in the PMT]
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Get With The Guidelines® Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke not otherwise specified)		[Calculated in the PMT]
*In-hospital Death?	<input type="radio"/> Yes <input type="radio"/> No	
*Discharge Status	<input type="radio"/> 01 Discharged to home or self care (routine discharge) <input type="radio"/> 02 Dsch/Trans to a short term general hospital for inpatient care <input type="radio"/> 03 Dsch/Trans to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care <input type="radio"/> 04 Dsch/Trans to a facility that provides custodial or supportive care <input type="radio"/> 05 Discharged/transferred to a Designated Cancer Center or Children’s Hospital <input type="radio"/> 06 Dsch/Trans to home under care of organized home health service organization <input type="radio"/> 07 Left against medical advice or discontinued care <input type="radio"/> 20 Expired <input type="radio"/> 21 Dsch/Trans to court/law enforcement <input type="radio"/> 43 Dsch/Trans to a federal health care facility <input type="radio"/> 50 Hospice-home <input type="radio"/> 51 Hospice - medical facility (certified) providing hospice level of care <input type="radio"/> 61 Dsch/Trans to hospital-based Medicare approved swing bed <input type="radio"/> 62 Dsch/Trans to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital <input type="radio"/> 63 Dsch/Trans to a Medicare certified long term care hospital (LTCH) <input type="radio"/> 64 Dsch/Trans to a nursing facility certified under Medicaid but not certified under Medicare <input type="radio"/> 65 Dsch/Trans to a psychiatric hospital or psychiatric distinct part unit of a hospital <input type="radio"/> 66 Discharged/transferred to a Critical Access Hospital (CAH) <input type="radio"/> 70 Dsch/Trans to another type of health care institution not defined elsewhere in this code list (See Code 05)	