American Heart Association. Get With The Guidelines. Stroke

GWTG-Stroke Case Report Form (CRF)
December 2025

Layer / Element Groups: ShowAll

Pink Font = New/Updated

Required = required to save as complete
Warning = encouraged but not required

Tab	Element	Allowable Values	GWTG	TJC	DNV	Special	Any Criteria for Required
All	**Patient ID:**	_____					Required
Demographics	**Georgia LONGID:**	_____				GA-Coverdell	None
Demographics	**Stroke Band ID:**	_____				Arkansas	Required
Demographics	**Patient First Name:**	_____	PHI				None
Demographics	**Patient Last Name:**	_____	PHI				None
Demographics	**Gender**	○ Male Gender ○ Female Gender ○ Gender Diverse				Canada	None
Demographics	**Sex:**	○ Male ○ Female				Mexico	None
Demographics	**Patient Gender Identity:**	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other: _____ ○ Did not disclose	Stroke, Stroke-Limited	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS	None
Demographics	**Patient-Identified Sexual Orientation:**	○ Straight or heterosexual ○ Lesbian or gay ○ Bisexual ○ Queer, pansexual, and/or questioning ○ Something else, please specify: ____ ○ Don't know ○ Declined to answer ○ Other Patient-Identified Sexual Orientation:_____	Stroke, Stroke-Limited	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS	None
Demographics	**Date of Birth:**	_____ / _____ / _____	Stroke, Stroke-Limited	ASR, CSTK, STK, TSC		LA-EMS, Middle-East, Canada, Mexico	Required
Demographics	**Age:**	_____	Stroke, Stroke-Limited, BPCI	TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico, ShowAll	Required
Demographics	**Homeless**	☐	Stroke			MDCHIA, Canada, Mexico, Arkansas	None
Demographics	**State:**	▽ _____				Mexico	None
Demographics	**Zip Code:**	_____	Stroke			MDCHIA, Arkansas	None (Stroke) Required (AR)
Demographics	**Patient Postal Code:**	_____				Canada	None
Demographics	**Patient Postal Code:**	_____				Mexico	None
Demographics	**Province or Territory**	▽ _____				Canada	None
Demographics	**Street Address:**	_____	PHI				None
Demographics	**Payment Source:**	☐ Medicare Title 18 ☐ Medicaid Title 19 ☐ Medicare - Private/HMO/PPO/Other ☐ Medicaid - Private/HMO/PPO/Other ☐ Private/HMO/PPO/Other ☐ VA/CHAMPVA/Tricare ☐ Self-Pay/No Insurance ☐ Other/Not Documented/UTD	Stroke			Coverdell, Ohio, Michigan, MDCHIA	Required
Demographics	**Payment Source:**	☐ Government Insurance ☐ Private insurance ☐ Combination Government/Private ☐ No insurance				Mexico	None
Demographics	**Government Insurance Type:**	☐ IMSS ☐ ISSSTE ☐ INSABI ☐ EJERCITO ☐ MARINA ☐ PEMEX				Mexico	None
Demographics	**What is the patient's source of payment for this episode of care?**	○ Medicare ○ Non-Medicare		ASR, CSTK, STK, TSC			Required
Demographics	**MBI:**	_____	PHI				None
Demographics	**Medical Record Number:**	_____	MRN				None
	Race and Ethnicity						
Demographics	**Race and/or Ethnicity:**	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ UTD	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS	Required
Demographics	**American Indian/Alaska Native - MDH**	☐ Anishinaabe/Ojibwa ☐ Dakota/Lakota ☐ Other American Indian or Alaska Native Tribal Nation				MDH	None

Demographics	**Black or African American - MDH**	☐ African American ☐ Ethiopian ☐ Ghanaian ☐ Kenyan ☐ Liberian ☐ Nigerian ☐ Somali ☐ Sudanese ☐ Other Black Ethnicity				MDH	None
Demographics	**White - MDH**	☐ Russian ☐ Other White Ethnicity				MDH	None
Demographics	**Race:**	☐ Black ☐ East/ Southeast Asian ☐ Indigenous ☐ First Nations ☐ Metis ☐ Inuk/Inuit ☐ Prefer not to answer (Indigenous) ☐ Latino ☐ Middle Eastern ☐ South Asian ☐ White ☐ Another Race Category ☐ Do not know ☐ Prefer not to answer				Canada	None
Demographics	**Race:**	☐ Blanco (White) ☐ Mestizo (Half Blood) ☐ Indigena (Indian) ☐ Negro (Black) ☐ Mulato (Mulatto) ☐ Asiatico (Asian) ☐ Otro (Other)				Mexico	None
Demographics	**Ethnicity:**	☐ Black ☐ White ☐ Asian ☐ UTD ☐ Arab/Middle Eastern ☐ Other				Middle-East	None
Demographics	**Asian Ethnicity:**	☐ Asian Indian ☐ Bangladeshi ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Pakistani ☐ Vietnamese ☐ Other Asian				Middle-East	None
Demographics	**If Asian:**	☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	Stroke, Stroke-Limited			Coverdell, LA-EMS, Michigan, Ohio, PSS	None
Demographics	**If Native Hawaiian or Pacific Islander**	☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander	Stroke, Stroke-Limited			Coverdell, LA-EMS, Michigan, Ohio, PSS	None
Demographics	**Additional Asian - MDH**	☐ Burmese ☐ Cambodian ☐ Hmong ☐ Karen ☐ Lao ☐ Other Asian Ethnicity not listed in GWTG element list above or in 'Additional Asian - MDH' list				MDH	None
Demographics	**Arab/Middle Eastern:**	☐ Bedouin ☐ Egyptian ☐ Emirati ☐ Iraqi ☐ Lebanese ☐ Iranian ☐ Rahaida ☐ Saudi ☐ Syrian ☐ Turkish ☐ Other Middle Eastern ☐ Jordanian ☐ Kuwaiti ☐ Omani ☐ Libyan ☐ Palestinian ☐ Sudanese ☐ Yemeni				Middle-East	None
Demographics	**Current Place of Residence:**	○ KSA ○ UAE ○ Other ○ Bahrain ○ Jordan ○ Kuwait ○ Oman				Middle-East	None
Demographics	**Bahraini Governorate:**	○ Capital Governorate ○ Muharraq Governorate ○ Northern Governorate ○ Southern Governorate				Middle-East	None

Demographics	**Jordanian Governorate:**	○ Ajloun ○ Aqaba ○ Amman ○ Balqa ○ Irbid ○ Jerash ○ Karak ○ Ma'an ○ Madaba ○ Mafraq ○ Tafilah ○ Zarqa				Middle-East	None
Demographics	**Emirates:**	○ Abu Dhabi ○ Ajman ○ Dubai ○ Fujairah ○ Ras Al Khaimah ○ Sharjah ○ Umm Al Quwain				Middle-East	None
Demographics	**Province:**	○ Al-Baha ○ Jouf ○ Qassim ○ Asir ○ Eastern Province ○ Hail ○ Jizan ○ Makkah ○ Madinah ○ Najran ○ Northern Borders ○ Riyadh ○ Tabuk				Middle-East	None
Demographics	**Kuwaiti Governorate:**	○ Ahmadi Governorate ○ Al Asimah Governorate (Capital Governorate) ○ Farwaniya Governorate ○ Hawalli Governorate ○ Jahra Governorate ○ Mubarak Al-Kabeer Governorate				Middle-East	None
Demographics	**Omani Governorate:**	○ Al Batinah North ○ Al Batinah South ○ Al Buraimi ○ Al Dakhiliyah ○ Al Dhahirah ○ Al Wusta ○ Ash Sharqiyah North ○ Ash Sharqiyah South ○ Dhofar ○ Musandam ○ Muscat				Middle-East	None
Demographics	**Source of payment (Middle East):**	○ Insured ○ Other ○ Not Insured				Middle-East	None
Demographics	**Hispanic Ethnicity:**	○ Yes ○ No/UTD	Stroke, Stroke-Limited	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS	Required (JC)
Demographics	**Select Hispanic Origin Group(s):**	☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino or Spanish Origin	Stroke, Stroke-Limited, BPCI	STK, TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS	Warning
Demographics	**Additional Hispanic Origin Group(s) – MDH**	☐ Colombian ☐ Ecuadorian ☐ Guatemalan ☐ Salvadoran ☐ Spanish/Spanish American ☐ Other Hispanic, Latino/a, and/or Spanish Origin Not Listed in 'Select Hispanic Origin Group(s)' or 'Additional Hispanic Origin Group(s) – MDH'				MDH	None
	ADMIN						
Admin	**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	Stroke, Stroke-Limited, BPCI			Coverdell, Ohio, Michigan, PSS, LA-EMS, Mexico, West-Region-Rural, Canada	Required
Admin	**If No Stroke Related Diagnosis:**	○ Migraine ○ Seizure ○ Delirium ○ Electrolyte or metabolic imbalance ○ Functional disorder ○ Other ○ Uncertain	Stroke			Canada, Middle-East, Mexico	None
Admin	**Was the stroke etiology documented in the patient medical record:**	○ Yes ○ No	Stroke			Canada, Mexico, Middle-East	Required
Admin	**Select documented stroke etiology:**	○ 1: Large-artery atherosclerosis (e.g., carotid or basilar artery stenosis) ○ 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI) ○ 3: Small-vessel disease (e.g., Subcortical or brain stem lacunar infarction <1.5 cm) ○ 4: Stroke of other determined etiology ○ Dissection ○ Hypercoagualability ○ Other (e.g., vasculopathy or other hematologic disorders) ○ 5: Cryptogenic Stroke ○ Multiple potential etiologies identified ○ Stroke of undetermined etiology ○ Unspecified	Stroke			Canada, Mexico, Middle-East	Required
Admin	**When is the earliest physician/APN/PA documentation of comfort measures only?**	○ 1 - Day 0 or 1 ○ 2 - Day 2 or after ○ 3 - Timing Unclear ○ 4 - Not Documented/UTD	Stroke, Stroke-Limited, BPCI			Coverdell, Ohio, Michigan, PSS, Middle-East, Canada, Mexico	Required

Admin	**Is there clear documentation for comfort care/palliative care measures established prior to hospital arrival?**	○ Yes ○ Not Documented / UTD	ICH		DNV		Required
Admin	**Arrival Date/Time:**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited, BPCI	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admin	**Was this patient a Stroke alert (Code Stroke) at your facility?**	○ Yes ○ No ○ ND	Stroke, Stroke-Limited		DNV		Required (DNV)
Admin	**Location of Stroke alert (Code Stroke)**	○ Emergency Department ○ EMS ○ Inpatient ○ MSU ○ Outpatient Procedure ○ Other _____	Stroke, Stroke-Limited				None
Admin	**Date/Time Stroke alert (Code Stroke) received**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited				None
Admin	**Not Admitted:**	○ Yes, not admitted ○ No, patient admitted as inpatient	Stroke, Stroke-Limited, BPCI			Coverdell, Ohio, Michigan, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admin	**Admission Date:**	_____/_____/_____	Stroke, Stroke-Limited, BPCI	CSTK, STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Admin	**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 _____	Stroke, Stroke-Limited			Middle-East, West-Region-Rural, Canada, Mexico	Required
Admin	**If patient transferred from your ED to another hospital, specify hospital name:**	_____ ○ Transfer to Hospital Not on the List ○ Transfer to Hospital Not Documented	Stroke			Canada, Mexico	None
Admin	**Select reason(s) for why patient transferred:**	☐ Evaluation for IV Thrombolytics up to 4.5 hours ☐ Post Management of IV Thrombolytics (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 ☐ Advanced Stroke care (non-time critical therapy) ☐ Administrative (insurance, bed availability)	Stroke, Stroke-Limited			West-Region-Rural, Middle-East, Canada, Mexico	Required
Admin	**Discharge Date/Time**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	CSTK, STK		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, PSS	required
Admin	**Documented reason for delay in transfer to referral facility?**	○ Yes ○ No/ND	Stroke, Stroke-Limited		DNV	West-Region-Rural, Canada, Mexico	Required
Admin	**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 * ☐ Bed availability at receiving center* ☐ Delay in transport arrival*	Stroke, Stroke-Limited			West-Region-Rural, Canada, Mexico	Required
Admin	**EMS Agency Transporting Patient from Referring Hospital:**	▽ _____ ○ ND				Arkansas	Required
Admin	**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)	Stroke, Stroke-Limited, BPCI	CSTK, STK		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, PSS	Required
Admin	**If Discharged to Other Health Care Facility:**	○ Skilled Nursing Facility (SNF) ○ Inpatient Rehabilitation Facility (IRF) ○ Long Term Care Hospital (LTCH) ○ Intermediate Care facility (ICF) ○ Other	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	Required
Admin	**If patient was discharged to a skilled nursing facility (SNF), specify SNF name:**	_____ ○ Skilled Nursing Facility not on list ○ Skilled Nursing Facility not documented				West-Region-Stroke	None
	Clinical Codes						
Clinical Codes	**Clinical Trial NOT in Stroke:**	_____		CSTK, STK		Coverdell	None
Clinical Codes	**ICD-10-CM Principal Diagnosis Code:**	_____	Stroke, Stroke-Limited, BPCI, SAH	ASR, CSTK, STK, TSC	DNV, DNV-ADV	Coverdell, Ohio, Michigan, LA-EMS, Arkansas, Middle-East, Canada, Mexico	Required
Clinical Codes	**ICD-10-CM Other Diagnosis Codes:**	_____	Stroke, SAH	CSTK, STK, TSC	DNV, DNV-ADV	Canada, Middle-East, Mexico	None
Clinical Codes	**ICD-10-PCS Principal Procedure Code:**	_____ ○ No ICD-10-PCS Procedure Code Documented	SAH	CSTK, STK, TSC	DNV, DNV-ADV	Canada, Middle-East, Mexico	Required
Clinical Codes	**Principal Procedure Date/Time:**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown		CSTK, STK, TSC	DNV, DNV-ADV	Canada, Middle-East, Mexico	None

Clinical Codes	**ICD-10-PCS Other Procedure Codes:**	_____		CSTK, STK, TSC	DNV, DNV-ADV	Canada, Middle-East, Mexico	None
Clinical Codes	**Other Procedure Code Date/Time:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		CSTK, STK, TSC	DNV, DNV-ADV	Canada, Middle-East, Mexico	None
Clinical Codes	**ICD-10-CM Admitting Diagnosis Code:**	_____		CSTK		Canada, Middle-East, Mexico	Required
	Discharge Diagnosis						
Clinical Codes	**ICD-10-CM Discharge Diagnosis Related to Stroke:**	_____	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Clinical Codes	**No Stroke or TIA Related ICD-10-CM Code Present:**	☐	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Clinical Codes	**OP STK ICD-10-CM Principal Diagnosis Code**	_____				CMS-OP-23	Required
Clinical Codes	**OP STK ICD-10-CM Diagnosis Codes**	_____				CMS-OP-23	None
Clinical Codes	**CSTK Initial Patient Population:**	○ Ischemic Stroke Without Procedure ○ Ischemic Stroke With IV alteplase, IA alteplase, or MER ○ Hemorrhagic Stroke		CSTK, STK, TSC			None
	ADMISSION						
Admission	**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	Stroke, Stroke-Limited, Endovascular-Therapy, Telestroke, EMS-Pre-Hospital-Care, BPCI, SAH	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, NYSDOH, LA-EMS, PTSN, CMS-OP-23, Florida-Stroke-Registry, AZ-EMS, GA-Coverdell, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admission	**If Yes, Type of Clinical Trial(s) (select all that apply):**	☐ Antithrombotics ☐ VTE Prophylaxis ☐ Anticoagulation for AFib/Aflutter ☐ Smoking Cessation ☐ Intensive Statin Therapy ☐ Thrombolytic administration ☐ Endovascular Therapy ☐ Other	Stroke, Stroke-Limited, Endovascular-Therapy, Telestroke, EMS-Pre-Hospital-Care, SAH, BPCI	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, NYSDOH, LA-EMS, PTSN, CMS-OP-23, AZ-EMS, Florida-Stroke-Registry, GA-Coverdell, Middle-East, West-Region-Rural, Canada, Mexico	None
Admission	**Was this patient admitted for the sole purpose of performance of elective carotid intervention?**	○ Yes ○ No	Stroke, Stroke-Limited, Endovascular-Therapy, EMS-Pre-Hospital-Care, SAH, Telestroke	CSTK, STK, TSC		Coverdell, Ohio, Michigan, PSS, NYSDOH, LA-EMS, PTSN, CMS-OP-23, AZ-EMS, Florida-Stroke-Registry, GA-Coverdell, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admission	**Point of Origin for Admission or Visit:**	○ Clinic ○ Court/Law Enforcement ○ Emergency Room ○ Non-health care facility point of origin ○ Transfer from a hospital (different facility) ○ Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) ○ Transfer from ambulatory surgery center ○ Transfer from another health care facility ○ Transfer from Hospice and is under a hospital Plan of Care or enrolled in Hospice program ○ Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer ○ Information not available ○ HMO referral ○ Transfer from a Critical Access Hospital	Stroke			LA-EMS	None (Stroke) Required (LA EMS)
Admission	**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	Stroke, Stroke-Limited, BPCI			Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admission	**How patient arrived at your hospital**	○ EMS from home/scene ○ Mobile Stroke Unit ○ Private transport/taxi/other from home/scene ○ Transfer from other hospital ○ ND or Unknown	Stroke, Stroke-Limited	CSTK, TSC		Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admission	**Referring Hospital Discharge Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke			Canada, Middle-East, Mexico	None
Admission	**If transfer from another hospital, specify hospital name:**	▽ _____ ☐ Transfer from Hospital Not on the List ☐ Transfer from Hospital Not Documented	Stroke			Canada, Mexico	None
Admission	**Referring Hospital Arrival Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke			Canada, Mexico, Middle-East	None
Admission	**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	Stroke			Canada, Mexico, Middle-East	None
Admission	**EMS Agency Transporting Patient to Receiving Hospital**	_____ ☐ Not Documented				Arkansas	Required
Admission	**Was the patient an ED patient at the facility?**	○ Yes ○ No		ASR, CSTK, STK, TSC			Required
Admission	**^Was the patient a direct admission to the hospital?**	○ Yes ○ No		CSTK, STK			Required
Admission	**Where patient first received care at your hospital:**	○ Emergency Department/Urgent Care ○ Direct Admit, not through ED ○ Imaging suite ○ ND or Cannot be determined	Stroke			Coverdell, Ohio, Michigan, PSS, Middle-East, Canada, Mexico	None
Admission	**Did a stroke-capable Provider consult in decision-making during the acute phase of treatment?**	○ Yes ○ No/ND	Stroke, Stroke-Limited				Required

Admission	**Stroke-capable Provider(s) (specify)**	☐ Emergency Provider ☐ TeleEmergency Provider ☐ Neurospecialist ☐ Telestroke Provider ☐ Medical Hospitalist ☐ Advanced Practice Provider	Stroke, Stroke-Limited				Required
Admission	**Advanced notification by EMS or MSU?**	○ Yes ○ No/ND	Stroke, Stroke-Limited			PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Admission	**Initial admitting service:**	☐ Medicine ☐ Neurocritical care ☐ Neurology ☐ Neurosurgery ☐ Surgery ☐ Other	Stroke, ICH			Middle-East, Canada, Mexico	None
Admission	**In which settings were care delivered - Other:**	☐ Neuro/Neurosurgery ICU ☐ General care floor ☐ Other ICU ☐ Observation ☐ Stroke unit (non-ICU) ☐ Other	Stroke, ICH			Middle-East, Canada, Mexico	Required (ICH)
Admission	**Specialized unit admission date/time:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required
Admission	**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	Stroke, ICH			Middle-East, Canada, Mexico	None
	NPI						
Admission	**ED Physician**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Stroke NP/ PA**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Admitting Physician**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Attending Physician**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Neurologist**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Neurosurgeon**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Interventionalist**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Discharging Provider**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
Admission	**Other Provider**	_____	Stroke, Stroke-Limited			Ohio, Michigan, PSS, Canada, Mexico	None
	Telestroke						
Admission	**Was telestroke consultation performed?**	○ Yes, the patient received telestroke consultation from my hospital staff when the patient was located at another hospital ○ Yes, the patient received telestroke consultation from someone other than my hospital staff when the patient was at another hospital ○ Yes, the patient received telestroke consultation from a remotely located expert when the patient was located at my hospital ○ No telestroke consult performed ○ Not Documented	Stroke, Stroke-Limited, Telestroke		DNV	Middle-East, Canada, Mexico, Coverdell, Stroke-Rural	Required
	Medical History						
Admission	**Previously known medical history of:**	○ No Previous Medical History ☐ Atrial Fib/Flutter ☐ CAD/ Prior MI ☐ Cancer ☐ Carotid Stenosis ☐ Chronic Kidney Disease (CKD) ☐ Current Pregnancy (up to 6 weeks postpartum) ☐ DVT/PE ☐ Dementia ☐ Depression ☐ Diabetes Mellitus ☐ Diabetes Type ☐ Drugs/Alcohol Abuse ☐ Dyslipidemia ☐ E-Cigarette Use (Vaping) ☐ Familial Hypercholesterolemia ☐ Family History of Stroke	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Admission	**Previously known medical history of:** **(cont)**	☐ HF ☐ HRT ☐ Hx of Emerging Infectious Disease ☐ Hypertension ☐ Hypertriglyceridemia ☐ Migraine ☐ Obesity/Overweight ☐ Postpartum (6 weeks to 12 months postpartum) ☐ Previous Stroke ☐ Previous TIA ☐ Prosthetic Heart Valve ☐ PVD ☐ Renal Insufficiency – Chronic ☐ Sickle Cell ☐ Sleep Apnea ☐ Smoker	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Admission	**Most Recent CKD Stage Prior to This Encounter**	○ Stage 1 ○ Stage 2 ○ Stage 3 ○ Stage 4 ○ Stage 5 ○ Unable to Determine				CKMH	Required
Admission	**Currently pregnant?**	○ Yes, currently pregnant ○ No, postpartum up to 6 weeks	Stroke, Stroke-Limited				None

Admission	**Diabetes Type**	○ Type 1 ○ Type 2 ○ ND	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Admission	**Diabetes Duration**	○ <5 years ○ 5- < 10 years ○ 10- < 20 years ○ >=20 years ○ Unknown	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	None
Admission	**Emerging Infectious Disease**	☐ MERS ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ Other infectious respiratory pathogen	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Admission	**Previous Stroke**	☐ Ischemic stroke ☐ ICH ☐ SAH ☐ Not Specified	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Admission	**Ambulatory status prior to the current event?**	○ Able to ambulate independently (no help from another person) w/ or w/o device ○ With assistance (from person) ○ Unable to ambulate ○ ND	Stroke			Coverdell, Ohio, Michigan, LA-EMS, Middle-East, Canada, Mexico	Warning Required (Coverdell)
Admission	**Pre-stroke Modified Rankin Score:**	○ 0 – No symptoms as all ○ 1 – No significant disability despite symptoms: Able to carry out all usual activities ○ 2 – Slight disability ○ 3 – Moderate disability: Requiring some help but able to walk without assistance ○ 4 – Moderate to severe disability: Unable to walk without assistance and unable to attend to own bodily needs without assistance ○ 5 – Severe disability; Bedridden, incontinent and requiring constant nursing care and attention ○ 8 – Modified Rankin Score not performed, OR unable to determine (UTD) from the medical record documentation	Stroke	CSTK, TSC	DNV	Middle-East, Canada, Mexico	Required (DNV)
Admission	**Pre-stroke Modified Rankin Score Group**	○ 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. ○ 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. ○ A score value was not documented, OR unable to determine (UTD) from the medical record documentation	Stroke	CSTK, TSC		Middle-East, Canada, Mexico	Required
	Diagnosis & Evaluation						
Admission	**Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)**	○ Less than 10 minutes ○ 10-59 minutes ○ ≥ 60 minutes ○ ND	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
Admission	**Had stroke symptoms resolved at time of presentation?**	○ Yes ○ No ○ ND	Stroke			Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Warning Required (Coverdell)
Admission	**^Is there documentation that an initial NIHSS score was done at this hospital?**	○ Yes ○ No	Stroke, Stroke-Limited	CSTK, STK, TSC	DNV	PSS, Canada, Mexico	Required
Admission	**^What is the date and time that the NIHSS score was first performed at this hospital?**	_____ / _____ / _____	____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	CSTK, STK, TSC		PSS, Canada, Mexico	Required
Admission	**NIHSS Total Score**	_____	Stroke, Stroke-Limited		DNV	Coverdell, Ohio, Michigan, PSS, Middle-East, LA-EMS, West-Region-Rural, Canada, Mexico	Required
Admission	**^What is the first NIHSS score obtained prior to or after hospital arrival?**	_____ ☐ UTD		CSTK, TSC			Required
Admission	**^Was the initial NIHSS score after hospital arrival less than 6?**	○ Yes ○ No		CSTK, TSC			Required
Admission	**NIHSS score obtained from transferring facility:**	_____ ○ ND	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Admission	**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	Stroke			Coverdell, Ohio, Michigan, Middle-East, Mexico	Required
Admission	**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	Stroke			Coverdell, Ohio, Michigan, Middle-East, CSTK, Mexico	Warning
	Hemorrhagic Stroke Scales						
Admission	**GCS Eye:**	_____	ICH	CSTK			None
Admission	**GCS Verbal:**	_____	ICH	CSTK			None
Admission	**GCS Intubated:**	☐	ICH	CSTK			None
Admission	**GCS Motor:**	_____	ICH	CSTK			None
Admission	**Total GCS:**	_____	ICH	CSTK			Warning
Admission	**Total GCS Not Documented**	☐	ICH	CSTK			None
	Subarachnoid Hemorrhage						
Admission	**^Is there documentation any time during the hospital stay that the hemorrhage was non-aneurysmal or due to head trauma?**	○ Yes ○ No	Stroke, Stroke-Limited, SAH	CSTK	DNV		Required

Admission	**^Was an initial Hunt and Hess scale done at this hospital?**	○ Yes ○ No	SAH	CSTK	DNV		Required
Admission	**^^If yes, Hunt and Hess score:**	_____	SAH	CSTK	DNV		Required
Admission	**^What is the date and time that the Hunt and Hess Scale was first performed at this hospital?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH	CSTK	DNV		Required
Admission	**Was an initial World Federation of Neurological Surgeons (WFNS) scale done at this hospital?**	○ Yes ○ No	SAH		DNV		Required
Admission	**^^WFNS SAH Grading Scale**	_____	SAH	CSTK	DNV		Required
Admission	**What is the date and time the WFNS scale was first performed at this hospital?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH		DNV		Required
	Intracerebral Hemorrhage (ICH)						
Admission	**^Was an initial ICH score done at this hospital?**	○ Yes ○ No	ICH	CSTK	DNV		Required
Admission	**^^If yes, ICH score:**	_____	ICH	CSTK	DNV		Required
Admission	**^What is the date and time that the ICH score was first performed at this hospital?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH	CSTK	DNV		Required
Admission	**ICH Volume:**	_____cm3 ☐ ND	ICH				Required
Admission	**IVH**	○ Present ○ Not Present	ICH				Required
Admission	**Hemorrhage location (center of origin)**	○ Superficial (i.e., lobar) ○ Deep ○ Unknown	ICH				Required
Admission	**Hemorrhage location - Superficial (ie, lobar)**	○ Frontal ○ Parietal ○ Temporal ○ Occipital	ICH				None
Admission	**Hemorrhage location - Deep**	○ Thalamus ○ Basal ganglia (caudate, putamen, globus pallidus) ○ Brainstem (midbrain, pons, medulla) ○ Cerebellum	ICH				None
Admission	**Was the ICH etiology documented in the patient medical record?**	○ Yes ○ No	ICH				Required
Admission	**Documented ICH etiology (select all that apply) :**	☐ Hypertension ☐ Anticoagulant-associated (warfarin, DOACs) ☐ Coagulopathy (liver cirrhosis hemophilia, sickle cell anemia, DIC, thrombocytopenia) ☐ Vascular malformations (cerebral aneurysms, AVM, dural AV fistula, capillary telangiectasia, cavernous malformation) ☐ Tumor ☐ Substance use (cocaine, stimulants) ☐ Amyloid angiopathy ☐ spontaneous/idiopathic ☐ Cortical vein thrombosis and venous sinus thrombosis ☐ Amyloid related imaging abnormalities – hemorrhage (ARIA-H) ☐ Other determined cause: _____	ICH				Required
Admission	**^^FUNC Score (ICH)**	_____		CSTK			None
	Medications Prior to Admission						
Admission	**No medications prior to admission**	☐	Stroke			Middle-East, Canada, Mexico	None
Admission	**Antiplatelet or Anticoagulant Medication(s) prior to admission:**	○ Yes ○ No	Stroke, ICH			Middle-East, Canada, Mexico	Required
Admission	**Prior Antithrombotic Class**	☐ Antiplatelet ☐ Anticoagulant	Stroke, ICH			Middle-East, Canada, Mexico	Required
Admission	**Prior Antithrombotic Medication**	Antiplatelet: ○ aspirin ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ prasugrel (Effient) ○ ticagrelor (Brilinta) ○ ticlopidine (Ticlid) ○ Other Antiplatelet Anticoagulant: ○ 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	Stroke			Middle-East, Canada, Mexico	Required
Admission	**Date/Time of last anticoagulant dose prior to admission**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, ICH				Required (ICH Dx)
Admission	**Date/Time of last antiplatelet dose prior to admission**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke				None

Admission	**Antihypertensive Medication prior to admission:**	○ Yes ○ No/ND	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Admission	**Antihypertensive Medication Class:**	☐ ACEI ☐ ARB ☐ ARNI ☐ Beta Blocker ☐ Ca+ Channel Blocker ☐ Diuretic ☐ Other ☐ Unknown/ND				CKMH	Required
Admission	**Cholesterol reducer prior to admission:**	○ Yes ○ No/ND	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Admission	**Cholesterol-Reducer type prior to admission (select all that apply):**	☐ Statin ☐ Fibrate ☐ Niacin ☐ Absorption Inhibitor ☐ PCSK9 Inhibitor ☐ Other cholesterol reducer type ☐ Not Documented	Stroke, ICH				Required (ICH Layer)
Admission	**Anti-hyperglycemic medications prior to admission:**	○ Yes ○ No/ND	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico	Required
Admission	**If yes, select Anti-hyperglycemic medications (select all that apply)**	☐ DPP-4 Inhibitors ☐ GLP-1 receptor agonist ☐ Insulin ☐ Metformin ☐ SGLT2 Inhibitor ☐ Sulfonyurea ☐ Thiazolidinedione ☐ Other oral agents ☐ Other injectable/subcutaneous agents	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico	Required
Admission	**Antidepressant medication prior to admission:**	○ Yes ○ No/ND	Stroke			Middle-East, Canada, Mexico	None
Admission	**Antidepressant type, prior to admission:**	○ SSRI ○ Other antidepressant ○ Not documented	Stroke, ICH				Required (ICH Layer)
Admission	**Alzheimer's Disease Immunotherapies prior to admission**	○ Yes ○ No/ND	Stroke, Stroke-Limited				Warning
	Vaccinations & Testing						
Admission	**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	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Admission	**COVID-19 Vaccination Date:**	_____ / _____ / _____	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Admission	**COVID-19 Vaccine Manufacturer:**	○ AstraZeneca ○ Johnson & Johnson's / Janssen ○ Moderna ○ Novavax ○ Pfizer ○ Other ○ Not Documented	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Admission	**Did the patient receive both doses of vaccine? (if applicable)**	○ Yes ○ No ○ Not applicable	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Admission	**Is there documentation that this patient was included in a COVID-19 vaccine trial?**	○ Yes ○ No/ND	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Admission	**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	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
	Pre-Hospital Care						
Pre-hospital Care	**Source used to obtain prehospital care data:**	○ Copy of ePCR in Hospital Medical Record ○ ePCR in EMS Data System ○ EMS Record not Available ○ Other	EMS-Pre-Hospital-Care			Coverdell	Required
Pre-hospital Care	**ePCR Patient Finder**	_____	ePCR				None
Pre-hospital Care	**EMS Vendor**	_____	ePCR				None
Pre-hospital Care	**EMS Agency Number**	_____	ePCR				None
Pre-hospital Care	**EMS PCR ID**	_____	ePCR				None
Pre-hospital Care	**Patient care record available at time of patient arrival?**	○ Yes ○ No/ND	EMS-Pre-Hospital-Care			Middle-East	None
Pre-hospital Care	**Patient care record available at a later time during hospitalization?**	○ Yes ○ No/ND	EMS-Pre-Hospital-Care			Middle-East	None
Pre-hospital Care	**EMS Agency List**	_____ ☐ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required (West Region)

Pre-hospital Care	**Run/Sequence number**	_____ ☐ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required (West Region)
Pre-hospital Care	**Date/Time Brain Imaging initiated by MSU:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East	None
Pre-hospital Care	**Date/ Time IV alteplase administered by MSU:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East	None
Pre-hospital Care	**NDak Form Group Present**	☐				West-Region-Stroke	None
Pre-hospital Care	**Initial 911 Call for Help:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				MSN, West-Region-Stroke	Required
Pre-hospital Care	**EMS Unit Notified by Dispatch:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required (West Region)
Pre-hospital Care	**Dispatched as suspected stroke?**	○ Yes ○ No ○ Not Documented	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**EMS Unit Arrived on Scene:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke, Coverdell	Required
Pre-hospital Care	**EMS Arrived at Patient:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**ALS Intercept Initiated:**	○ Yes ○ No/ND				West-Region-Stroke	Required
Pre-hospital Care	**ALS Unit Notified by Dispatch:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				West-Region-Stroke	Required
Pre-hospital Care	**ALS Interception Time:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				West-Region-Stroke	Required
Pre-hospital Care	**ALS Agency List**	▽ _____ ○ Unknown				West-Region-Stroke	Required
Pre-hospital Care	**EMS Unit Left Scene:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke, Coverdell	Required
Pre-hospital Care	**Last Known Well as Documented by EMS:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**LKW by EMS Unknowable**	☐	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**Discovery of Stroke symptoms by EMS:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**Discovery of Stroke symptoms by EMS Unknowable**	☐	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**Date/Time Pre-Notification provided to Hospital:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**Additional Information provided as part of pre-notification?**	☐ Blood Glucose value ☐ Blood Pressure ☐ Result of Stroke Screen/Severity Score ☐ LKW time per EMS ☐ Seizure Activity	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**Blood Glucose level (mg/dL):**	_____ ○ ND ○ Too High ○ Too Low	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke, AZ-EMS, Coverdell	Required
Pre-hospital Care	**Initial Blood Pressure by EMS**	Systolic: _____ Diastolic: _____ ☐ Not Documented	EMS-Pre-Hospital-Care			West-Region-Stroke	Required (West Region)
Pre-hospital Care	**Were any antihypertensive medications, including nitro given by EMS?**	○ Yes ○ No/ND				West-Region-Stroke	Required
Pre-hospital Care	**EMS Suspected stroke? (Primary or Secondary Impression)**	○ Yes ○ No ○ Not Documented	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**Indicate the stroke screen tool used:**	○ BE FAST ○ CPSS ○ DPSS ○ FAST ○ LAPSS ○ MASS ○ Med PACS ○ MEND ○ mLAPSS ○ OPSST ○ ROSIER ○ Stroke screen tool used, but tool used is unknown ○ No stroke screen tool used ○ Not documented ○ Other _____	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke, AZ-EMS, Coverdell	Required

Pre-hospital Care	**Stroke Screen Outcome:**	○ Positive ○ Negative ○ Not documented	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**Indicate the Severity Scale used:**	○ CPSSS/CSTAT ○ FAST ED ○ LAMS ○ MPSS ○ RACE ○ VAN ○ Other _____ ○ Severity scale used, but tool used is unknown ○ No severity scale used ○ Not Documented	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**If Other severity scale used, specify:**	_____	EMS-Pre-Hospital-Care			Middle-East	Required
Pre-hospital Care	**Severity Scale Positive for LVO?**	○ Yes ○ No ○ ND	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**If Severity Scale assessment completed, enter total score:**	_____ ☐ ND	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required
Pre-hospital Care	**How was destination decision made?**	○ Directed to designated stroke center by protocol ○ Directed to nearest facility by protocol ○ Patient/Family choice ○ Online Medical Direction ○ Closest facility ○ Other ○ Unknown/ND	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**If Other destination decision, specify:**	_____	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**What was destination hospital's level of service?**	○ Non-stroke designated hospital ○ ASRH ○ PSC ○ CSC ○ TSC ○ ND				West-Region-Stroke	None
Pre-hospital Care	**Was closest facility bypassed?**	○ Yes ○ No ○ ND				West-Region-Stroke	None
Pre-hospital Care	**Was a Thrombolytic Checklist used?**	○ Yes ○ No/ND	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
Pre-hospital Care	**If severity scale used, did result alter hospital destination (e.g. CSC vs. PSC)?**	○ Yes ○ No/ND	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	Required (West Region)
Pre-hospital Care	**EMS Additional Comments**	_____	EMS-Pre-Hospital-Care			Middle-East, West-Region-Stroke	None
	HOSPITALIZATION						
Hospitalization	**When was the patient last known to be well?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Date/Time of discovery of stroke symptoms?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown ☐ Same as time last known well	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
	Brain Imaging						
Hospitalization	**Was brain or vascular imaging performed prior to transfer to your facility?**	○ Yes ○ No/ND	Endovascular-Therapy				None
Hospitalization	**Imaging type at prior facility not documented**	☐	Endovascular-Therapy				None
Hospitalization	**If yes, which imaging tests were performed prior to transfer to your facility? (select all that apply)**	☐ CT ☐ CTA ☐ CT Perfusion ☐ MRI ☐ MRA ☐ MR Perfusion	Endovascular-Therapy				None
Hospitalization	**Date/Time 1st vessel or perfusion imaging initiated at prior hospital:**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Endovascular-Therapy				None
Hospitalization	**Brain imaging completed at your hospital for this episode of care?**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited		DNV	Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Type of brain imaging completed at your hospital for this episode of care**	☐ CT ☐ MRI	Stroke, Stroke-Limited		DNV	Coverdell, Canada, Mexico	Required (Coverdell & DNV)
Hospitalization	**Date/Time Brain Imaging First Initiated at your hospital:**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Documented reason for delay in initial brain imaging at your hospital?**	○ Yes ○ No/ND	Stroke, Stroke-Limited				None
Hospitalization	**Specify reason for delay in initial brain imaging at this hospital (select all that apply)**	☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Delay in stroke diagnosis ☐ In-hospital time delay ☐ Equipment-related delay ☐ Other (specify) _____	Stroke, Stroke-Limited				None
Hospitalization	**Date/Time Brain Imaging Reported:**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	STK	DNV	LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required (West Region, Rural, DNV)

Hospitalization	**Interpretation of first brain image after symptom onset, done at any facility:**	○ Acute Hemorrhage ○ No Acute Hemorrhage ○ Not Available	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Warning
Hospitalization	**Vascular imaging (e.g., CTA, MRA, DSA) performed?**	○ Yes ○ No	Stroke, Stroke-Limited, Endovascular-Therapy			Middle-East, Canada, Mexico, Coverdell	Required
Hospitalization	**Date/Time 1st vessel or perfusion imaging initiated at your hospital**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Hospitalization	**Vascular or perfusion imaging performed at your hospital (select all that apply)**	☐ CTA ☐ CT Perfusion ☐ MRA ☐ MR Perfusion ☐ DSA (catheter angiography) ☐ ND	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Hospitalization	**Vascular Imaging Result**	○ 0- Normal ○ 1- Mismatch Present ○ 2- Absent Mismatch				MSN	Required
Hospitalization	**Target lesion visualized?**	○ Yes ○ No/ND	Stroke, Stroke-Limited, Endovascular-Therapy		DNV-ADV	Middle-East, Canada, Mexico	Required
Hospitalization	**Site of occlusion:**	○ ICA ○ MCA ○ Basilar Artery ○ Other Cerebral Artery Branch ○ Vertebral Artery	Stroke, Stroke-Limited, Endovascular-Therapy		DNV-ADV	Middle-East, Canada, Mexico	Required
Hospitalization	**ICA segment**	☐ Intracranial ICA ☐ Cervical ICA ☐ Other/UTD	Stroke, Stroke-Limited, Endovascular-Therapy		DNV-ADV	Middle-East, Canada, Mexico	Required
Hospitalization	**MCA segment**	☐ M1 ☐ M2 ☐ Other/UTD	Stroke, Stroke-Limited, Endovascular-Therapy		DNV-ADV	Middle-East, Canada, Mexico	Required
Hospitalization	**Vascular imaging at an outside hospital for a hemorrhage patient**	○ Yes ○ No	SAH		DNV, DNV-ADV		Required
Hospitalization	**Vascular imaging at your hospital for a hemorrhage patient**	○ Yes ○ No	SAH		DNV, DNV-ADV		Required
Hospitalization	**Type of vascular imaging**	☐ CTA ☐ MRA ☐ DSA	SAH				Warning
Hospitalization	**Structural cause of hemorrhage**	☐ None ☐ Aneurysm ☐ Arteriovenous malformation (AVM) ☐ Brain neoplasm ☐ Other _____	SAH		DNV, DNV-ADV		Required
Hospitalization	**ASPECT Total Score**	_____ ○ ND	Endovascular-Therapy			MSN	Warning (GWTG) Required (MSN)
	IV Thrombolytic Therapy						
Hospitalization	**IV thrombolytic initiated at this hospital?**	○ Yes ○ No	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**IV Thrombolytic Initiation Date/Time**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	CSTK, TSC		Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Thrombolytic used**	○ Alteplase (Class 1 evidence) ○ Tenecteplase (Class 2b evidence)	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Alteplase total dose (mg):**	_____ ☐ ND	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Tenecteplase total dose (mg):**	_____ ☐ ND	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Reason for selecting tenecteplase instead of alteplase**	○ Large Vessel Occlusion (LVO) with potential thrombectomy ○ Mild Stroke ○ Other	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**If IV thrombolytic administered beyond 4.5-hour, was imaging used to identify eligibility?**	○ Yes, Diffusion-FLAIR mismatch ○ Yes, Core-Perfusion mismatch ○ None ○ Other _____	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**BP before alteplase**	Systolic: _____ Diastolic: _____ ☐ ND				MSN	Required
Hospitalization	**Documented exclusions or relative exclusions (contraindications or warnings) for not initiating IV thrombolytic in the 0-3 hr treatment window?**	○ Yes ○ No	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Documented exclusions or relative exclusions (contraindications or warnings) for not initiating IV thrombolytic in the 3-4.5 hr treatment window?**	○ Yes ○ No	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required

Hospitalization	**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)	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**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) ☐ W12: Currently taking Alzheimer's Disease Immunotherapy	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**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)	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**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) ☐ W12: Currently taking Alzheimer's Disease Immunotherapy	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**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)	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	None
Hospitalization	**Other Reasons (Hospital-related or other factors) 0-3 hr treatment window. Select all that apply:**	☐ 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 _____	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**Other Reasons (Hospital-related or other factors) 3-4.5 hr treatment window. Select all that apply:**	☐ 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 _____	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**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	Stroke, Stroke-Limited, BPCI			LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**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	Stroke, Stroke-Limited, BPCI			LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**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	Stroke, Stroke-Limited, BPCI			LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**Cause for IV thrombolytic delay, Eligibility Reason(s):**	☐ Social/Religious ☐ Initial refusal ☐ Care-team unable to determine eligibility ☐ Specify eligibility reason for delay in IV thrombolytic _____	Stroke, Stroke-Limited, BPCI			LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Cause for IV thrombolytic delay, 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 for delay in IV thrombolytic _____	Stroke, Stroke-Limited, BPCI			LA-EMS, Middle-East, West-Region-Rural, Canada, Mexico, Coverdell	Required
Hospitalization	**Cause for IV thrombolytic delay, Hospital Related or Other Reason(s):**	☐ Need for additional imaging ☐ Delay in stroke diagnosis ☐ In-hospital time delay ☐ Equipment-related delay ☐ Other _____	Stroke, Stroke-Limited			LA-EMS, Middle-East, Canada, Mexico	None
Hospitalization	**IV thrombolytic at an outside hospital or EMS / Mobile Stroke Unit?**	○ Yes ○ No	Stroke, Stroke-Limited, BPCI			Coverdell, Ohio, Michigan, PSS, Middle-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	**Thrombolytic administered at outside hospital or Mobile Stroke Unit**	○ Alteplase ○ Tenecteplase	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, Middle-East, Canada, Mexico	Required

Hospitalization	**Investigational or experimental protocol for thrombolysis?**	○ Yes ○ No ○ Specify investigational or experimental protocol for thrombolysis: _____	Stroke			Middle-East, Canada, Mexico	Warning
	Endovascular Therapy						
Hospitalization	**Is there documentation of a suspected LVO in the medical record?**	○ Yes ○ No		ASR, STK, TSC			Required
Hospitalization	**Is there documentation in the medical record that the patient is eligible for MER therapy or a mechanical thrombectomy procedure?**	○ Yes ○ No		ASR, STK, TSC			Required
Hospitalization	**Catheter-based stroke treatment at this hospital?**	○ Yes ○ No	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**IA alteplase or MER Initiation Date/Time**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	CSTK, TSC		Coverdell, Ohio, Michigan, PSS, Middle-East, Canada, Mexico	Required
Hospitalization	**Catheter-based stroke treatment at outside hospital?**	○ Yes ○ No	Stroke, Stroke-Limited			PSS, Middle-East, Canada, Mexico	Warning
	Complications of Reperfusion Therapy						
Hospitalization	**Complications of IV Thrombolytic Therapy**	☐ Symptomatic intracranial hemorrhage <36 hours ☐ Other serious complication ☐ Life threatening, serious systemic hemorrhage <36 hours ☐ No serious complications ☐ UTD	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**Complications of IA Thrombolytic Therapy or MER**	☐ Symptomatic intracranial hemorrhage with >= 4 point increase in NIHSS < 36 hours since the onset of treatment ☐ Access site complication ☐ Other serious complication ☐ No serious complications ☐ UTD	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, PSS, LA-EMS, Middle-East, Canada, Mexico	Required
Hospitalization	**If bleeding complications occur in patient transferred after IV thrombolytic**	○ Symptomatic hemorrhage detected prior to patient transfer ○ Symptomatic hemorrhage detected only after patient transfer ○ Unable to determine ○ N/A	Stroke			Coverdell, Ohio, Michigan, PSS, Middle-East, Canada, Mexico	Required
	Other In-Hospital Treatments and Screening						
Hospitalization	**Was an initial dysphagia screen performed**	○ Yes, within 24 hours of arrival ○ Yes, greater than 24 hours after arrival ○ No ○ NC	ICH				Required
Hospitalization	**Patient NPO throughout the entire hospital stay?**	○ Yes ○ No	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Hospitalization	**Was patient screened for dysphagia prior to any oral intake including water or medications?**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Hospitalization	**If yes, Dysphagia screening results:**	○ Pass ○ Fail ○ ND	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Hospitalization	**Treatment for Hospital-Acquired Pneumonia:**	○ Yes ○ No/ND ○ NC	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Hospitalization	**Which assessment(s) were completed or attempted within 24 hours of admission?**	☐ Occupational Therapy ☐ Physical Therapy ☐ Speech-Language Pathology ☐ None of the above			DNV		Required
Hospitalization	**Was there a medical reason for Occupational Therapy assessment not being completed or attempted within 24 hours of admission?**	○ Yes ○ No/ND			DNV		Required
Hospitalization	**Was there a medical reason for Physical Therapy assessment not being completed or attempted within 24 hours of admission?**	○ Yes ○ No/ND			DNV		Required
Hospitalization	**Was there a medical reason for Speech-Language Pathology assessment not being completed or attempted within 24 hours of admission?**	○ Yes ○ No/ND			DNV		Required
Hospitalization	**Was an Occupational Therapy assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND			DNV		Required
Hospitalization	**Was a Physical Therapy assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND			DNV		Required
Hospitalization	**Was a Speech-Language Pathology assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND			DNV		Required
	VTE Interventions						
Hospitalization	**VTE Interventions**	☐ 1: Low dose unfractionated heparin (LDUH) ☐ 2: Low molecular weight heparin (LMWH) ☐ 3: Intermittent pneumatic compression devices (IPC) ☐ 4: GCS ☐ 5: Factor Xa Inhibitor ☐ 6: Warfarin ☐ 7: Venous foot pumps ☐ 8: Oral Factor Xa Inhibitor ☐ 9: Aspirin ☐ A-None of the above or not documented or unable to determine from medical record documentation	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Hospitalization	**What date was the VTE prophylaxis administered after hospital admission?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited	STK, TSC		Coverdell, Middle-East, Canada, Mexico	Required
Hospitalization	**What was the Date and Time the IPC device was placed?**	_____/_____/_____| ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required

Hospitalization	**Is there physician/ APN/ PA documentation why IPC was not used for VTE prophylaxis?**	○ Yes ○ No	ICH				Required
Hospitalization	**Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Middle-East, Canada, Mexico	Required
Hospitalization	**Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Middle-East, Canada, Mexico	Required
Hospitalization	**Other Therapeutic Anticoagulation**	☐ apixaban (Eliquis) ☐ Argatroban ☐ Dabigatran (Pradaxa) ☐ Desirudin (Iprivask) ☐ Edoxaban (Savaysa) ☐ Lepirudin (Refludan) ☐ Rivaroxaban (Xarelto) ☐ Unfractionated heparin IV ☐ Other Anticoagulant	Stroke, Stroke-Limited	STK, TSC		Coverdell, Middle-East, Canada, Mexico	None
Hospitalization	**Was DVT or PE documented?**	○ Yes ○ No	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None (Stroke) Required (Coverdell)
Hospitalization	**Was antithrombotic therapy administered by the end of hospital day 2?**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico	Required
Hospitalization	**Select type(s) of antithrombotic therapy administered by the end of hospital day 2?**	○ Antiplatelet ○ Anticoagulation	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
Hospitalization	**Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?**	○ Yes ○ No		ASR, STK, TSC		Coverdell	Required
Hospitalization	**Was patient treated for a urinary tract infection (UTI) during this admission?**	○ Yes ○ No/ND				Coverdell	None
Hospitalization	**If patient was treated for a UTI, did the patient have a Foley catheter during this admission?**	○ Yes, patient had catheter in place on arrival ○ No ○ Yes, but only after admission ○ Unable to determine				Coverdell	None
Hospitalization	**Active bacterial or viral infection at admission or during hospitalization:**	☐ None/ND ☐ Bacterial Infection ☐ Emerging Infectious Disease ☐ Influenza ☐ Seasonal Cold ☐ Other Viral Infection	Stroke, Stroke-Limited			Coverdell, Middle-East, Canada, Mexico	Required
Hospitalization	**Is there a new diagnosis of Chronic Kidney Disease (CKD) during this hospital stay?**	○ Yes ○ No/ND				CKMH	Required
Hospitalization	**What components were used to make the diagnosis?**	☐ Prior abnormal labs ☐ Labs during admission ☐ Physician documentation				CKMH	Required
Hospitalization	**CKD Stage assigned during this hospital stay**	○ Stage 1 ○ Stage 2 ○ Stage 3a ○ Stage 4 ○ Stage 5 ○ Unable to Determine				CKMH	Required
	Measurements						
Hospitalization	**Total Cholesterol:**	_____	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	None (Stroke) Required (CKMH)
Hospitalization	**Triglycerides:**	_____	Stroke, Stroke-Limited			Middle-East, Canada, Mexico, CKMH	None (Stroke) Required (CKMH)
Hospitalization	**HDL:**	_____	Stroke, Stroke-Limited			Middle-East, Canada, Mexico, CKMH	None (Stroke) Required (CKMH)
Hospitalization	**LDL:**	_____	Stroke, Stroke-Limited, ASCVD			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Hospitalization	**Lipids: ND**	☐	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	None
Hospitalization	**Lipids: NC**	☐	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	None
Hospitalization	**LP(a) measurement obtained**	○ This hospitalization ○ Prior to this hospitalization ○ Planned after discharge ○ No measurement documented	Stroke, Stroke-Limited, ASCVD			CKMH	Required (ASCVD & CKMH)
Hospitalization	**LP(a) Value:**	_____	Stroke, Stroke-Limited			CKMH	Required
Hospitalization	**LP(a) Unit:**	_____	Stroke, Stroke-Limited			CKMH	Required
Hospitalization	**LP(a): ND**	☐	Stroke, Stroke-Limited			CKMH	None
Hospitalization	**A1C:**	_____ ☐ ND	Stroke			Middle-East, Canada, Mexico, CKMH	Warning (Stroke) Required (CKMH)
Hospitalization	**^What is the first blood glucose value obtained prior to or after hospital arrival? (mg/dL)**	_____ ☐ ND	Stroke	CSTK, TSC		Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Hospitalization	**Serum Creatinine**	_____ ☐ ND	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	Warning
Hospitalization	**What is the first platelet count obtained prior to or after hospital arrival?**	_____ ☐ UTD	ICH	CSTK, TSC			Required

Hospitalization	**Is there documentation of any platelet count after arrival of <100,000 mcL?**	○ Yes ○ No	ICH				None
Hospitalization	**aPTT (sec)**	_____ ☐ ND	ICH				Required
Hospitalization	**Xa Activity**	_____ ☐ ND				MSN	None
Hospitalization	**INR**	_____ ☐ ND ☐ NC	Stroke, ICH			Ohio, Michigan, Middle-East, Canada, Mexico	Warning (Stroke) Required (ICH)
Hospitalization	**INR Value >= 1.4**	○ Yes ○ No	ICH	CSTK			Required
Hospitalization	**Anti-Factor Xa level:**	_____	ICH				None
Hospitalization	**Heart Rate (beats per minute):**	_____	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	Warning
Hospitalization	**^What is the first blood pressure obtained prior to or after hospital arrival?**	Blood Pressure (Systolic) - Initial: _____ Blood Pressure (Diastolic) - Initial: _____	Stroke, ICH	CSTK		Ohio, Michigan, Middle-East, Canada, Mexico	Required
Hospitalization	**Vital Signs: UTD**	☐	Stroke, ICH	CSTK		Ohio, Michigan, Middle-East, Canada, Mexico	None
Hospitalization	**Height:**	_____ ○ lb ○ kg ☐ ND	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required (Diabetes & CKMH)
Hospitalization	**Weight:**	_____ ○ in ○ cm ☐ ND	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Hospitalization	**Waist Circumference**	_____ ○ in ○ cm ☐ ND	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	None
Hospitalization	**BMI:**	_____ ☐ ND	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required (Diabetes & CKMH)
	ADDITIONAL TIME TRACKER						
Time Tracker	**Date/Time Stroke Team Activated:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time Stroke Team Arrived:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK	DNV	Canada, Mexico, Middle-East	Required (DNV)
Time Tracker	**Date/Time ED Provider Assessment:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK	DNV	Canada, Mexico, Middle-East	Required (DNV & MSN)
Time Tracker	**Date/Time Neurosurgical Services Consulted:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time Brain Imaging Ordered:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East, LA-EMS	None
Time Tracker	**Date/Time IV Thrombolytic Ordered:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited			Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time Lab Tests Ordered:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK	DNV	Canada, Mexico, Middle-East	Required (DNV)
Time Tracker	**Date/Time Lab Tests Completed:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK	DNV	Canada, Mexico, Middle-East	Required (DNV)
Time Tracker	**Date/Time ECG Ordered:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time ECG Completed:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time Chest X-ray Ordered:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
Time Tracker	**Date/Time Chest X-ray Completed:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Canada, Mexico, Middle-East	None
	Endovascular Care Time Tracker						
Time Tracker	**Date/Time Neurointerventional Team Activation:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Middle-East, Canada, Mexico	None
Time Tracker	**Date/Time Patient Arrival in Neurointerventional Suite:**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Stroke, Stroke-Limited	STK		Middle-East, Canada, Mexico	None
	ADVANCED STROKE CARE						
	Catheter-based/Endovascular Stroke Treatment						
Advanced	**^Is there documentation that the route of alteplase administration was intra-arterial (IA)?**	○ Yes ○ No		CSTK, TSC			Required
Advanced	**^Is there documentation that IA thrombolytic therapy was initiated at this hospital?**	○ Yes ○ No		CSTK			Required
Advanced	**^What is the date and time that IA thrombolytic therapy was initiated for this patient at this hospital?**	____/____/____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		CSTK			Required
Advanced	**^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		CSTK, TSC			Required
Advanced	**^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		CSTK, TSC	DNV-ADV		Required
Advanced	**^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	Endovascular-Therapy	CSTK, TSC	DNV-ADV	Middle-East	Required
Advanced	**^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		CSTK, TSC			Required
Advanced	**^^Was a mechanical endovascular reperfusion procedure attempted during this episode of care (at this hospital)?**	○ Yes ○ No	Endovascular-Therapy	CSTK	DNV, DNV-ADV	Middle-East, PSS	Required

Advanced	**^Was a mechanical thrombectomy procedure attempted but unsuccessful or aborted before removal of the LVO?**	○ Yes ○ No		CSTK, TSC			Required
Advanced	**^^Are reasons for not performing mechanical endovascular reperfusion therapy documented?**	○ Yes ○ No	Endovascular-Therapy		DNV		Required
Advanced	**^^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 * Does not exclude from measure population ☐ Equipment-related delay ☐ No endovascular specialist available ☐ Delay in stroke diagnosis ☐ Vascular imaging not performed ☐ Advanced Age ☐ Other _____	Endovascular-Therapy		DNV	Middle-East	Required
Advanced	**^^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	Endovascular-Therapy	CSTK		Middle-East	Required
Advanced	**^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	Endovascular-Therapy	CSTK	DNV-ADV	PSS	Required
Advanced	**^What is the date and time of the first pass of a clot retrieval device at this hospital?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Endovascular-Therapy	CSTK	DNV-ADV	PSS, Middle-East	Required
Advanced	**^^Is a cause(s) for delay in performing mechanical endovascular reperfusion therapy documented?**	○ Yes ○ No	Endovascular-Therapy		DNV-ADV	Middle-East	Required
Advanced	**^^Reasons for delay in performing mechanical endovascular reperfusion therapy (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 * Does not exclude from measure population ○ Delay in stroke diagnosis * ○ In-hospital time delay * ○ Equipment-related delay * ○ Need for additional imaging * ○ Catheter lab not available * ○ Other *	Endovascular-Therapy		DNV-ADV	Middle-East	Required
Advanced	**^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		CSTK			None
Advanced	**^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.		CSTK, TSC			Required
Advanced	**^^Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade**	○ Grade 0 ○ Grade 1 ○ Grade 2a ○ Grade 2b ○ Grade 3 ○ ND	Endovascular-Therapy	CSTK	DNV-ADV	Middle-East	Required (DNV)
Advanced	**^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		CSTK, TSC			Required
Advanced	**^What was the date and time that TICI 2b/3 was first documented during the mechanical thrombectomy procedure?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Endovascular-Therapy	ASR, CSTK	DNV-ADV	Middle-East	Required
Advanced	**Date/Time End of Endovascular Procedure**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Endovascular-Therapy	CSTK		Michigan, Middle-East	None
	Complications						
Advanced	**^Was there a positive finding on brain imaging of parenchymal hematoma, subarachnoid hemorrhage, and/or intraventricular hemorrhage following IV or IA alteplase therapy, or mechanical endovascular reperfusion therapy initiation?**	○ Yes ○ No	Endovascular-Therapy	CSTK, TSC			Required
Advanced	**^Date/Time of positive brain image:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Endovascular-Therapy	CSTK, TSC			Required

Advanced	**^^Results of abnormal 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	Endovascular-Therapy	CSTK, TSC			Required
Advanced	**This score obtained from (documented prior to initiation of IV alteplase at this hospital):**	○ Baseline NIHSS ○ Subsequent NIHSS		CSTK		Middle-East	None
Advanced	**^What is the last NIHSS score documented prior to initiation of IV alteplase at this hospital?**	_____ ☐ UTD	Endovascular-Therapy	CSTK, TSC			Required
Advanced	**^What is the highest NIHSS score documented within 36 hours following initiation of IV alteplase?**	_____ ☐ UTD	Endovascular-Therapy	CSTK, TSC			Required
Advanced	**This score obtained from (documented prior to initiation of IA alteplase or MER at this hospital):**	○ Baseline NIHSS ○ Subsequent NIHSS	Endovascular-Therapy	CSTK, TSC		Middle-East	Required
Advanced	**^What is the last NIHSS score documented prior to initiation of IA alteplase or MER at this hospital?**	○ Baseline NIHSS ○ Subsequent NIHSS	Endovascular-Therapy	CSTK, TSC		Middle-East	Required
Advanced	**^What is the highest NIHSS score documented within 36 hours following IA alteplase or MER initiation?**	_____ ☐ UTD	Endovascular-Therapy	CSTK, TSC			Required
Advanced	**BP lowering agent administered at your hospital**	○ Yes ○ No/ND ○ NC	ICH				Required
Advanced	**Date/Time of first administration of a BP lowering agent at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required
Advanced	**Date/Time Systolic BP first sustained at <= 149 for >= 5 minutes**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required
Advanced	**Systolic BP never sustained at <=149 for >=5 minutes**	☐	ICH				None
Advanced	**^Is there documentation that a procoagulant reversal agent was initiated at this hospital?**	○ Yes ○ No	ICH	CSTK			Required
Advanced	**If yes, select reversal agent administered (at this hospital):**	☐ Prothrombin complex concentrates (PCC) ☐ 3-factor prothrombin complex concentrate (3-factor PCC) ☐ 4-factor prothrombin complex concentrate (4-factor PCC) ☐ Activated prothrombin complex concentrate (aPCC) ☐ Fresh frozen plasma (FFP) ☐ Factor Xa reversal - Andexxa (andexanet alfa) ☐ Pradaxa (dabigatran) reversal - Praxbind (idarucizumab) ☐ IV protamine ☐ Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) ☐ Other _____	ICH				Required
Advanced	**^^Date/Time procoagulant initiated**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH	CSTK			Required
Advanced	**If reversal therapy was initiated greater than 60 minutes after arrival, were reason(s) documented as cause for delay?**	○ Yes ○ No	ICH				Required
Advanced	**Cause for delay in reversal therapy (greater than 60 minutes after arrival)**	☐ Unable to determine last dose of anticoagulant ☐ Information on anticoagulant status not initially available ☐ Unable to determine time of symptom onset ☐ Lab delay in INR or PTT/aPTT results* ☐ Delay in stroke diagnosis* ☐ Delay in initiative imaging* ☐ Delay in imaging results reported* ☐ Equipment-related delay* ☐ Initial Refusal ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Social/religious ☐ Other* _____	ICH				Required
Advanced	**If reversal therapy was initiated greater than 90 minutes after arrival, were reason(s) documented as cause for delay?**	○ Yes ○ No	ICH				Required
Advanced	**Cause for delay in reversal therapy (greater than 90 minutes after arrival)**	☐ Unable to determine last dose of anticoagulant ☐ Information on anticoagulant status not initially available ☐ Unable to determine time of symptom onset ☐ Lab delay in INR or PTT/aPTT results* ☐ Delay in stroke diagnosis* ☐ Delay in initiative imaging* ☐ Delay in imaging results reported* ☐ Equipment-related delay* ☐ Initial Refusal ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Social/religious ☐ Other* _____	ICH				Required
Advanced	**Was a repeat dose of procoagulant reversal agent required for this patient?**	○ Yes ○ No	ICH				None
Advanced	**If yes, select reversal agent used for redosing administered:**	☐ Prothrombin complex concentrates (PCC) ☐ 3-factor prothrombin complex concentrate (3-factor PCC) ☐ 4-factor prothrombin complex concentrate (4-factor PCC) ☐ Activated prothrombin complex concentrate (aPCC) ☐ Fresh frozen plasma (FFP) ☐ Factor Xa reversal - Andexxa (andexanet alfa) ☐ Pradaxa (dabigatran) reversal - Praxbind (idarucizumab) ☐ IV protamine ☐ Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) ☐ Other _____	ICH				Required

Advanced	**Date/Time of Procoagulant redosing**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required
Advanced	**Was a procoagulant reversal agent administered to the patient prior to arrival at your hospital (in MSU or first hospital):**	○ Yes ○ No	ICH				Required
Advanced	**If yes, select reversal agent administered (prior to arrival):**	☐ Prothrombin complex concentrates (PCC) ☐ 3-factor prothrombin complex concentrate (3-factor PCC) ☐ 4-factor prothrombin complex concentrate (4-factor PCC) ☐ Activated prothrombin complex concentrate (aPCC) ☐ Fresh frozen plasma (FFP) ☐ Factor Xa reversal - Andexxa (andexanet alfa) ☐ Pradaxa (dabigatran) reversal - Praxbind (idarucizumab) ☐ IV protamine ☐ Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) ☐ Other _____	ICH				Required
Advanced	**Was Vitamin K administered to this patient?**	○ Yes, prior to arrival (in MSU or first hospital) ○ Yes, at your hospital ○ No	ICH				Required
Advanced	**Other reversal therapies administered at this hospital**	☐ Activated charcoal ☐ Renal replacement therapy (RRT) ☐ Other non-pharmacological therapy ☐ Specify other non-pharmacological therapy at this hospital: _____ ☐ None	ICH				Required
Advanced	**Other reversal therapies prior to arrival**	☐ Activated charcoal ☐ Renal replacement therapy (RRT) ☐ Other non-pharmacological therapy ☐ Specify other non-pharmacological therapy at this hospital: _____ ☐ None	ICH				Required
Advanced	**^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	ICH	CSTK			Required
Advanced	**If patient is currently taking DOACs, is there documentation in the medical record of a reason for not administering an anticoagulant reversal agent ?**	○ Yes, medical Reason ○ Yes, patient reason ○ Yes, system reason ○ No	ICH				Required
Advanced	**^^If initial INR > 1.4 and treated with procoagulant, Date/Time first INR <=1.4 after treatment:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		CSTK			None
Advanced	**No documented INR <= 1.4 after treatment**	☐		CSTK			None
	External Ventricular Drain						
Advanced	**Was an External Ventricular Drain (EVD) placed during this hospitalization?**	○ Yes ○ No	SAH, Aneurysm-Repair		DNV, DNV-ADV		Required
Advanced	**Date/Time EVD placed**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH		DNV		Required
Advanced	**Was the patient diagnosed with ventriculitis during this hospitalization?**	○ Yes ○ No	SAH, Aneurysm-Repair		DNV, DNV-ADV		Required
	Hemorrhagic Stroke Treatment						
Advanced	**^Is there documentation that nimodipine was administered at this hospital?**	○ Yes ○ No	SAH	CSTK	DNV		Required
Advanced	**^What is the date and time that nimodipine was first administered to this patient at this hospital?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH	CSTK	DNV		Required
Advanced	**^Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not administering nimodipine treatment?**	○ Yes ○ No	SAH	CSTK	DNV		Required
Advanced	**Specify reason(s) for not administering nimodipine treatment**	☐ Nimodipine Allergy ☐ Hypotension or on pressor ☐ Route of administration unavailable ☐ Other	SAH				Required
Advanced	**Was nimodipine continued until discharge?**	○ Yes ○ No			DNV		Required
Advanced	**Date and time that nimodipine was discontinued**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown			DNV		Required
Advanced	**Documented reason(s) for not continuing nimodipine treatment**	○ Yes ○ No			DNV		Required
Advanced	**^^Surgical treatment for ICH at this hospital?**	○ Yes ○ No	ICH	CSTK	DNV		Required
Advanced	**^^If surgical treatment for ICH at this hospital, type:**	☐ Conventional craniotomy and evacuation of clot under direct vision ☐ External Ventricular Drain (EVD) ☐ Fibrinolytic infusion via catheter ☐ Hemicraniectomy ☐ Without clot evacuation ☐ With clot evacuation ☐ Minimally invasive ☐ Catheter evacuation followed by thrombolysis ☐ Tubular tractors ☐ Endoscope assisted ☐ Suboccipital decompression ☐ Other intracranial monitoring ☐ Other neurosurgical treatment	ICH	CSTK			Required

Advanced	**If surgical treatment for ICH at this hospital is yes, what was the procedure date/ time?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH		DNV		Required
Advanced	**^^If ICH was evacuated, time from ictus to evacuation procedure start was:**	_____	ICH	CSTK			None
Advanced	**Was an AVM repair attempted during this episode of care at this hospital?**	○ Yes ○ No			DNV-ADV		None
Advanced	**Did the patient experience any serious complications within 24 hours of the AVM repair procedure?**	☐ No serious complications ☐ Ischemic Stroke ☐ Symptomatic Intracranial Hemorrhage ☐ Death ☐ Other Serious			DNV-ADV		Required
Advanced	**Was the patient treated with an IV or oral corticosteroid?**	○ Yes, prior to arrival (in MSU or first hospital) ○ Yes, at your hospital ○ No	ICH				Required
Advanced	**Documentation of a neurological or other medical reason for prescribing corticosteroids:**	○ Yes ○ No	ICH				Required
Advanced	**Was the patient administered a platelet transfusion at your hospital?**	○ Yes ○ No	ICH				Required
Advanced	**Initial Platelet Transfusion Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	ICH				Required
	Aneurysm Repair						
Advanced	**Was a cerebral aneurysm repair attempted during this episode of care at this hospital?**	○ Yes ○ No	SAH, Aneurysm-Repair		DNV, DNV-ADV		Required
Advanced	**Documented reason for not attempting aneurysm repair**	○ Yes ○ No	SAH				Required
Advanced	**Repair Approach(es):**	☐ Surgical clipping ☐ Endovascular coiling (endcoilapp) ○ Conventional ○ Stent-assisted (stent permanently deployed) ○ Temporary balloon or stent-assisted ☐ Flow diverter ☐ Other endovascular device ☐ Other (specify) _____	SAH, Aneurysm-Repair		DNV, DNV-ADV		Required
Advanced	**What is the location of the cerebral aneurysm?**	○ Anterior circulation ○ Posterior circulation	SAH, Aneurysm-Repair				None
Advanced	**What is the size of the aneurysm (mm):**	_____	SAH, Aneurysm-Repair				None
Advanced	**Was the aneurysm ruptured prior to repair procedure?**	○ Yes ○ No ○ Not Documented	SAH, Aneurysm-Repair		DNV, DNV-ADV		Required
Advanced	**Fisher Scale grade prior to repair:**	○ Grade 1: No subarachnoid hemorrhage or intraventricular hemorrhage detected ○ Grade 2: Diffuse thin (<1 mm) subarachnoid hemorrhage ○ Grade 3: Localized clots and/or layers of blood >1 mm in thickness ○ Grade 4: Diffuse or no subarachnoid hemorrhage, intracerebral hemorrhage or intraventricular hemorrhage present ○ ND or Unable to Determine from medical record	SAH, Aneurysm-Repair				None
Advanced	**Date/time repair procedure initiated:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH, Aneurysm-Repair		DNV		Required
Advanced	**Date/time repair procedure completed**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH				Required
Advanced	**Documented reason for delay in aneurysm repair**	○ Yes ○ No/ND	SAH				Required
Advanced	**Specify reason(s) for delay in aneurysm repair**	☐ Social/religious ☐ Initial refusal ☐ Care team unable to determine eligibility ☐ Patient not medically stable ☐ Medical futility ☐ Resource limitations*	SAH				Required
Advanced	**Post-procedure Hunt and Hess scale done**	○ Yes ○ No/ND	SAH				Required
Advanced	**Post-procedure Hunt and Hess score**	_____	SAH				None
Advanced	**What is the date and time that the Hunt and Hess scale was first performed post-procedure?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	SAH				Required
Advanced	**Did the patient experience any serious complications during the aneurysm repair procedure, or within 24 hours of the procedure?**	☐ No serious complications ☐ Ischemic Stroke ☐ Symptomatic Intracranial Hemorrhage ☐ Death ☐ Other serious (please specify) _____	SAH, Aneurysm-Repair				Required
	DISCHARGE						
Discharge	**Get With The Guidelines® - Ischemic Stroke-Only Estimated Mortality Rate**	[Calculated in the IRP]	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Discharge	**Get With The Guidelines® - Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke not otherwise specified)**	[Calculated in the IRP]	Stroke, Stroke-Limited			Middle-East, Canada, Mexico	None
Discharge	**Was a Modified Rankin Scale (mRS) performed at discharge?**	○ Yes ○ No/ND	Stroke		DNV	LA-EMS, PTSN, Middle-East, Canada, Mexico	Required

Discharge	**Method used to obtain Modified Rankin Scale at Discharge:**	○ Actual ○ Estimated from the record ○ ND	Stroke			LA-EMS, PTSN, Middle-East, Canada, Mexico	None
Discharge	**Modified Rankin at Discharge, Total Score:**	_____	Stroke		DNV	Coverdell, LA-EMS, Middle-East, Canada, Mexico	Required
Discharge	**Modified Rankin Scale at Discharge**	○ 0 - No symptoms at all ○ 1 - No significant disability despite symptoms: Able to carry out all usual activities ○ 2 - Slight disability ○ 3 - Moderate disability: Requiring some help but able to walk without assistance ○ 4 - Moderate to severe disability: Unable to walk without assistance and unable to attend to own bodily needs without assistance ○ 5 - Severe disability: Bedridden, incontinent and requiring constant nursing care and attention ○ 6 - Death	Stroke			LA-EMS, PTSN, Middle-East, Canada, Mexico	None
Discharge	**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	Stroke			Coverdell, Ohio, Michigan, LA-EMS, Mexico, Canada, Middle-East	Required
	Discharge Blood Pressure (closest to discharge)						
Discharge	**Blood Pressure (Systolic) - Discharge:**	_____	Stroke, ICH			Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Blood Pressure (Diastolic) - Discharge:**	_____	Stroke, ICH			Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Discharge Blood Pressure Not Documented**	☐	Stroke, ICH			Ohio, Michigan, Middle-East, Canada, Mexico	None
Discharge	**Did the patient receive any antihypertensive medication on the day of or the day prior to discharge?**	○ Yes ○ No/ND	ICH				Required
Discharge	**Were there two or more systolic blood pressure readings < 130 within 24 hours prior to the time of discharge?**	○ Yes ○ No/ND	ICH				Required
	Discharge Labs						
Discharge	**Urinary Albumin (mg/dL)**	_____ ☐ Unavailable				CKMH	Required
Discharge	**Urinary Serum Creatinine (mg/dL)**	_____ ☐ Unavailable				CKMH	Required
Discharge	**Urinary Albumin-to-Creatinine Ratio (mg/g)**	_____ ☐ Unavailable				CKMH	Required
Discharge	**eGFR (mL/min/1.73m2)**	_____ ☐ Unavailable				CKMH	Required
Discharge	**CKD Risk Calculated During this Hospital Stay**	_____ ☐ Unavailable				CKMH	None
	Discharge Treatments						
Discharge	**Antithrombotic Medication(s) Prescribed at Discharge:**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Antithrombotic Class**	☐ Antiplatelet ☐ Anticoagulation	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Antithrombotics Medication**	Antiplatelet: ☐ aspirin ☐ aspirin/dipyridamole (Aggrenox) ☐ clopidogrel (Plavix) ☐ prasugrel (Effient) ☐ ticagrelor (Brilinta) ☐ ticlopidine (Ticlid) ☐ Other Antiplatelet Anticoagulation: ☐ 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	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Antithrombotic Dosage**	_____	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Discharge	**Antithrombotic Frequency**	_____	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Discharge	**Documented reason for not prescribing an antithrombotic approved in stroke**	○ Yes ○ No/ND	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Discharge	**Select documented contraindications for antithrombotics at discharge:**	☐ 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	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Mineralocroticoid Receptor Antagonist (MRA) Prescribed?**	○ Yes ○ No ○ NC				CKMH	Required
Discharge	**Mineralocroticoid Receptor Antagonist (MRA) Medication**	○ Aldactone (Spironolactone) ○ Inspra (Eplerenone) ○ Keren Dia (finerenone)				CKMH	Required

Discharge	**Mineralocroticoid Receptor Antagonist (MRA) Dosage**	○ 6.25 mg ○ 10 mg ○ 12.5 mg ○ 20 mg ○ 25 mg ○ 50 mg ○ 100 mg ○ Other ○ Unknown				CKMH	Required
Discharge	**Mineralocroticoid Receptor Antagonist (MRA) Frequency**	○ Every day ○ Every other day ○ Other ○ Unknown				CKMH	Required
Discharge	**Contraindications or Other Documented Reason(s) for Not Providing Mineralocorticoid Receptor Antagonist (MRA) at Discharge**	☐ Contraindicated ☐ Allergy due to aldosterone receptor antagonist ☐ Hyperkalemia ☐ Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women ☐ Other contraindications ☐ Not Eligible ☐ Not Tolerant ☐ Patient Enrolled in Clinical Trial ☐ Patient Reason ☐ System Reason ☐ Other Reason				CKMH	Required
Discharge	**Persistent or Paroxysmal Atrial Fibrillation/Flutter:**	○ Yes ○ No	Stroke, Stroke-Limited	TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**If Atrial Fibrillation/Flutter or history of PAF documented, was patient discharged on anticoagulation?**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Documented reason for no anticoagulation with history of AF (Select all that apply):**	☐ Allergy to or complicated r/t warfarin or heparins (hx or current) ☐ 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	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Warning
Discharge	**Antihypertensive Prescribed at Discharge (Select all that apply):**	☐ None prescribed/ND ☐ None - contraindicated ☐ ACE Inhibitor ☐ ARB ☐ ARNI ☐ Beta Blocker ☐ Ca++ Channel Blocker ☐ Diuretic ☐ Other anti-hypertensive med	Stroke, ICH			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Contraindications or Other Documented Reasons for Not Prescribing ACEI at Discharge**	○ Yes ○ No				CKMH	Required
Discharge	**Contraindications or Other Documented Reasons for Not Prescribing ARB at Discharge**	○ Yes ○ No				CKMH	Required
Discharge	**Contraindications or Other Documented Reasons for Not Prescribing ARNI at Discharge:**	○ Yes ○ No				CKMH	Required
Discharge	**Cholesterol Reducer Prescribed at Discharge (Select all that apply):**	☐ None prescribed/ND ☐ None - contraindicated ☐ Absorption inhibitor ☐ Fibrate ☐ Niacin ☐ PCSK 9 inhibitor ☐ Statin ☐ Other med	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**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)	Stroke, Stroke-Limited			Coverdell, Middle-East, Canada, Mexico	Required
Discharge	**Statin Total Daily Dose**	_____	Stroke, Stroke-Limited			Coverdell, Middle-East, Canada, Mexico	Required
Discharge	**Documented reason for not prescribing guideline recommended statin 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	Stroke, Stroke-Limited			Coverdell, Middle-East, Canada, Mexico	Required
Discharge	**Documented reason for not prescribing a statin medication at discharge?**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Follow-up for lipid management**	○ Yes ○ No ○ NC	ASCVD			CKMH	Required
Discharge	**LP(a) treatment plan**	☐ None ☐ Lipoprotein apheresis ☐ Patient education on LP(a) ☐ Referred to lipid management ☐ Risk factor management ☐ Other _____	Stroke, Stroke-Limited, ASCVD				Required
Discharge	**New Diagnosis of Diabetes**	○ Yes ○ No ○ ND	Stroke, Stroke-Limited	STK		Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required

Discharge	**New Diagnosis of Diabetes Type**	○ Type 1 ○ Type 2 ○ ND				CKMH	Required
Discharge	**Basis for Diabetes Diagnosis (Select all that apply):**	☐ HbA1c ☐ Fasting Blood Sugar ☐ Oral Glucose Tolerance ☐ Test Other	Stroke, Stroke-Limited			CKMH	Required
Discharge	**Antihyperglycemic Medication(s) Prescribed at Discharge:**	○ Yes ○ No ○ NC	Stroke, Stroke-Limited, Diabetes			CKMH, Middle-East, Canada, Mexico, Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Antihyperglycemic Class**	☐ Biguanide ☐ DPP-4 Inhibitor ☐ GLP-1 receptor agonist ☐ Insulin ☐ SGLT2 Inhibitor ☐ Sulfonylurea ☐ Thiazolidinedione ☐ Other subcutaneous/injectable agents ☐ Other oral agents	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Antihyperglycemic Medication**	_____	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Was there a documented reason for not prescribing a medication with proven CVD benefit?**	○ Yes ○ No/ND	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Follow-up appointment scheduled for diabetes management?**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Date of diabetes management follow-up visit:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Stroke, Stroke-Limited, Diabetes			Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Anti-Smoking Treatment:**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Smoking Cessation Therapies Prescribed**	☐ Counseling ☐ Over the Counter Nicotine Replacement Therapy ☐ Prescription Medications ☐ Other ☐ Treatment not specified	Stroke			Canada, Mexico, CKMH	None
Discharge	**Follow-up for Weight Management?**	○ Yes ○ No/ND ○ NC				CKMH	Required
Discharge	**Referral for CKD Evaluation?**	○ Yes ○ No/ND ○ NC				CKMH	Required
Discharge	**Where was the patient referred to?**	○ Primary Care ○ Nephrology ○ Other (specify) _____ ○ Not Documented				CKMH	Required
Discharge	**Referral to CKM Coordinator?**	○ Yes ○ No/ND ○ NC				CKMH	Required
Discharge	**Was the patient prescribed any antidepressant class of medication at discharge?**	○ Yes, SSRI ○ Yes, any other antidepressant class ○ No/ND	Stroke			Canada, Mexico	None
	Other Lifestyle Interventions						
Discharge	**Reducing weight and/or increasing activity recommendations:**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**TLC Diet or Equivalent:**	○ Yes ○ No/ND ○ NC	Stroke, Stroke-Limited			Ohio, Michigan, Middle-East, Canada, Mexico, CKMH	Required
Discharge	**Anti-hypertensive Diet:**	○ Yes ○ No/ND ○ NC	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	Warning
Discharge	**Was Diabetes Teaching Provided?**	○ Yes ○ No/ND ○ NC	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
	Stroke Education						
Discharge	**Check all Stroke Education as Yes:**	☐	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	None
Discharge	**Risk Factors for Stroke**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Stroke Warning Signs and Symptoms**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**How to Activate EMS for Stroke**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Need for Follow-Up After Discharge**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Their Prescribed Medications**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
	Stroke Rehabilitation						

Discharge	**Patient assessed for and/or received rehabilitation services during this hospitalization?**	○ Yes ○ No	Stroke, Stroke-Limited	STK, TSC		Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Required
Discharge	**Check all rehabilitation 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)	Stroke			Coverdell, Ohio, Michigan, Middle-East, Canada, Mexico	Warning
	Care Coordination						
Discharge	**Is there documentation that the patient was engaged in a shared decision-making discussion regarding the benefits and risks of anticoagulation and the specific type of anticoagulation therapy to prevent stroke?**	○ Yes ○ No/ND				MDCHIA	Required
Discharge	**Was a decision aid used as part of the shared decision-making discussion?**	○ Yes ○ No/ND				MDCHIA	Required
Discharge	**What decision aid was used? (Select all that apply)**	☐ Health Decision: Shared Decision-making tool for Atrial Fibrillation ☐ National Institute for Health and Care Excellence (NICE): Patient decision aid: Atrial fibrillation: medicines to help reduce your risk of a stroke - what are the options? ☐ Healthwise: Atrial Fibrillation: Should I Take an Anticoagulant to Prevent Stroke? ☐ Healthwise: Atrial Fibrillation: Which Anticoagulant Should I Take to Prevent Stroke? ☐ American College of Cardiology: Afib Decision Aid for Anticoagulation for Non-Valvular AFib ☐ Other decision aid related to use of or choice of anticoagulant for AF for stroke prevention ☐ Not documented				MDCHIA	Required
Discharge	**Is there documentation that the patient was enrolled in a clinical trial related to Atrial Fibrillation or Atrial Flutter?**	○ Yes ○ No/ND				MDCHIA	Required
Discharge	**Is there documentation that a care transition record, including all required components, was transmitted to the follow up care provider?**	○ Yes ○ No/ND				MDCHIA, Care-Coordination	Required
Discharge	**Date/Time care transition record was transmitted:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				MDCHIA, Care-Coordination	Required
Discharge	**Specialty of follow up care provider who received the care transition record:**	○ Primary care/Family Medicine/Internal Medicine (Physician, APN or PA) ○ Cardiologist or Electrophysiologist ○ Neurologist ○ Other specialist ○ Home Health agency (visit with an RN, APN, PA or MD) ○ Not documented				MDCHIA, Care-Coordination	Required
Discharge	**Was the patient assessed for potential barriers to following up with a provider after discharge?**	○ Yes ○ No/ND				MDCHIA, Care-Coordination	Required
Discharge	**What potential barriers to follow up were documented, if any: (Select all that apply)**	☐ Transportation ☐ Work or family responsibilities ☐ Unable to schedule at a convenient time ☐ Financial concerns ☐ Lack of/inadequate health insurance or provider won't accept insurance ☐ Other barrier(s) ☐ No barrier documented				MDCHIA, Care-Coordination	Required
	Health Related Social Needs Assessment						
Discharge	**During this admission, was a standardized health related social needs form or assessment completed?**	○ Yes ○ No/ND	Stroke, Stroke-Limited			MDCHIA, Canada, Mexico, CKMH, Care-Coordination	None (Stroke) Required (MDCHIA, Care-Coord, CKMH)
Discharge	**If yes, identify the areas of unmet social need. (select all that apply)**	☐ None of the areas of unmet social needs listed ☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing ☐ Mental Health ☐ Personal Safety ☐ Substance Use Disorder ☐ Transportation Barriers ☐ Utilities	Stroke, Stroke-Limited			MDCHIA, Canada, Mexico, CKMH, Care-Coordination	Required
	Stroke Diagnostic Tests and Interventions						
Discharge	**Cardiac ultrasound/echocardiography**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Extended implantable cardiac rhythm monitoring**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Carotid imaging**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Hypercoagulability testing**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Carotid revascularization**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Intracranial vascular imaging**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Extended surface cardiac rhythm monitoring > 7 days**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required
Discharge	**Short-term cardiac rhythm monitoring <= 7 days**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Stroke			Middle-East, Canada, Mexico	Required

	OPTIONAL						
Optional	**PMT used concurrently or retrospectively or combination?**	○ Concurrently ○ Retrospectively ○ Combination	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
Optional	**Was a stroke admission order set used in this patient?**	○ Yes ○ No	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
Optional	**Was a stroke discharge checklist used in this patient?**	○ Yes ○ No	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
Optional	**Patient adherence contract/compact used?**	○ Yes ○ No	Stroke			Ohio, Michigan, Middle-East, Canada, Mexico	None
	CUSTOM FIELDS						
Custom	_____						None
Custom	_____						None
Custom	_____						None
Custom	_____						None
Custom	_____						None
	CERTIFICATION						
Certification	**Check if patient is part of a sample:**	☐		ASR, CSTK, STK, TSC			None
	Demographics						
Certification	**Race**	○ Black or African American ○ American Indian or Alaska Native ○ Asian (2020) / Asian or Pacific Islander (2021) ○ Native Hawaiian or Pacific Islander (discharges prior to 2021) ○ White ○ UTD		ASR, CSTK, STK, TSC			Required
	History & Last Known Well						
Certification	**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		STK, TSC			Required
Certification	**Is there documentation that the date and time of last known well was witnessed or reported?**	○ Yes ○ No		ASR, STK, TSC			Required
Certification	**What was the date and time at which the patient was last known to be well or at his or her baseline state of health?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		ASR, STK, TSC			Required
Certification	**When is the earliest physician/APN/PA documentation of comfort measures only? (STK)**	○ 1- Day 0 or 1 ○ 2- Day 2 or after ○ 3- Timing unclear ○ 4- Not Documented/UTD		ASR, STK, CSTK, TSC			Required
	Thrombolytics						
Certification	**Is there documentation that IV alteplase was initiated at this hospital?**	○ Yes ○ No		ASR, STK, CSTK, TSC			Required
Certification	**Is there documentation on the day of or day after hospital arrival of a reason for extending the initiation of IV alteplase to 3 to 4.5 hours of Time Last Known Well?**	○ Yes ○ No		ASR, STK, TSC		Coverdell	Required
Certification	**Did the patient receive IV or IA alteplase at this hospital or within 24 hours prior to arrival?**	○ Yes ○ No		ASR, STK, TSC			Required
Certification	**Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV alteplase?**	○ Yes ○ No		ASR, STK, TSC			Required
	Early Antithrombotics						
Certification	**Was antithrombotic therapy administered by the end of hospital day 2? (STK)**	○ Yes ○ No		ASR, STK, TSC			Required
	Discharge Information						
Certification	**Discharge Date/Time (TJC)**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ UTD		ASR, STK, CSTK, TSC			Required
Certification	**Was antithrombotic therapy prescribed at hospital discharge?**	○ Yes ○ No		ASR, STK, TSC			Required
Certification	**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		ASR, STK, TSC			Required
Certification	**Was anticoagulation therapy prescribed at hospital discharge?**	○ Yes ○ No		STK, TSC			Required
Certification	**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		STK, TSC			Required
Certification	**Was a statin medication prescribed at discharge?**	○ Yes ○ No		STK, TSC			Required
	OUTPATIENT						
Outpatient	**Hospital MRN**	_____				CMS-OP-23	None
Outpatient	**Other MRN**	_____				CMS-OP-23	None
Outpatient	**External Tracking ID**	_____				CMS-OP-23	None

Outpatient	**Encounter Date**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		ASR, STK, TSC		CMS-OP-23	Required
Outpatient	**E/M Code**	_____		ASR, STK, TSC		CMS-OP-23	Required
Outpatient	**Arrival Date/Time (OP STK)**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				CMS-OP-23	None
	Demographics						
Outpatient	**Birth Date (OP STK)**	_____/_____/_____				CMS-OP-23	Required
Outpatient	**Sex (OP STK)**	○ Female ○ Male				CMS-OP-23	None
Outpatient	**Race (OP STK)**	○ American Indian or Alaska Native ○ Asian (2020) / Asian or Pacific Islander (2021) ○ Black or African American ○ Native Hawaiian or Pacific Islander (discharges prior to 2021) ○ White ○ UTD				CMS-OP-23	Required
Outpatient	**Hispanic Ethnicity (OP STK)**	○ Yes ○ No				CMS-OP-23	Required
Outpatient	**Patient Zip Code (OP STK)**	_____				CMS-OP-23	Required
Outpatient	**Zip Code Extension (OP STK)**	_____				CMS-OP-23	None
Outpatient	**Homeless (OP STK)**	☐				CMS-OP-23	None
	Insurance						
Outpatient	**What is the patient's source of payment for this outpatient encounter?**	○ Medicare ○ Non-Medicare				CMS-OP-23	Required
	Discharge						
Outpatient	**What is the date/time the patient departed from the emergency department?**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown		ASR, STK, TSC		CMS-OP-23	Required
Outpatient	**For discharges on or after 07/01/2012: What was the patient's discharge code from the outpatient setting?**	○ 1 Home ○ 2 Hospice - Home ○ 3 Hospice - Health Care Facility ○ 4a Acute Care Facility - General Inpatient Care ○ 4b Acute Care Facility - Critical Access Hospital ○ 4c Acute Care Facility - Cancer Hospital or Children's Hospital ○ 4d Acute Care Facility - Department of Defense or Veteran's Administration ○ 5 Other Health Care Facility ○ 6 Expired ○ 7 Left Against Medical Advice/AMA ○ 8 Not Documented or Unable to Determine (UTD)		ASR, STK, TSC		CMS-OP-23	Required
	Head CT or MRI Scan and Last Known Well						
Outpatient	**Was a Head CT or MRI scan ordered by the physician during the emergency department visit?**	○ Yes ○ No				CMS-OP-23	Required
Outpatient	**Is there documentation that the date and time of last known well was witnessed or reported? (Outpatient)**	○ Yes ○ No				CMS-OP-23	Required
Outpatient	**What was the date and time at which the patient was last known to be well or at his or her baseline state of health? (Outpatient)**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				CMS-OP-23	Required
Outpatient	**What is the date and time the earliest Head CT or MRI Scan Interpretation was completed or reported?**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				CMS-OP-23	Required
	SPECIAL INITIATIVES						
	Arizona EMS						
Special	**If yes, Reasons transported to this facility:**	○ Met EMS stroke protocol criteria ○ Presumed diagnosis in the field is Ischemic Stroke, Transient Ischemic Attack, Intracerebral Hemorrhage, Intraventricular Hemorrhage, or Subarachnoid Hemorrhage ○ Nearest hospital ○ Transferred from another hospital for higher level of care ○ None of the above				AZ-EMS	None
Special	**Receiving Facilities:**	▽ _____				AZ-EMS	Required
Special	**Provider Agency:**	_____				AZ-EMS	Required
Special	**Run Number:**	_____				AZ-EMS	Required
Special	**Unit Number:**	_____ ☐ Unknown				AZ-EMS	None
Special	**Dispatched as a Stroke:**	○ Yes ○ No ○ ND				AZ-EMS	None
Special	**Date/Time patient last known well per EMS:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required
Special	**Date/Time of discovery of stroke symptoms per EMS:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required
Special	**Date/Time Dispatched:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required

Special	**Date/Time EMS arrival at patient**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required
Special	**Date/Time EMS departed scene:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required
Special	**Date/Time EMS arrived at hospital:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	Required
Special	**Transfer from a Hospital (Different Facility):**	▽ _____				AZ-EMS	Required
Special	**If IA catheter-based reperfusion initiated at this hospital, type:**	○ IA Thrombolysis ○ Endovascular Aspiration Device ○ Endovascular Retrieval Device ○ Angioplasty and/or Stenting ○ Other				AZ-EMS	None
Special	**Date/Time groin puncture (military time):**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				AZ-EMS	None
	NYSDOH						
Special	**Pre-hospital stroke screen findings**	○ Yes ○ No				NYSDOH	None
Special	**Last Known Well**	○ Yes ○ No				NYSDOH	None
Special	**If advanced notification by EMS, was the stroke team activated prior to patient arrival**	○ Yes ○ No ○ Not Documented ○ Not Applicable				NYSDOH	None
Special	**Was patient transferred from an inpatient floor to another acute care hospital?**	○ Yes ○ No				NYSDOH	None
Special	**If patient was transferred from your ED or from an inpatient floor to another acute care hospital, select reason for transfer (check all that apply):**	☐ Ischemic Stroke (for IV alteplase within the 3 hr treatment window) ☐ Ischemic Stroke (for IV alteplase within the 3-4.5 hr treatment window) ☐ Ischemic Stroke (for reperfusion interventions only; not IV alteplase) ☐ Ischemic Stroke neurocritical or neurosurgical care ☐ ICH interventional procedure, neurocritical, or neurosurgical care ☐ SAH interventional procedure, neurocritical, or neurosurgical care ☐ Patient/Family requests transfer ☐ Transferred for a procedure or treatment not related to stroke ☐ Reason for transfer not documented ☐ Other, please specify _____				NYSDOH	Required
Special	**Date/Time MD/DO/PA/NP Assessment:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH	None
Special	**Date/Time Stroke Team Arrival (treatment decision maker):**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH	None
Special	**Date/Time Brain Image Reported/Read:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH	None
Special	**NIH Stroke Scale at discharge**	_____				NYSDOH	None
	Michigan						
Special	**Did EMS pre-notification contain the following (check all that apply):**	☐ Atrial Fib ☐ Dyslipidemia ☐ Previous Stroke/TIA ☐ CAD/Prior MI ☐ Hypertension ☐ Smoker ☐ Diabetes Mellitus				Michigan	None
	Transfer Time Tracker						
Special	**Date/Time Transport Requested:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH, MSN, West-Region-Stroke, Interfacility-Transfer	None
Special	**Date/Time Transport Arrived:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH, MSN, West-Region-Stroke, Interfacility-Transfer	None
Special	**Date/Time Transfer Requested by Referring Hospital:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				NYSDOH, MSN, West-Region-Stroke, Interfacility-Transfer	None
Special	**Date/Time Transfer Accepted by Receiving Hospital:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				MSN, MSN, West-Region-Stroke, Interfacility-Transfer	None
Special	**Mode of Transport**	○ Air ○ Ground Ambulance				West-Region-Stroke, Interfacility-Transfer	None
Special	**Inter-Facility EMS Agency**	_____				West-Region-Stroke, Interfacility-Transfer	None
Special	**Date/Time of Acute Stroke Team Consultation:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				Michigan	None
Special	**No Acute Stroke Team Consultation:**	☐				Michigan	None
Special	**N/A - No Acute Stroke Team:**	☐				Michigan	None
	Ohio						

Special	**Admit From:**	○ Home ○ Nursing Home ○ Skilled Nursing Facility or Inpatient Rehabilitation Facility ○ Another Acute Care Hospital (Inpatient) ○ Other ○ ND				Ohio	None
Special	**Follow-up not applicable due to discharge status**	○ Yes ○ No				Ohio	None
Special	**Was a follow-up appointment made prior to discharge for the patient to see their pre-admission Primary Care Provider (PCP)?**	○ Yes - Evidence that appointment was made ○ No - Patient has a PCP but no evidence that appointment was made ○ NA - Patient did not have a PCP prior to hospitalization				Ohio	None
Special	**If the patient was not being followed by a PCP prior to admission, was a PCP assigned prior to discharge?**	○ Yes - Patient was assigned a PCP ○ No - Patient was not assigned a new PCP ○ Yes - Evidence that appointment was made ○ No - No evidence that appointment was made				Ohio	None
Special	**If a new PCP was assigned to the patient, was a follow-up appointment with the new PCP made prior to discharge?**	○ Yes - Evidence that appointment was made ○ No - No evidence that appointment was made				Ohio	None
Special	**Was a referral ordered or recommended for a follow-up appointment after discharge with a Neurologist, Neurosurgeon or Neurology Provider?**	○ Yes - Referral was ordered or recommended ○ No - No evidence of a referral ordered or recommended ○ NA - Referral to Neurology Provider was not appropriate				Ohio	None
Special	**Was a follow-up appointment made prior to discharge for the patient to see a Neurologist, Neurosurgeon or Neurology Provider?**	○ Yes - Evidence that appointment was made ○ No - No evidence that appointment was made				Ohio	None
Special	**Date/Time First Seen by ED MD:**	_____/_____/_____	____:____ ○ MM/DD/YYYY only ○ Unknown				Ohio	None
	FLPR						
Special	**FPR: What is your preferred language?**	○ English ○ Spanish ○ French/Creole ○ Other ○ Not Documented/UTD				Florida-Stroke-Registry	Required
Special	**FPR: What is your highest grade or year of school you have completed?**	○ Less than high school ○ Completed high school ○ Some college or more ○ Not Documented/UTD				Florida-Stroke-Registry	Required
	Arkansas						
Special	**Was a mobile communications app used to manage this patient?**	○ Yes ○ No ○ ND				Arkansas	Required
Special	**Mobile communications app that was used**	○ Pulsara ○ Other _____				Arkansas	Required
Special	**What was the indication for use of a mobile communications app?**	○ To pre-notify Stroke team ○ Interfacility transfer ○ Transmit CT/neuro image ○ Neurology consult ○ To contact sending or "drip and ship" facility ○ Other _____				Arkansas	Required
Special	**Who created the patient channel using the mobile communications app?**	○ EMS (prior to arrival) ○ ED ○ Other _____				Arkansas	Required
Special	**What time was the patient channel opened?**	____:____ ○ Unknown				Arkansas	Required
Special	**What time was the communication sent through the mobile communications app?**	____:____ ○ Unknown				Arkansas	Required
	Telestroke						
Telestroke	**If Yes, telestroke consult performed, select all applicable delivery methods.**	☐ Interactive Video ☐ Teleradiology ☐ Telephone Call ☐ ND		Telestroke		Middle-East	None
Telestroke	**What was the type of Telestroke provider?**	○ Hospital Based (In-State) ○ Hospital Based (Out-of-State) ○ Private Provider (Independent)		Telestroke		Middle-East	Required
Telestroke	**Who provided Telestroke Service?**	_____		Telestroke		Middle-East	None
Telestroke	**Did the Telestroke consultant recommend transfer?**	○ Yes ○ No ○ ND		Telestroke		Middle-East	None
Telestroke	**Patient transfer status after Telestroke consult (TJC or equivalent):**	○ Not Transferred ○ Transferred to ○ Transferred to TSC ○ Transferred to CSC ○ Transferred to Unknown		Telestroke		Middle-East	Required
Telestroke	**Which option best describes the destination facility for transferred patient:**	○ Hospital where the telestroke consultant primarily practices ○ Hospital unrelated to the telestroke consultant and outside of my health system ○ Hospital unrelated to the telestroke consultant but within my health system ○ Unable to determine from medical record		Telestroke		Middle-East	Required
Telestroke	**Did Telestroke consultation result in thrombolytic administration at the referring site?**	○ Yes ○ No ○ ND		Telestroke		Middle-East	Required
	Telestroke Time Tracker						
Telestroke	**Date/Time of End of Neurologist Videoconference**	_____/_____/_____	____:____ ○ MM/DD/YYYY only ○ Unknown	Telestroke		MSN	Required

Telestroke	**Date/Time of first Telestroke consultation request:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Telestroke		DNV	Middle-East	Required
Telestroke	**Date/Time Telestroke Response:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Telestroke		DNV	Middle-East	Required
Telestroke	**Date/Time start of Telestroke video session:**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Telestroke			Middle-East	Required
Telestroke	**Date/Time Decision to Administer Thrombolytic (By Telestroke):**	_____/_____/_____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Telestroke			Middle-East	None
Telestroke	**Additional Comments:**	_____	Telestroke			Middle-East	None
	Providence Telestroke Network						
Telestroke	**How was telestroke used?**	○ Camera on ○ Phone only ○ No Consult ○ Not a telestroke case ○ ND				PTSN	None
Telestroke	**Beam-in Time (the time the robot was turned on):**	_____/_____/_____ | ____:____ ○ ND/UTD ○ N/A				PTSN	None
Telestroke	**Consulting Neurologist or Neurosurgeon?**	_____				PTSN	None
Telestroke	**Stroke Symptom Onset Zip Code**	_____ ☐ None				PTSN	None
Telestroke	**Date and Time first ED physician saw the patient**	_____/_____/_____ | ____:____ ○ ND/UTD ○ N/A				PTSN	None
Telestroke	**When was first NIHSS done?**	○ In ED ○ On admission to hospital unit ○ Within 12 hours from ED arrival ○ Between 12 and 24 hours from ED arrival ○ More than 24 hours from ED arrival ○ ND				PTSN	None
Telestroke	**24 hour post treatment NIHSS (+/- 6 hours from the 24 hour mark)**	_____ ☐ ND ☐ NA				PTSN	None
Telestroke	**Discharge NIHSS (All Patients)**	_____ ☐ ND ☐ NA				PTSN	None
Telestroke	**Treatment related mortality? (if your patient died, did they die due to documented complications from treatment with alteplase?)**	○ Yes ○ No/ND ○ NA				PTSN	None
Telestroke	**What state was the hospital in?**	○ Oregon ○ Washington ○ Idaho ○ Not Documented				PTSN	None
Telestroke	**Please select the Hospital:**	_____				PTSN	None
Telestroke	**Type of Transfer; if your patient transferred FROM your hospital to another acute care facility, by what mode did they travel?**	○ Air ○ Ambulance ○ Combination of Air and Ambulance				PTSN	None
Telestroke	**Pre-symptom onset Rankin Score**	○ 0: No symptoms at all ○ 1: No significant disability despite symptoms; able to carry out all usual duties and activities ○ 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance ○ 3: Moderate disability; requiring some help, but able to walk without assistance ○ 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance ○ 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention ○ 6: Dead ○ Unknown: Check this category only if you definitely cannot classify the patient status				PTSN	None
Telestroke	**Discharge Rankin Scale**	○ 0: No symptoms at all ○ 1: No significant disability despite symptoms; able to carry out all usual duties and activities ○ 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance ○ 3: Moderate disability; requiring some help, but able to walk without assistance ○ 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance ○ 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention ○ 6: Dead ○ Unknown: Check this category only if you definitely cannot classify the patient status				PTSN	None
Telestroke	**What state was the hospital in?**	○ Oregon ○ Washington ○ Idaho ○ Not Documented				PTSN	None
Telestroke	**Patient Transferred From Location**	_____				PTSN	None

Telestroke	**Type of Transfer; if your patient transferred TO your hospital from another acute care facility, by what mode did they travel?**	○ Air ○ Ambulance ○ Combination of Air and Ambulance				PTSN	None
Telestroke	**Optional Field 1**	_____				PTSN	None
Telestroke	**Optional Field 2**	_____				PTSN	None
	LA EMS						
LA EMS	**INCLUSION CRITERIA: Patients Transported by 9-1-1 to Your Facility OR Arrival to Prior Facility was by 9-1-1**	○ Yes ○ No				LA-EMS	Required
LA EMS	**If yes, select all that apply:**	☐ Did the Patient Meet the Prehospital Care Stroke Policy? ☐ Was the Final Hospital or ED Diagnosis Ischemic Stroke, Transient Ischemic Attack, Intracerebral Hemorrhage, Intraventricular Hemorrhage, or Subarachnoid Hemorrhage? ☐ Was the Patient Transported to Your Facility because Facility is a Stroke Center? ☐ Was Patient Transferred from Another Facility for Stroke Care?				LA-EMS	Required
LA EMS	**Transfer from a Hospital (Different Facility):**	_____				LA-EMS	None
LA EMS	**Receiving Facilities:**	_____				LA-EMS	Required
LA EMS	**Provider Agency/Code:**	_____				LA-EMS	Required
LA EMS	**Sequence Number:**	_____				LA-EMS	Required
LA EMS	**ALS Unit Number:**	_____ ☐ Unknown				LA-EMS	None
LA EMS	**Dispatch Date/time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown				LA-EMS	Required
LA EMS	**Mode of arrival**	○ 911 air ○ 911 ground ○ Air private ○ Ground private ○ Mobile Stroke Unit ○ ND				LA-EMS	Required
LA EMS	**Patient Initial Complaint Codes:**	▽ _____				LA-EMS	Required
LA EMS	**Provider Primary Impression**	▽ _____				LA-EMS	Required
LA EMS	**Advanced Notification by EMS**	○ Yes ○ No ○ ND				LA-EMS	Required
LA EMS	**Field Triage Decision:**	○ M - Most Accessible Receiving Facility (MAR) ○ A - Primary Stroke Center (PSC) ○ K - Comprehensive Stroke Center (CSC) ○ U – Unknown ○ ND - Not Documented				LA-EMS	None
LA EMS	**Last Known Well Date/Time Documented by EMS?**	○ Yes ○ No ○ Unknown				LA-EMS	None
LA EMS	**Date/Time patient last known well per EMS**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				LA-EMS	Required
LA EMS	**Date/Time of EMS arrival at patient?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Not Documented				LA-EMS	Required
LA EMS	**mLAPSS Documented?**	○ Yes ○ No ○ ND				LA-EMS	Required
LA EMS	**mLAPSS criteria met:**	○ Met ○ Not Met ○ ND ○ NA				LA-EMS	Required
LA EMS	**LAMS performed**	○ Yes ○ No ○ ND				LA-EMS	Required
LA EMS	**LAMS Score**	_____ ☐ ND				LA-EMS	Required
LA EMS	**Pre-hospital Research Study Enrollment**	○ Yes ○ No				LA-EMS	None
LA EMS	**Blood Glucose (mg/dL) documented by EMS**	_____ ☐ Unknown				LA-EMS	Required
LA EMS	**Complications of Thrombolytic Therapy?**	○ Yes ○ No ○ ND				LA-EMS	None

LA EMS	**Complications:**	○ ICH - Intracranial hemorrhage <36 hours from initiation of therapy – a CT within 36 hours shows intracranial hemorrhage AND physician's notes indicate clinical deterioration due to hemorrhage ○ HEM - Systemic hemorrhage <36 hours from initiation of therapy – bleeding within 36 hours of therapy and > 3 transfused units of blood within 7 days, or before discharge (whichever is earlier) AND physician note attributing bleeding problem as reason for transfusion ○ OTH – Other _____				LA-EMS	Required
LA EMS	**ED Disposition:**	○ Admitted to OR ○ Admitted to ICU ○ Admitted to Tele/Step-down ○ Admitted to Ward ○ Admitted to < 24 hour observation unit ○ Neuro Interventional Radiology ○ Post Hospital (complete hospital disposition)				LA-EMS	Required
LA EMS	**Hospital Disposition**	○ Home/Previous place of residence ○ Acute Care Facility ○ SNF ○ Rehab center ○ Hospice ○ AMA/Eloped/LWBS ○ Morgue/Mortuary				LA-EMS	Required
LA EMS	**Rationale for Disposition to an Acute Care Facility:**	○ F- Financial Health Plan ○ H - Higher level or specialized care ○ ND - Not documented ○ OT – Other _____				LA-EMS	None
LA EMS	**Transfer to:**	_____				LA-EMS	None
LA EMS	**Date of Birth**	_____ / _____ / _____				LA-EMS	None
LA EMS	**If IA catheter-based reperfusion initiated at this hospital, type:**	○ IA Thrombolysis ○ Endovascular Retrieval Device ○ Endovascular Aspiration Device ○ Angioplasty and/or Stenting ○ Other _____				LA-EMS	Required