Patient ID:		**Bold Question = Required**

DEMOGRAPHICS *Demographics Tab*

Gender	○ Male ○ Female ○ Unknown		
Date of Birth: _____/_____/_____		**Age:**	_____
Zip Code: _____ - _____ ☐ Homeless			
Payment Source	☐ Medicare Title 18 ☐ Medicaid – Private/ HMO/ PPO/ Other ☐ Self Pay/ No Insurance	☐ Medicaid Title 19 ☐ Private/ HMO/ PPO/ Other ☐ Other/ Not Documented/ UTD	☐ Medicare – Private/ HMO/ PPO/ Other ☐ VA/ CHAMPVA/ Tricare

RACE AND ETHNICITY

Race (Select all that apply):

☐ American Indian/Alaska Native
☐ Asian
[if Asian selected]
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American
☐ Native Hawaiian or Pacific Islander
[if native Hawaiian or pacific islander selected]
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White
☐ UTD

Hispanic Ethnicity:	○ Yes ○ No/UTD		
If Yes,	☐ Mexican, Mexican American, Chicano/a ☐ Another Hispanic, Latino or Spanish Origin	☐ Puerto Rican	☐ Cuban

ADMIN *Admin Tab*

Final clinical diagnosis related to stroke	○ Ischemic Stroke ○ Transient Ischemic Attack (<24 hours) ○ Subarachnoid Hemorrhage	○ Intracerebral Hemorrhage ○ Stroke not otherwise specified ○ No stroke related diagnosis ○ Elective Carotid Intervention only
If not Stroke Related Diagnosis:	○ Migraine ○ Seizure ○ Delirium	○ Electrolyte or metabolic imbalance ○ Functional disorder ○ Other ○ Uncertain
Was the Stroke etiology documented in the patient medical record:	○ Yes No	

Select documented stroke etiology (select all that apply**):**

- ○ 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis)
- ○ 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI)
- ○ 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm)
- ○ 4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders.
  - ○ Dissection
  - ○ Hypercoagulability
  - ○ Other
- ○ 5: Cryptogenic stroke (stroke of undetermined etiology)
  - ○ Multiple potential etiologies identified
  - ○ Stroke of undetermined etiology
  - ○ Unspecified

When is the earliest documentation of comfort measures only?	○ Day 0 or 1	○ Day 2 or after	○ Timing unclear	○ Not Documented/UTD
Arrival Date/Time:	____/_____/_____:____	☐ MM/DD/YYYY only ☐ Unknown	**Admit Date:**	_____/_____/_____

Not Admitted:	○ Yes, not admitted ○ No, patient admitted as in patient	Reason Not Admitted:	○ Transferred from your ED to another acute care hospital ○ Discharged directly from ED to home or other location that is not an acute care hospital ○ Left from ED AMA ○ Died in ED ○ Discharged from observation status without an inpatient admission ○ other
If patient transferred from your ED to another hospital, specify hospital name	[Select hospital name from picker list] ☐ Hospital not on list ☐ Hospital not documented		
Select reason(s) for why patient transferred	☐ 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		
Discharge Date:	____/_____/_____:____ ☐ MM/DD/YYYY only		
Documented reason for delay in transfer to referral facility?	○ Yes ○ No/ND		
Specific reason for delay documented in transfer patient (check all that apply):	☐ Social/religious ☐ Initial refusal ☐ Care team unable to determine eligibility ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Investigational or experimental protocol for reperfusion ☐ Delay in stroke diagnosis * ☐ In-hospital time delay * ☐ Equipment-related delay * ☐ Need for additional imaging* ☐ Catheter lab not available* ☐ Other *		
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	○ Inpatient Rehabilitation Facility (IRF) ○ Intermediate Care facility (ICF) ○ Long Term Care Hospital (LTCH)	○ Skilled Nursing Facility (SNF) ○ Other	

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 No Stroke or TIA Related ICD-10-CM Code Present	☐ _ ☐ _

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	○ Not in a healthcare setting ○ Another acute care facility ○ Chronic health care facility ○ Outpatient healthcare setting ○ Stroke occurred after hospital arrival (in ED/Obs/inpatient) ○ ND or Cannot be determined
How patient arrived at your hospital	○ EMS from home/scene ○ Mobile Stroke Unit ○ Private Transportation/Taxi/Other from home/scene ○ Transfer from another hospital ○ ND or Unknown
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
Was the patient an ED patient at the facility?	○ Yes ○ No
^Was the patient a direct admission to the hospital?	○ Yes ○ No
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
Initial Admitting Service	○ Neurology ○ Neurosurgery ○ Neurocritical Care ○ Medicine ○ Surgery ○ Other: _____
In which settings were care delivered? Select all that apply.	☐ Neuro/ Neurosurgery ICU ☐ Other ICU ☐ Stroke Unit (Non-ICU) ☐ General Care Floor ☐ Observation ☐ Other: _____
If the patient was not cared for in a dedicated stroke unit, was a formal inpatient consultation from a stroke expert obtained?	○ Yes ○ No ○ ND
Physician / Provider NPI:	

MEDICAL HISTORY

Previously known medical hx of:	☐ None ☐ Atrial Fib/Flutter ☐ Current Pregnancy (up to 6 weeks post-partum) ☐ Diabetes Mellitus ☐ Type I ☐ Type II ☐ ND Duration: ○ < 5 years ○ 5 - < 10 years ○ 10 - < 20 years ○ >= 20 years ○ Unknown	☐ CAD/ Prior MI ☐ DVT/ PE ☐ Drugs/ Alcohol Abuse ☐ Familial Hypercholesterolemia ☐ HRT ☐ Migraine ☐ Previous TIA ☐ Renal Insufficiency – Chronic ☐ Smoker	☐ Carotid Stenosis ☐ Dementia ☐ Depression ☐ Dyslipidemia ☐ Family History of Stroke ☐ Hx of Emerging Infectious Disease ☐ MERS ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ Other Infectious Respiratory Pathogen ☐ Obesity Overweight ☐ Prosthetic Heart Valve

	☐ E-Cigarette Use (Vaping) ☐ Sickle Cell ☐ HF ☐ Hypertension ☐ Previous Stroke ☐ Ischemic Stroke ☐ ICH ☐ SAH ☐ Not Specified ☐ PVD ☐ Sleep Apnea
Ambulatory status prior to current event	○ Able to ambulate independently (no help from another person) w/ or w/o device ○ With assistance (from person) ○ Unable to ambulate ○ ND
Pre-stroke Modified Rankin Score	○ 1 – A score value of 0, 1, or 2 was documented in the medical record, OR physician/ APN/PA documentation that the patient was able to look after self without daily help prior to this acute stroke episode. ○ 2- A score value of 3, 4, or 5 was documented in the medical record, OR physician/ APN/ PA documentation that the present could NOT look after self without daily help prior to this acute stroke episode. ○ 3 – A score value was not documented, OR unable to determine (UTD) from the medical record documentation

DIAGNOSIS & EVALUATION

Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)	○ Less than 10 minutes ○ 10 – 59 minutes ○ > = 60 minutes ○ ND
Had stroke symptoms resolved at time of presentation?	○ Yes ○ No ○ ND
Initial NIH Stroke Scale	○ Yes ○ No/ND
If yes:	○ Actual ○ Estimate from record ○ ND
Total Score:	_____ (refer to web program for questions)
^What is the first NIHSS score obtained prior to or after hospital arrival?	_____ ☐ UTD
^Was the initial NIHSS score after hospital arrival less than 6?	○Yes ○No
^Is there documentation that an initial NIHSS score was done at this hospital	○Yes ○No
^What is the date and time that the NIHSS score was first performed at this hospital?	____/____/_____:____ ☐MM/DD/YYY only ☐Unknown
NIHSS score obtained from transferring facility:	_____ ○ ND
Initial exam findings (Select all that apply)	☐ Weakness/Paresis ☐ Altered Level of Consciousness ☐ Aphasia/Language Disturbance ☐ Other neurological signs/symptoms ☐ No neurological signs/symptoms ☐ND
Ambulatory status on admission	○ Able to ambulate independently (no help from another person) w/ or w/o device ○ With assistance (from person) ○ Unable to ambulate ○ ND

HEMORRHAGIC STROKE SCALES

^^First Glasgow Coma Scale (GCS)	Eye ____	Verbal ____	☐ Intubated	Motor _____	Total GCS _____ ☐ ND

SUBARACHNOID HEMORRHAGE (SAH)

^Is there documentation any time during the hospital stay that the hemorrhage was non-aneurysmal or due to head trauma?	○Yes ○No
^Was an initial Hunt and Hess scale done at this hospital?	○Yes ○No
^^If yes, Hunt and Hess score:	_____

^What is the date and time that the Hunt and Hess Scale was first performed at this hospital?	____/_____/_____:____ ☐MM/DD/YYY only ☐Unknown
^^WFNS SAH Grading Scale	_____

INTRACEREBRAL HEMORRHAGE (ICH)

^Was an initial ICH score done at this hospital?	○Yes ○No
^^If yes, ICH score:	_____
^What is the date and time that the ICH score was first performed at this hospital?	____/_____/_____:____ ☐MM/DD/YYY only ☐Unknown
^^FUNC Score (ICH)	_____

MEDICATION PRIOR TO ADMISSION

No medications prior to admission ☐

Antiplatelet or Anticoagulant Medication(s): ☐ Yes ☐ No/ND

☐ **Antiplatelet Medication**
- ○ aspirin
- ○ aspirin/dipyridamole (Aggrenox)
- ○ clopidogrel (Plavix)
- ○ prasugrel (Effient)
- ○ ticagrelor (Brilinta)
- ○ ticlopidine (Ticlid)
- ○ Other Antiplatelet

☐ **Anticoagulant Medication**
- ○ apixaban (Eliquis)
- ○ argatroban
- ○ dabigatran (Pradaxa)
- ○ desirudin (Iprivask)
- ○ endoxaban (Savaysa)
- ○ fondaparinux (Arixtra)
- ○ full dose LMW heparin
- ○ lepirudin (Refludan)
- ○ rivaroxaban (Xarelto)
- ○ unfractionated heparin IV
- ○ warfarin (Coumadin)
- ○ other Anticoagulant

Antihypertensive	○ Yes ○ No/ND
Cholesterol-Reducer	○ Yes ○ No/ND
Anti-hyperglycemic medications:	○ Yes ○ No/ND

If yes, select medications (select all that apply)

☐ DPP-4 Inhibitors ☐ SGLT2 inhibitor ☐ Other injectable/ subcutaneous agent ☐ GLP-1 receptor agonist ☐ Sulfonylurea ☐ Insulin ☐ Thiazolidinedione ☐ Metformin ☐ Other oral agent

Antidepressant medication	○ Yes ○ No/ND

VACCINATIONS & TESTING

COVID-19 Vaccination:	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD
COVID-19 Vaccination date:	____/____/_____ ○ Not Documented
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND
Influenza Vaccination:	○ Influenza vaccine was given during this hospitalization during the current flu season ○ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ○ Documentation of patient's refusal of influenza vaccine ○ Allergy/sensitivity to influenza vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD

SYMPTOM TIMELINE ***Hospitalization Tab***

Date/Time Patient last known to be well?	☐Time of Discovery	Date/Time of discovery of stroke symptoms?

____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown	same as Last Known well	____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown	

Comments:	

BRAIN IMAGING

Brain imaging completed at your hospital for this episode of care?	○Yes ☐CT ☐MRI ○No/ND ○NC	**Date/Time Brain Imaging First Initiated at your hospital:**	____/____/_____:____ ☐ MM/DD/YYYY only ☐ Unknown

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?	○ Yes ○ No	Date/Time 1st vessel or perfusion imaging initiated at your hospital: ___/____/_____:____	☐ MM/DD/YYYY only ☐ Unknown

If yes, type of vascular imaging (select all that apply)	☐CTA ☐MR Perfusion ☐CT Perfusion ☐DSA (catheter angiography) ☐MRA ☐Image type not documented
Was a target lesion (large vessel occlusion) visualized?	○ Yes ○ No/ND
If yes, select site of large vessel occlusion (select al that apply):	☐ ICA ☐ Intracranial ICA ☐ Cervical ICA ☐ Other/UTD ☐ MCA ☐ M1 ☐ M2 ☐ Other/UTD ☐ Basilar ☐ Other cerebral artery branch ☐ Vertebral Artery

ADDITIONAL TIME TRACKER

Date/Time Stroke Team Activated: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Stroke Team Arrived: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Date/Time of ED Physician Assessment: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Neurosurgical services consult: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Date/Time Brain Imaging Ordered: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Brain Imaging Interpreted: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Date/Time IV alteplase Ordered: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A		
Date/Time Lab Tests Ordered: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown N/A	Date/Time lab Tests Completed: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Date/Time ECG Ordered: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time ECG Completed: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown
Date/Time Chest X-ray Ordered: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown	Date/Time Chest X-ray Completed: ____/____/_____ ____:_____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown

	○ N/A		
Additional Comments:			

IV THROMBOLYTIC THERAPY

IV thrombolytic initiated at this hospital?	○ Yes ○ No	**Date/Time IV thrombolytic initiated:** ____/____/_____ ____:_____
Thrombolytic used:	○ Alteplase (Class 1 evidence) Alteplase, total dose: _____(mg) ☐ Alteplase dose ND	○ Tenecteplase (Class 2b evidence) Tenecteplase, total dose: _____(mg) ☐ Tenecteplase dose ND
Reason for selecting tenecteplase instead of alteplase:	○ Large Vessel Occlusion (LVO) with potential thrombectomy ○ Mild Stroke ○ Other: _____	
If IV thrombolytic administered beyond 4.5-hour, was imaging used to identify eligibility?	○ Yes, Diffusion-FLAIR mismatch ○ Yes, Core-Perfusion mismatch ○ None ○ Other: _____	
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*

If IV thrombolytic was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No
If IV thrombolytic was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No
If IV thrombolytic was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No

Eligibility Reason(s):	☐ Social/Religious ☐ Initial refusal ☐ Care-team unable to determine eligibility ☐ Specify eligibility reason:_____

Medical Reason(s):	☐ Hypertension requiring aggressive control with IV medications ☐ Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 50), seizures, or major metabolic disorders ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Investigational or experimental protocol for thrombolysis ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Specify medical reason: _____
Hospital Related or Other Reason(s):	☐ Need for additional imaging ☐ Delay in stroke diagnosis ☐ In-hospital time delay ☐ Equipment-related delay ☐ Other _____
IV thrombolytic at an outside hospital or Mobile Stroke Unit?	○ Yes ○ No
If yes, select thrombolytic administered at outside hospital or Mobile Stroke Unit	○ Alteplase ○ Tenecteplase
Investigational or experimental protocol for thrombolysis?	○ Yes ○ No If yes, specify_____
Additional Comments Related to Thrombolytics:	

ENDOVASCULAR THERAPY

Is there documentation of a suspected LVO in the medical record?	○ Yes ○ No
Is there documentation in the medical record that the patient is eligible for MER therapy or a mechanical thrombectomy procedure?	○ Yes ○ No
Catheter-based stroke treatment at this hospital?	○ Yes ○ No
IA alteplase or MER Initiation Date/Time	____/____/_____ ____:_____ ☐ MM/DD/YYYY only ☐ Unknown
Catheter-based stroke treatment at outside hospital?	○ Yes ○ 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)	☐ Symptomatic Intracranial hemorrhage <36 hours ☐ Life threatening, serious systemic hemorrhage <36 hours ☐ UTD	☐ Other serious complications ☐ No serious complications
If bleeding complications occur in patient after IV alteplase:	○ Symptomatic hemorrhage detected prior to patient transfer ○ Symptomatic hemorrhage detected only after patient transfer	○ Unable to determine ○ N/A

OTHER IN-HOSPITAL TREATMENT AND SCREENING

Dysphagia Screening

Patient NPO throughout the entire hospital stay?	○ Yes	○ No/ND	
Was patient screened for dysphagia prior to any oral intake including water or medications?	○ Yes	○ No/ND	○ NC
If yes, Dysphagia screening results:	○ Pass	○ Fail	○ ND
Treatment for Hospital-Acquired Pneumonia	○ Yes	○ No	○ NC

VTE Interventions	☐ 1- Low dose unfractionated heparin (LDUH) ☐ 2- Low molecular weight heparin (LMWH) ☐ 3- Intermittent pneumatic compression devices (IPC) ☐ 4- Graduated compression stockings (GCS) ☐ 5- Factor Xa Inhibitor ☐ 6- Warfarin ☐ 7- Venous foot pumps (VFP) ☐ 8-Oral Factor Xa Inhibitor ☐ 9- Aspirin ☐ A- None of the above or ND
What date was the initial VTE prophylaxis administered after hospital admission?	_____/_____/_____ ☐ Unknown
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?	○ Yes ○ 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?	○ Yes ○ No
Other Therapeutic Anticoagulation	☐ apixaban (Eliquis) ☐ desirrudin (Iprivask) ☐ rivaroxaban (Xaralto) ☐ argatroba ☐ endoxaban (Savaysa) ☐ unfractionated heparin IV ☐ dabigatran (Pradaxa) ☐ lepirudin (Refludan) ☐ other anticoagulant
Was DVT or PE documented?	○ Yes ○ No/ND
Was antithrombotic therapy administered by the end of hospital day 2?	○ Yes ○ No/ND ○ NC
Active bacterial or viral infection at admission or during hospitalization:	☐ None ☐ Bacterial Infection ☐ Emerging Infectious Disease ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ MERS ☐ Other Emerging Infectious Disease ☐ Influenza ☐ Seasonal Cold ☐ Other Viral Infection

MEASUREMENTS (first measurement upon presentation to your hospital)

Total Chol: _____ mg/dl	Triglycerides: _____ mg/dl	HDL: _____ mg/dl	**LDL:** _____ **mg/dl**	☐ Lipids: NC ☐ Lipids: ND
A_1C: _____ % A_1C ☐ ND	Blood Glucose (required if patient received IV alteplase): _____ mg/dl ☐ ND ☐ Too Low ☐ Too High			
Serum Creatine: _____ ☐ ND	^What is the first platelet count obtained prior to or after hospital arrival? _____			
INR: _____ ☐ ND ☐ NC				
^Is there documentation in the medical record that the INR value performed closest to hospital arrival was greater than 1.4?	○Yes	○No		
Vital Signs:	Heart Rate (beats per minute): _____ bpm ^What is the first blood pressure obtained prior to or after hospital arrival? (required if patient received IV alteplase) _____/_____ ☐ Vital signs UTD			
Height: _____	○in	○cm	○ND	
Weight: _____	○lbs	○kg	○ND	
Waist Circumference: _____	○in	○cm	○ND	
BMI: _____	☐ ND			

CATHETER-BASED/ENDOVASCULAR STROKE TREATMENT	*Advanced stroke Care Tab*
^Is there documentation that the route of alteplase administration was intra-arterial (IA)?	○Yes ○No
^Is there documentation that IA thrombolytic therapy was initiated at this hospital?	○Yes ○No
^What is the date and time that IA thrombolytic therapy was initiated for this patient at this hospital?	____/____/_____ ____:_____ ☐ MM/DD/YYYY only ☐ Unknown
^Is there documentation in the medical record that the first endovascular treatment procedure was initiated greater than 8 hours after arrival at this hospital?	○ Yes ○ No
^Is there documentation of skin puncture at this hospital to access the arterial site selected for endovascular treatment of a cerebral artery occlusion?	○ Yes ○ No
^What is the date and time of skin puncture at this hospital to access the arterial site selected for endovascular treatment of a cerebral artery occlusion?	____/____/_____ ____:_____ ☐ MM/DD/YYYY only ☐ Unknown
^Did the patient receive intravenous (IV) alteplase at this hospital or a transferring hospital prior to receiving intra-arterial (IA) alteplase or mechanical reperfusion therapy at this hospital?	○ Yes ○ No
^^Was a mechanical endovascular reperfusion procedure attempted during this episode of care (at this hospital)?	○ Yes ○ No
^Was a mechanical thrombectomy procedure attempted but unsuccessful or aborted before removal of the LVO?	○ Yes ○ No
^^Are reasons for not performing mechanical endovascular reperfusion therapy documented?	○ Yes ○ No
^^Reasons for not performing mechanical endovascular reperfusion therapy (select all that apply):	☐ Significant pre-stroke disability (pre-stroke mRS > 1) ☐ No evidence of proximal occlusion ☐ NIHSS <6 ☐ Brain imaging not favorable/hemorrhage transformation (ASPECTS score <6) ☐ Groin puncture could not be initiated within 6 hours of symptom onset ☐ Anatomical reason - unfavorable vascular anatomy that limits access to the occluded artery ☐ Patient/family refusal ☐ MER performed at outside hospital ☐ Allergy to contrast material ☐ Equipment-related delay * ☐ No endovascular specialist available * ☐ Delay in stroke diagnosis * ☐ Vascular imaging not performed * ☐ Advanced Age * ☐ Other * * These reasons do not exclude from measure population
^^If MER treatment at this hospital, type of treatment:	☐ Retrievable stent ☐ Other mechanical clot retrieval device beside stent retrieval ☐ Clot suction device ☐ Intracranial angioplasty, with or without permanent stent ☐ Cervical carotid angioplasty, with or without permanent stent ☐ Other
^Is there documentation in the medical record of the first pass of a mechanical reperfusion device to remove a clot occluding a cerebral artery at this hospital?	○ Yes ○ No
^What is the date and time of the first pass of a clot retrieval device at this hospital?	____/____/_____ ____:_____ ☐ MM/DD/YYYY only Unknown
^^Is a cause(s) for delay in performing mechanical endovascular reperfusion therapy documented?	○ Yes ○ No
^^Reasons for delay (select all that apply):	☐ Social/religious ☐ Initial refusal ☐ Care-team unable to determine eligibility ☐ Management of concurrent emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Investigational or experimental protocol for thrombolysis ☐ Additional proximal vascular procedure required prior to first pass (stent) ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Delay in stroke diagnosis * ☐ In-hospital time delay *

	☐ Equipment-related delay * ☐ Need for additional imaging* ☐ Catheter lab not available * ☐ Other *
^What is the location of the clot in the cerebral circulation?	○ Proximal cerebral occlusion ○ Distal cerebral occlusion ○ Neither proximal or distal, OR unable to determine (UTD) from the medical record documentation
^What cerebral artery is occluded?	○ Anterior cerebral artery (ACA) ○ A1 ACA ○ Anterior communicating artery ○ Internal carotid artery (ICA) ○ ICA terminus (T-lesion; T occlusion) ○ Middle cerebral artery (MCA) ○ M1 MCA ○ M2 MCA ○ M3/M4 MCA ○ Vertebral artery (VA) ○ Basilar artery (BA) ○ Posterior cerebral artery (PCA) ○ Other cerebral artery branch/segment ○ The clinical location of the primary occluded vessel was not documented, OR unable to determine (UTD) from the medical record documentation.
^^Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade	○ Grade 0 ○ Grade 1 ○ Grade 2a ○ Grade 2b ○ Grade 3 ○ ND

^Is there a documented TICI reperfusion grade post-treatment?	○1 - A TICI reperfusion grade greater than or equal to (>=) 2B was documented posttreatment	○2 - A TICI reperfusion grade less than (<) 2B was documented post-treatment	○3 - A TICI reperfusion grade was not done post-treatment, OR Unable to determine (UTD) from the medical record documentation

^What was the date and time that a TICI was first documented during the mechanical thrombectomy procedure?	____/____/_____ ____:_____	☐ MM/DD/YYYY only ☐ Unknown

COMPLICATIONS

^Was there a positive finding on brain imaging of parenchymal hematoma, SAH, and/or IVH following IV or IA alteplase, or mechanical endovascular reperfusion therapy initiation?	○Yes ○No
^Date/Time of positive brain image :	____/____/_____ ____:_____ ☐ MM/DD/YYYY only ☐ Unknown
^^Results of positive brain image	☐ PH2 (Parenchymal Hematoma Type 2) ☐ IVH (Intraventricular Hemorrhage) ☐ SAH (Subarachnoid Hemorrhage) ☐ RIH (Remote site of intraparenchymal hemorrhage outside the area of infarction) ☐ Other positive finding not listed above ☐ Not documented
^What is the last NIHSS score documented prior to initiation of alteplase at this hospital?	_____
This score obtained from:	○ Baseline NIHSS ○ Subsequent NIHSS
^What is the highest NIHSS score documented within 36 hours following initiation of IV alteplase?	_____
^What is the last NIHSS score documented prior to initiation of IA alteplase or MER at this hospital?	_____
This score obtained from:	○ Baseline NIHSS ○ Subsequent NIHSS
^What is the highest NIHSS score documented within 36 hours following IA alteplase or MER initiation?	_____
^Is there documentation that a procoagulant reversal agent was	○ Yes ○ No

initiated at this hospital?	
^^Date/Time procoagulant initiated	____/____/_____ ____:____ ☐ MM/DD/YYYY only ☐ Unknown
^Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not administering a procoagulant reversal agent?	○ Yes ○ No
^^If initial INR > 1.4 and treated with procoagulant, Date/Time first INR <= 1.4 after treatment:	____/____/_____ ____:____ ☐ MM/DD/YYYY only ☐ Unknown ☐ No documented INR <= 1.4 after tx

HEMORRHAGIC STROKE TREATMENT

^Is there documentation that nimodipine was administered at this hospital?	○ Yes ○ No
^What is the date and time that nimodipine was first administered to this patient at this hospital?	____/____/_____ ____:____ ☐ MM/DD/YYYY only ☐ Unknown
^Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not administering nimodipine treatment?	○ Yes ○ No
^^Surgical treatment for ICH at this hospital?	○ Yes ○ No
^^If surgical treatment for ICH at this hospital, type:	☐ External Ventricular Drain (EVD) ☐ Endoscopic evacuation ☐ Conventional craniotomy and evacuation of clot under direct vision ☐ Stereotaxic evacuation ☐ Hemicraniectomy without clot evacuation ☐ Fibrinolytic infusion via catheter ☐ Other
^^If ICH was evacuated, time from ictus to evacuation procedure start was:	_____ hours

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	○ Yes	○ No/ND
If Yes:	○ Actual	○ Estimated from record ○ ND
Total Score:	_____	

Ambulatory status at discharge	○ Able to ambulate independently (no help from another person) w/ or w/o device ○ With assistance (from person) ○ Unable to ambulate ○ ND
Discharge Blood Pressure (Measurement closest to discharge)	_____/_____ mmHg (Systolic/Diastolic) ☐ ND

DISCHARGE TREATMENTS

Antithrombotic Therapy approved in stroke	Prescribed?	○ Yes ○ No/ND ○ NC	
	If yes,		
	☐ Antiplatelet	☐ Anticoagulant	
	○ aspirin ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ ticlopidine (Ticlid)	○ apixaban (Eliquis) ○ argatroban ○ dabigatran (Pradaxa) ○ endoxaban (Savaysa) ○ fondaparinux (Arixtra)	○ full dose LMW heparin ○ lepirudin (Refludan) ○ rivaroxaban (Xarelto) ○ Unfractionated heparin IV ○ 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	☐ Allergy to or complications r/t antithrombotic ☐ Patient/Family refused ☐ Risk for bleeding or discontinued due to bleeding	☐ Serious side effect to medication ☐ Terminal illness/Comfort Measures Only ☐ Other	
Other Antithrombotic(s)	Prescribed?	○ Yes ○ No		
	If yes,			
	Medication: ☐ Desirudin (Iprivask) ☐ Ticagrelor (Brilinta) ☐ Prasugrel (Effient) *contraindicated in stroke and TIA ☐ Other		Dosage 1. _____ 2. _____ 3. _____ 4. _____	Frequency 1. _____ 2. _____ 3. _____ 4. _____
Persistent or Paroxysmal Atrial Fibrillation/Flutter	○ Yes ○ No			
If atrial fib/flutter or history of PAF documented, was patient discharged on anticoagulation?	○ Yes ○ No/ND ○ NC			
If NC, documented reasons for no anticoagulation	☐ Allergy to or complication r/t warfarin or heparins ☐ Mental status ☐ Patient refused ☐ Risk for bleeding or discontinued due to bleeding		☐ Risk for falls ☐ Serious side effect to medication ☐ Terminal illness/Comfort Measures Only	
Anti-hypertensive Tx (Select all that apply)	☐ None prescribed/ND ☐ Other anti-hypertensive med ☐ Ace Inhibitors ☐ Beta Blockers	☐ None - Contraindicated ☐ Diuretics ☐ ARB ☐ CA++ Channel Blockers		
Cholesterol-Reducing Tx (Select all that apply)	☐ None prescribed/ND ☐ None – contraindicated ☐ Statin ☐ Fibrate	☐ Niacin ☐ Absorption Inhibitor ☐ PCSK 9 inhibitor ☐ Other med		
Statin Medication:	☐ Amlodipine + Atorvastatin (Caduet) ☐ Atorvastatin (Lipitor) ☐ Ezetimibe + Simvastatin (Vytorin) ☐ Fluvastatin (Lescol) ☐ Fluvastatin XL (Lescol XL) ☐ Lovastatin (Altoprev) ☐ Lovastatin (Mevacor) ☐ Lovastatin + Niacin (Advicor) ☐ Pitavastatin (Livalo) ☐ Pravastatin (Pravachol) ☐ Rosuvastatin (Crestor) ☐ Simvastatin (Zocor) ☐ Simvastatin + Niacin (Simcor)		**Statin Total Daily Dose:**	_____
Documented Reason for Not Prescribing Guideline Recommended Dose?	☐ Intolerant to moderate (>75yr) or high (<=75yr) intensity statin ☐ No evidence of atherosclerosis (cerebral, coronary, or peripheral vascular disease)		☐ Other documented reason ☐ Unknown/ND	
Documented reason for not prescribing a statin medication at discharge?	○ Yes ○ No			

New Diagnosis of Diabetes?		○ Yes ○ No ○ ND	
Basis for Diagnosis (Select all that apply)		☐ HbA1c ☐ Oral Glucose Tolerance	☐ Fasting Blood Sugar ☐ Test Other
Anti-hyperglycemic medications:	**Prescribed?**	○ Yes ○ No ○ 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?	○ Yes ○ No/ND	
Follow-up appointment scheduled for diabetes management?		○ Yes ○ No/ND ○ NC	
Date of scheduled diabetes follow-up appointment:		_____/_____/_____ ○ Unknown	
Anti-Smoking Tx		○ Yes ○ No/ND ○ NC	
Smoking Cessation Therapies Prescribed (select all that apply		☐ Counseling ☐ Over the Counter Nicotine Replacement Therapy ☐ Prescription Medications ☐ Other ☐ Treatment not specified	
Was the patient prescribed any antidepressant class of medication at discharge?		○ Yes, SSRI ○ Yes, any other antidepressant class ○ No/ND	

OTHER LIFESTYLE INTERVENTIONS

Reducing weight and/or increasing activity recommendations	○ Yes	○ No/ND	○ NC
TLC Diet or Equivalent	○ Yes	○ No/ND	○ NC
Antihypertensive Diet	○ Yes	○ No/ND	○ NC
Was Diabetic Teaching Provided?	○ Yes	○ No/ND	○ NC

STROKE EDUCATION

Patient and/or caregiver received education and/or resource materials regarding all the following:

Check all as Yes: ☐

Risk Factors for Stroke	○ Yes ○ No	**Stroke Warning Signs and Symptoms**	○ Yes ○ No
How to Activate EMS for Stroke	○ Yes ○ No	**Need for Follow-Up After Discharge**	○ Yes ○ No
Their Prescribed medications	○ Yes ○ No		

STROKE REHABILITATION

Patient assessed for and/or received rehabilitation services during this hospitalization?	○ Yes ○ No	
Check all rehab services that patient received or was assessed for:	☐ Patient received rehabilitation services during hospitalization ☐ Patient transferred to rehabilitation facility ☐ Patient referred to rehabilitation services following discharge ☐ Patient ineligible to receive rehabilitation services because symptoms resolved ☐ Patient ineligible to receive rehabilitation services due to impairment (i.e. poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen	

HEALTH RELATED SOCIAL NEEDS ASSESSMENT	
During this admission, was a standardized health related social needs form or assessment completed?	○ Yes ○ No/ND
If Yes, identify the areas of unmet social need. Select all that apply.	☐ Living Situation/ Housing ☐ Employment ☐ Food ☐ Education ☐ Utilities ☐ Mental Health ☐ None ☐ Personal Safety ☐ Substance Use ☐ Financial Strain ☐ Transportation Barriers

STROKE DIAGNOSTIC TESTS AND INTERVENTIONS		
Cardiac ultrasound/echocardiography ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Extended implantable cardiac rhythm monitoring ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Carotid imaging ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned
Hypercoagulability testing ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Carotid revascularization ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Extended surface cardiac rhythm monitoring > 7 days ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned
Intracranial vascular imaging ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Short-term cardiac rhythm monitoring <= 7 days ○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ 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	Field10

Field 11			Field 12		
Field 13	____/____/____ ____:____	☐MM/DD/YYY ☐Unknown	Field 14	____/____/____ ____:____	☐MM/DD/YYY ☐Unknown
Additional Comments:					

Administrative			
PMT used concurrently or retrospectively or combination?	○ Concurrently	○ Retrospectively	○ Combination
Was a stroke admission order set used in this patient?	○ Yes	○ No	
Was a stroke discharge checklist used in this patient?	○ Yes	○ No	
Patient adherence contract/compact used?	○ Yes	○ No	

Outpatient			*Outpatient Tab*
Patient			
Encounter Date:	___/___/_____	**E/M Code:**	_____

What is the date/time the patient departed from the emergency department?	___/___/_____ ____:____ ☐ MM/DD/YYYY only ☐ Unknown
For discharges on or after 07/01/2012: What was the patient's discharge code from the outpatient setting?	☐

Core Measure Tab

CORE MEASURE TAB (many elements are auto-populated within the online PMT)

Check if patient is part of a sample	☐					
First Name		Last Name				
Race	☐ Black or African American	☐ American Indian or Alaska Native	☐Asian (2020) / Asian or Pacific Islander (2021)	☐ White	☐ Native Hawaiian or Pacific Islander (discharges prior to 2021)	☐UTD
Zip Code	-	Homeless	☐			
What is the patient's source of payment for this episode of care?	☐☐Medicare ☐☐Non-Medicare					
HIC Number						

History & Last Known Well

Was there physician/APN/PA documentation of a diagnosis, signed ECG tracing, or a history of ANY atrial fibrillation/flutter in the medical record?	☐☐Yes ☐☐No
Is there documentation that the patient was on a lipid-lowering medication prior to hospital arrival?	☐☐Yes ☐☐No
Is there documentation that the date and time of last known well was witnessed or reported?	☐☐Yes ☐☐No
What was the date and time at which the patient was last known to be well or at his or her baseline state of	___/___/_____ ____:____ ☐ MM/DD/YYYY only ☐ Unknown
When is the earliest physician/APN/PA documentation of comfort measures only?	☐☐Day 0 or 1 ☐☐Day 2 or after ☐☐Timing unclear ☐☐Not Documented/UTD

Thrombolytics

Is there documentation that IV alteplase therapy initiated at this hospital?	☐☐Yes ☐☐No
Is there documentation on the day of or day after hospital arrival of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours of Time Last Known Well?	☐☐Yes ☐☐No
Did the patient receive IV or IA alteplase at this hospital or within 24 hours prior to arrival?	☐☐Yes ☐☐No
Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic?	☐☐Yes ☐☐No

Early Antithrombotics

Was antithrombotic therapy administered by the end of hospital day 2?	☐☐Yes ☐☐No

Labs

Was the LDL-cholesterol (LDL-c) measured within the first 48 hours or 30 days prior to hospital arrival?	☐☐Yes ☐☐No
Was the patient's highest LDL-cholesterol (LDL-c) level greater than or equal to 100 mg/dL in the first 48 hours or within 30 days prior to hospital arrival?	☐☐Yes ☐☐No

Discharge Information

Discharge Date/Time	___/___/_____ ____:____	☐ MM/DD/YYYY only ☐Unknown
Was antithrombotic therapy prescribed at hospital discharge?		☐☐Yes ☐☐No
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 prescribing antithrombotic therapy at hospital discharge?		☐☐Yes ☐☐No
Was anticoagulation therapy prescribed at hospital discharge?		☐☐Yes ☐☐No
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 prescribing anticoagulation therapy at hospital discharge?		☐☐Yes ☐☐No
Was a statin medication prescribed at discharge?		☐☐Yes ☐☐No

Stroke Core Measure Additional Comments:

CSTK Additional Comments:

END OF FORM