

Patient ID: _____		Bold Question = Required	
DEMOGRAPHICS <i>Demographics Tab</i>			
Gender	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Date of Birth: _____/_____/_____	Age: _____		
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			
Race (Select all that apply):	<input type="checkbox"/> White <input type="checkbox"/> UTD <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander
	[if Asian selected] <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian		[if native Hawaiian or pacific islander selected] <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander
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 not 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):	<input type="radio"/> 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis) <input type="radio"/> 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI) <input type="radio"/> 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm) <input type="radio"/> 4: 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 <input type="radio"/> 5: 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		Admit Date: _____/_____/_____

		<input type="checkbox"/> Unknown	
Not Admitted:	<input type="radio"/> Yes, not admitted <input type="radio"/> No, patient admitted as in patient	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 <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	[Select hospital name from picker list] <input type="checkbox"/> Hospital not on list <input type="checkbox"/> Hospital not documented		
Select reason(s) for why patient transferred	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (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:	___/___/____:___ <input type="checkbox"/> MM/DD/YYYY only		
Documented reason for delay in transfer to referral facility?	<input type="radio"/> Yes <input type="radio"/> No		
Specific reason for delay documented in transfer patient (check all that apply):	<input type="checkbox"/> Social/religious <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care team unable to determine eligibility <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 reperfusion <input type="checkbox"/> Delay in stroke diagnosis * <input type="checkbox"/> In-hospital time delay * <input type="checkbox"/> Equipment-related delay * <input type="checkbox"/> Need for additional imaging* <input type="checkbox"/> Catheter lab not available* <input type="checkbox"/> Other *		
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	<input type="checkbox"/> 1 – Home <input type="checkbox"/> 2 – Hospice – Home <input type="checkbox"/> 3 – Hospice – Health Care Facility <input type="checkbox"/> 4 – Acute Care Facility <input type="checkbox"/> 5 – Other Health Care Facility <input type="checkbox"/> 6 – Expired <input type="checkbox"/> 7 – Left Against medical Advise / AMA <input type="checkbox"/> 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-9CM or ICD-10-CM Principal Diagnosis Code ICD-9CM 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)? Yes No

Was this patient admitted for the sole purpose of performance of elective carotid intervention? Yes 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
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Referring hospital discharge Date/ Time: _____ MM/DD/YYYY only Unknown

If transferred from another hospital, specify hospital name: [Select hospital name from picker list]
 Hospital not on list
 Hospital not documented

Referring hospital arrival date/ time: _____ MM/DD/YYYY only Unknown

If patient transferred to your hospital, select transfer reason(s):

- Evaluation for IV alteplase up to 4.5 hours
- Post Management of IV alteplase (e.g. Drip and Ship)
- Evaluation for Endovascular thrombectomy
- Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy)
- Patient/family request
- Other advanced care (not stroke related)
- Not documented

Where patient first received care at your hospital: Emergency Department / Urgent Care Direct Admit, not through ED Imaging suite ND or Cannot be determined

Advanced Notification by EMS or MSU? Yes No/ND N/A

Where was the patient cared for and by whom? Check all that apply.

- Neuro Admit
- Stroke Consult
- In Stroke Unit
- Other Service Admission
- No Stroke Consult
- Not in Stroke Unit

Physician / Provider NPI: _____

MEDICAL HISTORY

Previously known medical hx of:	<input type="checkbox"/> None	<input type="checkbox"/> Drugs/Alcohol	<input type="checkbox"/> Previous Stroke
	<input type="checkbox"/> Atrial Fib/Flutter	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Ischemic stroke
	<input type="checkbox"/> CAD/Prior MI	<input type="checkbox"/> Familial hypercholesterolemia	<input type="checkbox"/> ICH
	<input type="checkbox"/> Carotid Stenosis	<input type="checkbox"/> Family History of Stroke	<input type="checkbox"/> SAH
	<input type="checkbox"/> Current Pregnancy (up to 6 weeks post-partum)	<input type="checkbox"/> HF	<input type="checkbox"/> Not Specified
	<input type="checkbox"/> DVT/PE	<input type="checkbox"/> HRT	<input type="checkbox"/> Previous TIA
	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Prosthetic Heart Valve
	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Migraine	<input type="checkbox"/> PVD
		<input type="checkbox"/> Obesity/Overweight	<input type="checkbox"/> Renal insufficiency – chronic

	<input type="checkbox"/> Type I <input type="checkbox"/> Type II Duration: <input type="radio"/> < 5 years <input type="radio"/> 5 - < 10 years <input type="radio"/> 10 - < 20 years <input type="radio"/> >= 20 years <input type="radio"/> Unknown	<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 (less than 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"/> Estimate from record <input type="radio"/> ND
Total Score:	_____ (refer to web program for questions)
NIHSS score obtained from transferring facility:	_____ <input type="radio"/> ND
Initial exam findings (Select all that apply)	<input type="checkbox"/> Weakness/Paresis <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Disturbance <input type="checkbox"/> 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

MEDICATION PRIOR TO ADMISSION

No medications prior to admission	<input type="checkbox"/>
Antiplatelet or Anticoagulant Medication(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND
<input type="checkbox"/> Antiplatelet Medication <input type="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> prasugrel (Effient) <input type="radio"/> ticagrelor (Brilinta) <input type="radio"/> ticlopidine (Ticlid) <input type="radio"/> Other Antiplatelet	<input type="checkbox"/> Anticoagulant Medication <input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> desirudin (Iprivask) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra) <input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> unfractionated heparin IV <input type="radio"/> warfarin (Coumadin) <input type="radio"/> other Anticoagulant
Antihypertensive	<input type="radio"/> Yes <input type="radio"/> No/ND
Cholesterol-Reducer	<input type="radio"/> Yes <input type="radio"/> No/ND
Anti-hyperglycemic medications:	<input type="radio"/> Yes <input type="radio"/> No/ND
If yes, select medications (select all that apply)	<input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> Metformin <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> GLP-1 receptor agonist <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> Other oral agents <input type="checkbox"/> Insulin <input type="checkbox"/> Sulfonyurea <input type="checkbox"/> Other injectable/subcutaneous agents
Antidepressant medication	<input type="radio"/> Yes <input type="radio"/> No/ND

Date/Time Patient last known to be well? ____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	<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
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Comments: _____

BRAIN IMAGING

Brain imaging completed at your hospital for this episode of care? <input type="radio"/> Yes <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="radio"/> No/ND <input type="checkbox"/> ONC	Date/Time Brain Imaging First Initiated at your hospital: ____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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Interpretation of first brain image after symptom onset, done at any facility:
 Acute Hemorrhage No Acute Hemorrhage Not Available

Was acute Vascular or perfusion imaging (e.g. CTA, MRA, DSA) performed at your hospital? <input type="radio"/> Yes <input type="radio"/> No	Date/Time 1 st vessel or perfusion imaging initiated at your hospital: ____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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If yes, type of vascular imaging (select all that apply) <input type="checkbox"/> CTA <input type="checkbox"/> CT Perfusion <input type="checkbox"/> MRA	<input type="checkbox"/> MR Perfusion <input type="checkbox"/> DSA (catheter angiography) <input type="checkbox"/> Image type not documented
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Was a target lesion (large vessel occlusion) visualized? Yes No

If yes, select site of large vessel occlusion (select all that apply): <input type="checkbox"/> ICA <input type="checkbox"/> Intracranial ICA <input type="checkbox"/> Cervical ICA <input type="checkbox"/> Other/UTD	<input type="checkbox"/> MCA <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> Other/UTD	<input type="checkbox"/> Basilar <input type="checkbox"/> Other cerebral artery branch <input type="checkbox"/> Vertebral Artery
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ADDITIONAL TIME TRACKER

Date/Time Stroke Team Activated: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Stroke Team Arrived: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Date/Time of ED Physician Assessment: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Neurosurgical services consult: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Date/Time Brain Imaging Ordered: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Brain Imaging Interpreted: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Date/Time IV alteplase Ordered: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A		
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Date/Time Lab Tests Ordered: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown N/A	Date/Time lab Tests Completed: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Date/Time ECG Ordered: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time ECG Completed: ____/____/____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Date/Time Chest X-ray Ordered: ____/____/____ ____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown <input type="radio"/> N/A	Date/Time Chest X-ray Completed: ____/____/____ ____:____	Select one option <input type="radio"/> MM/DD/YYYY HH:MM <input type="radio"/> MM/DD/YYYY <input type="radio"/> Unknown
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Additional Comments:

IV THROMBOLYTIC THERAPY

IV alteplase initiated at this hospital? Yes No **Date/Time IV alteplase initiated:** ____/____/____ ____:____

Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window? Yes No

Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window? Yes 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:

- C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment
- C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months
- C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm
- C4: Active internal bleeding
- C5: Acute bleeding diathesis (low platelet count, increased PTT, INR >= 1.7 or use of NOAC)
- C6: Symptoms suggest subarachnoid hemorrhage
- C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere)
- C8: Arterial puncture at non-compressible site in previous 7 days
- C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L)

Relative Exclusion Criteria (Warnings) 0-3 hr treatment window. Select all that apply:

- W1: Care-team unable to determine eligibility
- W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival
- W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission
- W4: Pregnancy
- W5: Patient/family refusal
- W7: Stroke severity too mild (non-disabling)
- W8: Recent acute myocardial infarction (within previous 3 months)
- W9: Seizure at onset with postictal residual neurological impairments
- W10: Major surgery or serious trauma within previous 14 days
- W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)

Exclusion Criteria (contraindications) 3-4.5 hr treatment window. Select all that apply:

- C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment
- C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months
- C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm
- C4: Active internal bleeding
- C5: Acute bleeding diathesis (low platelet count, increased PTT, INR ≥ 1.7 or use of NOAC)
- C6: Symptoms suggest subarachnoid hemorrhage
- C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere)
- C8: Arterial puncture at non-compressible site in previous 7 days
- 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:

- W1: Care-team unable to determine eligibility

- W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival
- W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission
- W4: Pregnancy
- W5: Patient/family refusal
- W7: Stroke severity too mild (non-disabling)
- W8: Recent acute myocardial infarction (within previous 3 months)
- W9: Seizure at onset with postictal residual neurological impairments
- W10: Major surgery or serious trauma within previous 14 days
- 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:

- AW1: Age > 80
- AW2: History of both diabetes and prior ischemic stroke
- AW3: Taking an oral anticoagulant regardless of INR
- AW4: Severe Stroke (NIHSS > 25)

Other Reasons (Hospital-related or other factors) 0-3-hour treatment window.

- Delay in Patient Arrival
- In-hospital Time Delay
- Delay in Stroke diagnosis
- No IV access
- Rapid or Early Improvement
- Advanced Age
- Stroke too severe
- 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.

- Delay in Patient Arrival
- In-hospital Time Delay
- Delay in Stroke diagnosis
- No IV access
- Rapid or Early Improvement
- Other – requires specific reason to be entered in the PMT when this option is selected

<p>If IV alteplase was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>If IV alteplase was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>If IV alteplase was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>Eligibility Reason(s):</p>	<ul style="list-style-type: none"> <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: _____
<p>Medical Reason(s):</p>	<ul style="list-style-type: none"> <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: _____
<p>Hospital Related or Other Reason(s):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> In-hospital time delay <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> Other _____
<p>IV alteplase at an outside hospital or Mobile Stroke Unit?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>

Investigational or experimental protocol for thrombolysis?	<input type="radio"/> Yes <input type="radio"/> No	If yes, specify _____
Additional Comments Related to Thrombolytics:		

ENDOVASCULAR THERAPY

Catheter-based stroke treatment at this hospital?	<input type="radio"/> Yes <input type="radio"/> No
IA alteplase or MER Initiation Date/Time	____/____/____ ____:____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> 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 Reperfusion Therapy (Thrombolytic or MER)	<input type="checkbox"/> Symptomatic Intracranial hemorrhage <36 hours <input type="checkbox"/> Life threatening, serious systemic hemorrhage <36 hours <input type="checkbox"/> UTD	<input type="checkbox"/> Other serious complications <input type="checkbox"/> No serious complications
	If bleeding complications occur in patient after IV alteplase: <input type="checkbox"/> Symptomatic hemorrhage detected prior to patient transfer <input type="checkbox"/> Symptomatic hemorrhage detected only after patient transfer	<input type="checkbox"/> Unable to determine <input type="checkbox"/> N/A

OTHER IN-HOSPITAL TREATMENT AND SCREENING

Dysphagia Screening		
Patient NPO throughout the entire hospital stay?	<input type="radio"/> Yes <input type="radio"/> No	
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	<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	<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
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What date was the initial VTE prophylaxis administered after hospital admission?	____/____/____ <input type="checkbox"/> Unknown
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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
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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
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Other Therapeutic Anticoagulation	<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> desirrudin (Iprivask) <input type="checkbox"/> argatroba <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> lepirudin (Refludan)	<input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> other anticoagulant
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Was DVT or PE documented?	<input type="radio"/> Yes <input type="radio"/> No/ND
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Was antithrombotic therapy administered by the end of hospital day 2?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC
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If yes, select all that apply	<input type="checkbox"/> Antiplatelet <input type="checkbox"/> Anticoagulant
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MEASUREMENTS (first measurement upon presentation to your hospital)

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 <input type="checkbox"/> ND	Blood Glucose (required if patient received IV alteplase): <input type="checkbox"/> ND _____ mg/dl			<input type="checkbox"/> Too Low <input type="checkbox"/> Too High
Serum Creatine:	_____ <input type="checkbox"/> ND			
INR:	_____ <input type="checkbox"/> ND <input type="checkbox"/> NC			
Vital Signs:	Heart Rate (beats per minute): _____ bpm		_____ / _____ <input type="checkbox"/> Vital signs UTD	
^What is the first blood pressure obtained prior to or after hospital arrival? (required if patient received IV alteplase)				
Height: _____	<input type="radio"/> in	<input type="radio"/> cm	<input type="radio"/> ND	
Weight: _____	<input type="radio"/> lbs	<input type="radio"/> kg	<input type="radio"/> ND	
Waist Circumference: _____	<input type="radio"/> in	<input type="radio"/> cm	<input type="radio"/> ND	
BMI: _____	<input type="checkbox"/> ND			
DISCHARGE INFORMATION				Discharge Tab
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 record <input type="radio"/> ND			
Total Score:	_____			
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="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> ticlopidine (Ticlid)	<input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra)	<input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> Unfractionated heparin IV <input type="radio"/> warfarin (Coumadin)	
	Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____	Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____

	If NC, documented contraindications	<input type="checkbox"/> Allergy to or complications r/t antithrombotic <input type="checkbox"/> Patient/Family refused <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 Measures Only <input type="checkbox"/> Other
Other Antithrombotic(s)	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No/ND	
	If yes,		
	Medication:	Dosage	Frequency
	<input type="checkbox"/> Desirudin (Iprivask)	1. _____	1. _____
	<input type="checkbox"/> Ticagrelor (Brilinta)	2. _____	2. _____
	<input type="checkbox"/> Prasugrel (Effient) *contraindicated in stroke and TIA	3. _____	3. _____
	<input type="checkbox"/> Other	4. _____	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	
Anti-hypertensive Tx (Select all that apply)	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> Other anti-hypertensive med <input type="checkbox"/> Ace Inhibitors <input type="checkbox"/> Beta Blockers	<input type="checkbox"/> None - Contraindicated <input type="checkbox"/> Diuretics <input type="checkbox"/> ARB <input type="checkbox"/> CA++ Channel Blockers	
Cholesterol-Reducing Tx (Select all that apply)	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> None – contraindicated <input type="checkbox"/> Statin <input type="checkbox"/> Fibrate	<input type="checkbox"/> Niacin <input type="checkbox"/> Absorption Inhibitor <input type="checkbox"/> PCSK 9 inhibitor <input type="checkbox"/> Other med	
Statin Medication:	<input type="checkbox"/> Amlodipine + Atorvastatin (Caduet) <input type="checkbox"/> Atorvastatin (Lipitor) <input type="checkbox"/> Ezetimibe + Simvastatin (Vytorin) <input type="checkbox"/> Fluvastatin (Lescol) <input type="checkbox"/> Fluvastatin XL (Lescol XL) <input type="checkbox"/> Lovastatin (Altoprev) <input type="checkbox"/> Lovastatin (Mevacor) <input type="checkbox"/> Lovastatin + Niacin (Advicor) <input type="checkbox"/> Pitavastatin (Livalo) <input type="checkbox"/> Pravastatin (Pravachol) <input type="checkbox"/> Rosuvastatin (Crestor) <input type="checkbox"/> Simvastatin (Zocor) <input type="checkbox"/> Simvastatin + Niacin (Simcor)	Statin Total Daily Dose:	_____
Documented Reason for Not Prescribing Guideline Recommended Dose?	<input type="checkbox"/> Intolerant to moderate (>75yr) or high (<=75yr) intensity statin <input type="checkbox"/> No evidence of atherosclerosis (cerebral, coronary, or peripheral vascular disease)	<input type="checkbox"/> Other documented reason <input type="checkbox"/> Unknown/ND	
Documented reason for not prescribing a statin medication at discharge?	<input type="radio"/> Yes <input type="radio"/> No		
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"/> Oral Glucose Tolerance	<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Test Other	
Anti-hyperglycemic medications:	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Class:	Medication:
		Class:	Medication:

	Class:	Medication:
	Class:	Medication:
	Was there a documented reason for not prescribing a medication with proven CVD benefit?	<input type="radio"/> Yes <input type="radio"/> No/ND
Follow-up appointment scheduled for diabetes management?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	
Date of scheduled diabetes follow-up appointment:	____/____/____ <input type="radio"/> Unknown	
Anti-Smoking Tx	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Smoking Cessation Therapies Prescribed (select all that apply)	<input type="checkbox"/> Counseling <input type="checkbox"/> Over the Counter Nicotine Replacement Therapy <input type="checkbox"/> Prescription Medications <input type="checkbox"/> Other <input type="checkbox"/> Treatment not specified	
Was the patient prescribed 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 Diabetic 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
How to Activate EMS for Stroke	<input type="radio"/> Yes <input type="radio"/> No	Need for Follow-Up After Discharge
Their Prescribed medications	<input type="radio"/> Yes <input type="radio"/> No	<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 in the 3 months prior <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 in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned	Carotid imaging <input type="radio"/> Performed during this admission or in the 3 months prior <input type="radio"/> Planned post discharge <input type="radio"/> Not performed or planned

<p>Hypercoagulability testing</p> <p><input type="radio"/> Performed during this admission or in the 3 months prior</p> <p><input type="radio"/> Planned post discharge</p> <p><input type="radio"/> Not performed or planned</p>	<p>Carotid revascularization</p> <p><input type="radio"/> Performed during this admission or in the 3 months prior</p> <p><input type="radio"/> Planned post discharge</p> <p><input type="radio"/> Not performed or planned</p>	<p>Extended surface cardiac rhythm monitoring > 7 days</p> <p><input type="radio"/> Performed during this admission or in the 3 months prior</p> <p><input type="radio"/> Planned post discharge</p> <p><input type="radio"/> Not performed or planned</p>
<p>Intracranial vascular imaging</p> <p><input type="radio"/> Performed during this admission or in the 3 months prior</p> <p><input type="radio"/> Planned post discharge</p> <p><input type="radio"/> Not performed or planned</p>	<p>Short-term cardiac rhythm monitoring <= 7 days</p> <p><input type="radio"/> Performed during this admission or in the 3 months prior</p> <p><input type="radio"/> Planned post discharge</p> <p><input type="radio"/> Not performed or planned</p>	

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 <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	

END OF FORM