GWTG-Stroke Case Report Form (CRF)
October 2026

Required = required to save as complete

Warning = encouraged but not required

Layer / Element Groups

▼ Stroke | Stroke-Limited | DNV | DNV-ADV | ASR | CSTK | STK | TSC | Aneurysm-Repair | ASCVD | CMS-OP-23 | Diabetes | EMS-Pre-Hospital-Care | Endovascular-Therapy | ICH | SAH | Stroke-Rural | Telestroke

Pink Font = New/Updated

Tab	Element	Allowable Values	Any Criteria for Required
All	**Patient ID:**	_____	Required
Demographics	**Sex:**	○ Male ○ Female ○ Unknown	Required
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	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:_____	None
Demographics	**Date of Birth:**	_____ / _____ / _____	Required
Demographics	**Age:**	_____	Required
Demographics	**Homeless**	☐	None
Demographics	**Zip Code:**	_____	Required (AR, PSS)
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	Required (PSS, Coverdell, MDCHIA)
Demographics	**What is the patient's source of payment for this episode of care?**	○ Medicare ○ Non-Medicare	Required
	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	Required

Demographics	**If Asian:**	☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	None
Demographics	**If Native Hawaiian or Pacific Islander**	☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander	None
Demographics	**Hispanic Ethnicity:**	○ Yes ○ No/UTD	Required (JC)
Demographics	**Select Hispanic Origin Group(s):**	☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino or Spanish Origin	Warning
	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 ○ Elective Aneurysm Repair *(only shows for Aneurysm Repair & DNV layer)*	Required
Admin	**If No Stroke Related Diagnosis:**	○ Migraine ○ Seizure ○ Delirium ○ Electrolyte or metabolic imbalance ○ Functional disorder ○ Other ○ Uncertain	Required
Admin	**Was the stroke etiology documented in the patient medical record:**	○ Yes ○ No	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 ○ Hypercoagulability ○ Other (e.g., vasculopathy or other hematologic disorders) ○ 5: Cryptogenic Stroke ☐ Multiple potential etiologies identified ☐ Stroke of undetermined etiology ☐ Unspecified	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	Required
Admin	**Is there clear documentation for comfort care/palliative care measures established prior to hospital arrival?**	○ Yes ○ Not Documented / UTD	Required

Admin	**Arrival Date/Time:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Admin	**Was this patient a Stroke alert (Code Stroke) at your facility?**	○ Yes ○ No ○ ND	Required (DNV, Middle-East)
Admin	**Location of Stroke alert (Code Stroke)**	○ Emergency Department ○ EMS ○ Inpatient ○ MSU ○ Outpatient Procedure ○ Other _____	None Stroke Required MiddleEast
Admin	**Date/Time Stroke alert (Code Stroke) received**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None Stroke Required MiddleEast
Admin	**Not Admitted:**	○ Yes, not admitted ○ No, patient admitted as inpatient	Required
Admin	**Admission Date:**	_____ / _____ / _____	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 _____	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	None (Stroke) Required (PSS)
Admin	**Select reason(s) for why patient transferred:**	☐ Evaluation for IV Thrombolytic up to 4.5 hours ☐ Post Management of IV Thrombolytic (e.g. Drip and Ship) ☐ Evaluation for Endovascular thrombectomy ☐ Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) ☐ Advanced Stroke care (non-time critical therapy) ☐ Patient/family request ☐ Other advanced care (not stroke related) ☐ Administrative (insurance, bed availability) ☐ Not documented	Required
Admin	**Discharge Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	required
Admin	**Documented reason for delay in transfer to receiving facility?**	○ Yes ○ No/ND	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*	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)	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	Required
	Clinical Codes		
Clinical Codes	**Clinical Trial NOT in Stroke:**	_____	None
Clinical Codes	**ICD-10-CM Principal Diagnosis Code:**	_____	Required
Clinical Codes	**ICD-10-CM Other Diagnosis Codes:**	_____	None
Clinical Codes	**ICD-10-PCS Principal Procedure Code:**	_____ ○ No ICD-10-PCS Procedure Code Documented	Required
Clinical Codes	**Principal Procedure Date/Time:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Clinical Codes	**ICD-10-PCS Other Procedure Codes:**	_____	None
Clinical Codes	**Other Procedure Code Date/Time:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Clinical Codes	**ICD-10-CM Admitting Diagnosis Code:**	_____	Required
	Discharge Diagnosis		
Clinical Codes	**ICD-10-CM Discharge Diagnosis Related to Stroke:**	_____	None
Clinical Codes	**No Stroke or TIA Related ICD-10-CM Code Present:**	☐	None
Clinical Codes	**OP STK ICD-10-CM Principal Diagnosis Code**	_____	Required
Clinical Codes	**OP STK ICD-10-CM Diagnosis Codes**	_____	None

Clinical Codes	**CSTK Initial Patient Population:**	○ Ischemic Stroke Without Procedure ○ Ischemic Stroke With IV alteplase, IA alteplase, or MER ○ Hemorrhagic Stroke	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	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	None
Admission	**Was this patient admitted for the sole purpose of performance of elective carotid intervention?**	○ Yes ○ No	Required
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	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	Required
Admission	**Referring Hospital Discharge Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Admission	**If transfer from another hospital, specify hospital name:**	▽ _____ ☐ Transfer from Hospital Not on the List ☐ Transfer from Hospital Not Documented	Require (PSS)
Admission	**Referring Hospital Arrival Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Require (PSS)
Admission	**If patient transferred to your hospital, select transfer reason(s)**	☐ Evaluation for IV Thrombolytic up to 4.5 hours ☐ Post Management of IV Thrombolytic (e.g. Drip and Ship) ☐ Evaluation for Endovascular thrombectomy ☐ Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) ☐ Advanced Stroke care (non-time critical therapy) ☐ Patient/family request ☐ Other advanced care (not stroke related) ☐ Administrative (insurance, bed availability) ☐ Not documented	Require (PSS)

Admission	**Was the patient an ED patient at the facility?**	○ Yes ○ No	Required
Admission	**^Was the patient a direct admission to the hospital?**	○ Yes ○ No	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	None
Admission	**Did a stroke-capable Provider consult in decision-making during the acute phase of treatment?**	○ Yes ○ No/ND	Required
Admission	**Stroke-capable Provider(s) (specify)**	☐ Emergency Provider ☐ TeleEmergency Provider ☐ Neurospecialist ☐ Telestroke Provider ☐ Medical Hospitalist ☐ Advanced Practice Provider	Required
Admission	**Advanced notification by EMS or MSU?**	○ Yes ○ No/ND	Required
Admission	**Initial admitting service:**	☐ Medicine ☐ Neurocritical care ☐ Neurology ☐ Neurosurgery ☐ Surgery ☐ Other	None
Admission	**In which settings were care delivered - Other:**	☐ Neuro/Neurosurgery ICU ☐ General care floor ☐ Other ICU ☐ Observation ☐ Stroke unit (non-ICU) ☐ Other	Required (ICH)
Admission	**Specialized unit admission date/time:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	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	None
Admission	**ED Physician**	_____	None
Admission	**Stroke NP/ PA**	_____	None
Admission	**Admitting Physician**	_____	None
Admission	**Attending Physician**	_____	None
Admission	**Neurologist**	_____	None
Admission	**Neurosurgeon**	_____	None
Admission	**Interventionalist**	_____	None

Admission	**Discharging Provider**	_____	None
Admission	**Other Provider**	_____	None
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	Required
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	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 ☐ Sickle Cell ☐ Sleep Apnea ☐ Smoker	Required
Admission	**Currently pregnant?**	○ Yes, currently pregnant ○ No, postpartum up to 6 weeks	Required (PSS)
Admission	**Diabetes Type**	○ Type 1 ○ Type 2 ○ ND	Required
Admission	**Diabetes Duration**	○ <5 years ○ 5- < 10 years ○ 10- < 20 years ○ >=20 years ○ Unknown	Required (PSS)
Admission	**Emerging Infectious Disease**	☐ SARS-COV-2 (COVID-19) ☐ Other infectious respiratory pathogen	Required

Admission	**Previous Stroke**	☐ Ischemic stroke ☐ ICH ☐ SAH ☐ Not Specified	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	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	Required (DNV, PSS)
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	Required
Admission	**Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)**	○ Less than 10 minutes ○ 10-59 minutes ○ ≥ 60 minutes ○ ND	Required
Admission	**Had stroke symptoms resolved at time of presentation?**	○ Yes ○ No ○ ND	Warning Required (Coverdell)
Admission	**^Is there documentation that an initial NIHSS score was done at this hospital?**	○ Yes ○ No	Required
Admission	**^What is the date and time that the NIHSS score was first performed at this hospital?**	_____ / _____ / _____	_____:_____ ○ MM/DD/YYYY only ○ Unknown	Required
Admission	**NIHSS Total Score**	_____	Required
Admission	**^What is the first NIHSS score obtained prior to or after hospital arrival?**	_____ ☐ UTD	Required
Admission	**^Was the initial NIHSS score after hospital arrival less than 6?**	○ Yes ○ No	Required
Admission	**NIHSS score obtained from transferring facility:**	_____ ○ ND	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	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	Warning
Admission	**GCS Eye:**	_____	None
Admission	**GCS Verbal:**	_____	None
Admission	**GCS Intubated:**	☐	None
Admission	**GCS Motor:**	_____	None
Admission	**Total GCS:**	_____	Warning
Admission	**Total GCS Not Documented**	☐	None
Admission	**^Is there documentation any time during the hospital stay that the hemorrhage was non-aneurysmal or due to head trauma?**	○ Yes ○ No	Required
Admission	**^Was an initial Hunt and Hess scale done at this hospital?**	○ Yes ○ No	Required
Admission	**^^If yes, Hunt and Hess score:**	_____	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	Required
Admission	**Was an initial World Federation of Neurological Surgeons (WFNS) scale done at this hospital?**	○ Yes ○ No	Required
Admission	**^^WFNS SAH Grading Scale**	_____	Required
Admission	**What is the date and time the WFNS scale was first performed at this hospital?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Admission	**^Was an initial ICH score done at this hospital?**	○ Yes ○ No	Required
Admission	**^^If yes, ICH score:**	_____	Required
Admission	**^What is the date and time that the ICH score was first performed at this hospital?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Admission	**ICH Volume:**	_____cm3 ☐ ND	Required

Admission	**IVH**	○ Present ○ Not Present	Required
Admission	**Hemorrhage location (center of origin)**	○ Superficial (i.e., lobar) ○ Deep ○ Unknown	Required
Admission	**Hemorrhage location - Superficial (ie, lobar)**	○ Frontal ○ Parietal ○ Temporal ○ Occipital	None
Admission	**Hemorrhage location - Deep**	○ Thalamus ○ Basal ganglia (caudate, putamen, globus pallidus) ○ Brainstem (midbrain, pons, medulla) ○ Cerebellum	None
Admission	**Was the ICH etiology documented in the patient medical record?**	○ Yes ○ No	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: _____	Required
Admission	**^^FUNC Score (ICH)**	_____	None
Admission	**No medications prior to admission**	☐	None
Admission	**Antiplatelet or Anticoagulant Medication(s) prior to admission:**	○ Yes ○ No	Required
Admission	**Prior Antithrombotic Class**	☐ Antiplatelet ☐ Anticoagulant	Required
Admission	**Prior Antithrombotic Medication**	Antiplatelet: ○ aspirin ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ prasugrel (Effient) ○ ticagrelor (Brilinta) ○ ticlopidine (Ticlid) ○ Other Antiplatelet	Required

Admission	**Prior Antithrombotic Medication**	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	Required
Admission	**Date/Time of last anticoagulant dose prior to admission**	_____ / _____ / _____	____:____ ○ MM/DD/YYYY only ○ Unknown	Required (ICH Dx)
Admission	**Date/Time of last antiplatelet dose prior to admission**	_____ / _____ / _____	____:____ ○ MM/DD/YYYY only ○ Unknown	None
Admission	**Antihypertensive Medication prior to admission:**	○ Yes ○ No/ND	Required
Admission	**Cholesterol reducer prior to admission:**	○ Yes ○ No/ND	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	Required (ICH Layer)
Admission	**GLP-1 Receptor Agonist prior to admission**	○ Yes ○ No/ND	Required
Admission	**SGLT2 Inhibitor prior to admission**	○ Yes ○ No/ND	Required
Admission	**Antihyperglycemic medications (regardless of indication) prior to admission:**	○ Yes ○ No/ND	Required
Admission	**If yes, select medications (select all that apply)**	☐ DPP-4 Inhibitors ☐ GLP-1 receptor agonist ☐ Insulin ☐ Metformin ☐ SGLT2 Inhibitor ☐ Sulfonylurea ☐ Thiazolidinedione ☐ Other oral agents ☐ Other injectable/subcutaneous agents	Required
Admission	**Antidepressant medication prior to admission:**	○ Yes ○ No/ND	None
Admission	**Antidepressant type, prior to admission:**	○ SSRI ○ Other antidepressant ○ Not documented	Required (ICH Layer)

Admission	**Alzheimer's Disease Immunotherapies prior to admission**	○ Yes ○ No/ND	Warning
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	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	Required
Pre-hospital Care	**Patient care record available at time of patient arrival?**	○ Yes ○ No/ND	None
Pre-hospital Care	**Patient care record available at a later time during hospitalization?**	○ Yes ○ No/ND	None
Pre-hospital Care	**EMS Agency List**	_____ ☐ Unknown	Required (West Region)
Pre-hospital Care	**Run/Sequence number**	_____ ☐ Unknown	Required (West Region)
Pre-hospital Care	**Date/Time Brain Imaging initiated by MSU:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Pre-hospital Care	**Date/ Time IV alteplase administered by MSU:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Pre-hospital Care	**EMS Unit Notified by Dispatch:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required (West Region)
Pre-hospital Care	**Dispatched as suspected stroke?**	○ Yes ○ No ○ Not Documented	None
Pre-hospital Care	**EMS Unit Arrived on Scene:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Pre-hospital Care	**EMS Arrived at Patient:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Pre-hospital Care	**EMS Unit Left Scene:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required

Pre-hospital Care	**Last Known Well as Documented by EMS:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Pre-hospital Care	**LKW by EMS Unknowable**	☐	None
Pre-hospital Care	**Discovery of Stroke symptoms by EMS:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Pre-hospital Care	**Discovery of Stroke symptoms by EMS Unknowable**	☐	None
Pre-hospital Care	**Date/Time Pre-Notification provided to Hospital:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	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	None
Pre-hospital Care	**Blood Glucose level (mg/dL):**	_____ ▽ Blood Glucose level ND ○ Glucometer Not Available ○ Patient Refused ○ Not Documented ○ Too High ○ Too Low	Required
Pre-hospital Care	**Initial Blood Pressure by EMS**	Systolic: _____ Diastolic: _____ ☐ Not Documented	Required (West Region)
Pre-hospital Care	**EMS Suspected stroke? (Primary or Secondary Impression)**	○ Yes ○ No ○ Not Documented	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 _____	Required
Pre-hospital Care	**Stroke Screen Outcome:**	○ Positive ○ Negative ○ Not documented	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	Required
Pre-hospital Care	**If Other severity scale used, specify:**	_____	Required
Pre-hospital Care	**Severity Scale Positive for LVO?**	○ Yes ○ No ○ ND	Required
Pre-hospital Care	**If Severity Scale assessment completed, enter total score:**	_____ ☐ ND	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	None
Pre-hospital Care	**If Other destination decision, specify:**	_____	None
Pre-hospital Care	**Was a Thrombolytic Checklist used?**	○ Yes ○ No/ND	None
Pre-hospital Care	**If severity scale used, did result alter hospital destination (e.g. CSC vs. PSC)?**	○ Yes ○ No/ND	Required (West Region)
Pre-hospital Care	**EMS Additional Comments**	_____	None
Hospitalization	**When was the patient last known to be well?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Date/Time of discovery of stroke symptoms?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown ☐ Same as time last known well	Required
Hospitalization	**Was brain or vascular imaging performed prior to transfer to your facility?**	○ Yes ○ No/ND	None
Hospitalization	**Imaging type at prior facility not documented**	☐	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	None
Hospitalization	**Date/Time 1st vessel or perfusion imaging initiated at prior hospital:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None

Hospitalization	**CT and/or MRI completed at your hospital within 24 hours of arrival?**	○ Yes ○ No/ND ○ NC	Required
Hospitalization	**Type(s) of brain imaging completed at your hospital within 24 hours of arrival**	☐ CT ☐ MRI	Required
Hospitalization	**Date/Time Brain Imaging First Initiated at your hospital:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Documented reason for delay in initial brain imaging at your hospital?**	○ Yes ○ No/ND	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) _____	None
Hospitalization	**Date/Time Brain Imaging Reported:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Interpretation of first brain image after symptom onset, done at any facility:**	○ Acute Hemorrhage ○ No Acute Hemorrhage ○ Not Available	Warning
Hospitalization	**Vascular or perfusion imaging performed at your hospital within 24 hours of arrival?**	○ Yes ○ No	Required
Hospitalization	**Type(s) of vascular or perfusion imaging performed at your hospital within 24 hours of arrival (select all that apply)**	☐ CTA ☐ CT Perfusion ☐ MRA ☐ MR Perfusion ☐ MRI DWI-FLAIR ☐ DSA (catheter angiography) ☐ ND	Required
Hospitalization	**Date/Time 1st vessel or perfusion imaging initiated at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Hospitalization	**Date/Time 1st vessel or perfusion imaging reported at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Date/Time CT Perfusion reported at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Date/Time MR Perfusion reported at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Date/Time MRI DWI-FLAIR reported at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required

Hospitalization	**Target lesion visualized?**	○ Yes ○ No/ND	Required
Hospitalization	**Site of occlusion:**	○ ICA ○ MCA ○ Basilar Artery ○ ACA ○ PCA ○ Other Cerebral Artery Branch ○ Vertebral Artery ○ Not Specified	Required
Hospitalization	**ICA segment**	☐ Intracranial ICA ☐ Cervical ICA ☐ Other/UTD	Required
Hospitalization	**MCA segment**	☐ M1 ☐ M2 ☐ Other/UTD	Required
Hospitalization	**Core Volume (cm3)**	_____	None
Hospitalization	**Penumbra Volume (cm3)**	_____	None
Hospitalization	**Mismatch Ratio**	_____	None
Hospitalization	**Vascular imaging at an outside hospital for a hemorrhage patient**	○ Yes ○ No	Required
Hospitalization	**Vascular imaging at your hospital for a hemorrhage patient**	○ Yes ○ No	Required
Hospitalization	**Type of vascular imaging**	☐ CTA ☐ MRA ☐ DSA	Warning
Hospitalization	**Structural cause of hemorrhage**	☐ None ☐ Aneurysm ☐ Arteriovenous malformation (AVM) ☐ Brain neoplasm ☐ Other _____	Required
Hospitalization	**ASPECT Total Score**	_____ ○ ND	Warning (GWTG) Required (MSN)
Hospitalization	**IV thrombolytic initiated at this hospital?**	○ Yes ○ No	Required
Hospitalization	**IV Thrombolytic Initiation Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Thrombolytic used**	○ Alteplase (Class 1 evidence) ○ Tenecteplase (Class 2b evidence)	Required
Hospitalization	**Alteplase total dose (mg):**	_____ ☐ ND	Required

Hospitalization	**Tenecteplase total dose (mg):**	_____ ☐ ND	Required
Hospitalization	**Documented exclusions or relative exclusions (contraindications or warnings) for not initiating IV thrombolytic in the 0-3 hr treatment window?**	○ Yes ○ No	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	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)	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	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)	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	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)	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 _____	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 _____	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	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	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	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 _____	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 _____	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 _____	None
Hospitalization	**IV thrombolytic at an outside hospital or EMS / Mobile Stroke Unit?**	○ Yes ○ No	Required
Hospitalization	**Thrombolytic administered at outside hospital or Mobile Stroke Unit**	○ Alteplase ○ Tenecteplase	Required
Hospitalization	**Investigational or experimental protocol for thrombolysis?**	○ Yes ○ No ○ Specify investigational or experimental protocol for thrombolysis: _____	Warning
Hospitalization	**Is there documentation of a suspected LVO in the medical record?**	○ Yes ○ No	Required
Hospitalization	**Is there documentation in the medical record that the patient is eligible for MER therapy or a mechanical thrombectomy procedure?**	○ Yes ○ No	Required
Hospitalization	**Catheter-based stroke treatment at this hospital?**	○ Yes ○ No	Required
Hospitalization	**IA alteplase or MER Initiation Date/Time**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Catheter-based stroke treatment at outside hospital?**	○ Yes ○ No	Warning
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	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	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	Required
Hospitalization	**Patient NPO throughout the entire hospital stay?**	○ Yes ○ No	Required
Hospitalization	**Was a dysphagia screen ever performed at your hospital?**	○ Yes ○ No	Required

Hospitalization	**Was patient screened for dysphagia prior to any oral intake including water or medications?**	○ Yes ○ No/ND ○ NC	Required
Hospitalization	**If yes, Dysphagia screening results:**	○ Pass ○ Fail ○ ND	None
Hospitalization	**Treatment for Hospital-Acquired Pneumonia:**	○ Yes ○ No/ND ○ NC	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	Required
Hospitalization	**Was there a medical reason for Occupational Therapy assessment not being completed or attempted within 24 hours of admission?**	○ Yes ○ No/ND	Required
Hospitalization	**Was there a medical reason for Physical Therapy assessment not being completed or attempted within 24 hours of admission?**	○ Yes ○ No/ND	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	Required
Hospitalization	**Was an Occupational Therapy assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND	Required
Hospitalization	**Was a Physical Therapy assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND	Required
Hospitalization	**Was a Speech-Language Pathology assessment completed or attempted within 24 hours once medically feasible?**	○ Yes ○ No/ND	Required
Hospitalization	**VTE Interventions**	☐ 1: Low dose unfractionated heparin (LDUH) ☐ 2: Low molecular weight heparin (LMWH) ☐ 3: Intermittent pneumatic compression devices (IPC) ☐ 5: Factor Xa Inhibitor ☐ 6: Warfarin ☐ 7: Venous foot pumps ☐ 8: Oral Factor Xa Inhibitor ☐ A-None of the above or not documented or unable to determine from medical record documentation	Required
Hospitalization	**What date was the VTE prophylaxis administered after hospital admission?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**What was the Date and Time the IPC device was placed?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Is there physician/ APN/ PA documentation why IPC was not used for VTE prophylaxis?**	○ Yes ○ No	Required
Hospitalization	**Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?**	○ Yes ○ No	Required

Hospitalization	**Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?**	○ Yes ○ No	Required
Hospitalization	**Other Therapeutic Anticoagulation**	☐ apixaban (Eliquis) ☐ Argatroban ☐ Dabigatran (Pradaxa) ☐ Desirudin (Iprivask) ☐ Edoxaban (Savaysa) ☐ Lepirudin (Refludan) ☐ Rivaroxaban (Xarelto) ☐ Unfractionated heparin IV ☐ Other Anticoagulant	None
Hospitalization	**Was DVT or PE documented?**	○ Yes ○ No	None (Stroke) Required (Coverdell)
Hospitalization	**Was antithrombotic therapy administered by the end of hospital day 2?**	○ Yes ○ No/ND ○ NC	Required
Hospitalization	**Select type(s) of antithrombotic therapy administered by the end of hospital day 2?**	○ Antiplatelet ○ Anticoagulation	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	Required
Hospitalization	**Active bacterial or viral infection at admission or during hospitalization:**	☐ None/ND ☐ Bacterial Infection ☐ Emerging Infectious Disease ☐ Influenza ☐ Seasonal Cold ☐ Other Viral Infection	Required
Hospitalization	**Total Cholesterol:**	_____	None (Stroke) Required (CKMH)
Hospitalization	**Triglycerides:**	_____	None (Stroke) Required (CKMH)
Hospitalization	**HDL:**	_____	None (Stroke) Required (CKMH)
Hospitalization	**LDL:**	_____	Required
Hospitalization	**Lipids: ND**	☐	None
Hospitalization	**Lipids: NC**	☐	None
Hospitalization	**LP(a) measurement obtained**	○ This hospitalization ○ Prior to this hospitalization ○ Planned after discharge ○ No measurement documented	Required (ASCVD & CKMH)
Hospitalization	**LP(a) Value:**	_____	Required
Hospitalization	**LP(a) Unit:**	_____	Required

Hospitalization	**LP(a): ND**	☐	None
Hospitalization	**A1C:**	_____ ☐ ND	Warning (Stroke) Required (CKMH)
Hospitalization	**^What is the first blood glucose value obtained prior to or after hospital arrival? (mg/dL)**	_____ ☐ ND	Required
Hospitalization	**Serum Creatinine**	_____ ☐ ND	Warning
Hospitalization	**What is the first platelet count obtained prior to or after hospital arrival?**	_____ ☐ UTD	Required
Hospitalization	**Is there documentation of any platelet count after arrival of <100,000 mcL?**	○ Yes ○ No	None
Hospitalization	**aPTT (sec)**	_____ ☐ ND	Required
Hospitalization	**INR**	_____ ☐ ND ☐ NC	Warning (Stroke) Required (ICH)
Hospitalization	**INR Value >= 1.4**	○ Yes ○ No	Required
Hospitalization	**Anti-Factor Xa level:**	_____	None
Hospitalization	**Heart Rate (beats per minute):**	_____	Warning
Hospitalization	**^What is the first blood pressure obtained prior to or after hospital arrival?**	Blood Pressure (Systolic) - Initial: _____ Blood Pressure (Diastolic) - Initial: _____	Required
Hospitalization	**Vital Signs: UTD**	☐	None
Hospitalization	**Height:**	_____ ○ lb ○ kg ☐ ND	Required (Diabetes & CKMH)
Hospitalization	**Weight:**	_____ ○ in ○ cm ☐ ND	Required
Hospitalization	**Waist Circumference**	_____ ○ in ○ cm ☐ ND	None
Hospitalization	**BMI:**	_____ ☐ ND	Required (Diabetes & CKMH)
	Dual Antiplatelet Therapy (DAPT)		
Hospitalization	**ABCD2 Score**	_____ ☐ ND	Required
Hospitalization	**Was Dual Antiplatelet Therapy (DAPT) loading dose initiated at your hospital?**	○ Yes ○ No/ND	Required

Hospitalization	**Documented reason for not initiating DAPT within 24 hours of last known well?**	☐ Route of administration unavailable ☐ Patient requires long-term anticoagulation therapy and DAPT treatment should not be initiated ☐ Increased risk of hemorrhage or known hemorrhage ☐ Allergy ☐ Patient on DAPT at time of presentation ☐ Etiology unknown within 24 hours of arrival ☐ Other ☐ ND/Unknown	Required
Hospitalization	**Initial DAPT P2Y12 Inhibitor Medication**	○ clopidogrel (Plavix) ○ ticagrelor (Brilinta)	Required
Hospitalization	**Initial DAPT P2Y12 Inhibitor Dosage**	_____	Required
Hospitalization	**Initial DAPT P2Y12 Inhibitor Dosage ND**	☐	Required
Hospitalization	**Initial DAPT Aspirin Dosage**	_____	Required
Hospitalization	**Initial DAPT Aspirin Dosage ND**	☐	Required
Hospitalization	**What is the date and time DAPT was first initiated?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Was DAPT continued to discharge?**	○ Yes ○ No/ND	Required
Hospitalization	**What is the date and time DAPT was discontinued?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Hospitalization	**Documented reason for discontinuing DAPT prior to 21 days after initiation**	☐ Route of administration unavailable ☐ Patient requires long-term anticoagulation therapy and DAPT treatment should not be continued ☐ Increased risk of hemorrhage or known hemorrhage ☐ Allergy ☐ Other ☐ ND/Unknown	Required
	ADDITIONAL TIME TRACKER		
Time Tracker	**Date/Time Stroke Team Activated:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Stroke Team Arrived:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Required (DNV) or (Transfer for EVT)
Time Tracker	**Date/Time ED Provider Assessment:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Required (DNV & MSN) or (Transfer for EVT)
Time Tracker	**Date/Time Neurosurgical Services Consulted:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Brain Imaging Ordered:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time IV Thrombolytic Ordered:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None

Time Tracker	**Date/Time Lab Tests Ordered:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Required (DNV)
Time Tracker	**Date/Time Lab Tests Completed:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	Required (DNV)
Time Tracker	**Date/Time ECG Ordered:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time ECG Completed:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Chest X-ray Ordered:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Chest X-ray Completed:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Neurointerventional Team Activation:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Patient Arrival in Neurointerventional Suite:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ N/A	None
Time Tracker	**Date/Time Transport Requested:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Time Tracker	**Date/Time Transport Arrived:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Time Tracker	**Date/Time Transfer Requested by Referring Hospital:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Time Tracker	**Date/Time Transfer Accepted by Receiving Hospital:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Time Tracker	**Mode of Transport**	○ Air ○ Ground Ambulance	Required (West-Region & Stroke Rural)
Time Tracker	**Inter-Facility EMS Agency**	_____	None
Advanced	**^Is there documentation that the route of alteplase administration was intra-arterial (IA)?**	○ Yes ○ No	Required
Advanced	**^Is there documentation that IA thrombolytic therapy was initiated at this hospital?**	○ Yes ○ No	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	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	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	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	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	Required
Advanced	**^^Was a mechanical endovascular reperfusion procedure attempted during this episode of care (at this hospital)?**	○ Yes ○ No	Required
Advanced	**^Was a mechanical thrombectomy procedure attempted but unsuccessful or aborted before removal of the LVO?**	○ Yes ○ No	Required
Advanced	**^^Are reasons for not performing mechanical endovascular reperfusion therapy documented?**	○ Yes ○ No	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 suggesting hemorrhagic transformation ☐ Brain imaging not favorable ☐ 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	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	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	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	Required
Advanced	**^^Is a cause(s) for delay in performing mechanical endovascular reperfusion therapy documented?**	○ Yes ○ No	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 *	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	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.	Required
Advanced	**^^Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade**	○ Grade 0 ○ Grade 1 ○ Grade 2a ○ Grade 2b ○ Grade 2c ○ Grade 3 ○ ND	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	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	Required
Advanced	**Date/Time End of Endovascular Procedure**	_____ / _____ / _____	____:____ ○ MM/DD/YYYY only ○ Unknown	None

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	Required
Advanced	**^Date/Time of positive brain image:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	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	Required
Advanced	**This score obtained from (documented prior to initiation of IV alteplase at this hospital):**	○ Baseline NIHSS ○ Subsequent NIHSS	None
Advanced	**^What is the last NIHSS score documented prior to initiation of IV alteplase at this hospital?**	_____ ☐ UTD	Required
Advanced	**^What is the highest NIHSS score documented within 36 hours following initiation of IV alteplase?**	_____ ☐ UTD	Required
Advanced	**This score obtained from (documented prior to initiation of IA alteplase or MER at this hospital):**	○ Baseline NIHSS ○ Subsequent NIHSS	Required
Advanced	**^What is the last NIHSS score documented prior to initiation of IA alteplase or MER at this hospital?**	○ Baseline NIHSS ○ Subsequent NIHSS	Required
Advanced	**^What is the highest NIHSS score documented within 36 hours following IA alteplase or MER initiation?**	_____ ☐ UTD	Required
Advanced	**BP lowering agent administered at your hospital**	○ Yes ○ No/ND ○ NC	Required
Advanced	**Date/Time of first administration of a BP lowering agent at your hospital**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Date/Time Systolic BP first sustained at <= 149 for >= 5 minutes**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Systolic BP never sustained at <=149 for >=5 minutes**	☐	None
Advanced	**^Is there documentation that a procoagulant reversal agent was initiated at this hospital?**	○ Yes ○ No	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 _____	Required
Advanced	**^^Date/Time procoagulant initiated**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**If reversal therapy was initiated greater than 60 minutes after arrival, were reason(s) documented as cause for delay?**	○ Yes ○ No	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* _____	Required
Advanced	**If reversal therapy was initiated greater than 90 minutes after arrival, were reason(s) documented as cause for delay?**	○ Yes ○ No	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* _____	Required
Advanced	**Was a repeat dose of procoagulant reversal agent required for this patient?**	○ Yes ○ No	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 _____	Required
Advanced	**Date/Time of Procoagulant redosing**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Was a procoagulant reversal agent administered to the patient prior to arrival at your hospital (in MSU or first hospital):**	○ Yes ○ No	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 _____	Required
Advanced	**Was Vitamin K administered to this patient?**	○ Yes, prior to arrival (in MSU or first hospital) ○ Yes, at your hospital ○ No	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	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	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	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	Required
Advanced	**^^If initial INR > 1.4 and treated with procoagulant, Date/Time first INR <=1.4 after treatment:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None

Advanced	**No documented INR <= 1.4 after treatment**	☐	None
Advanced	**Was an External Ventricular Drain (EVD) placed during this hospitalization?**	○ Yes ○ No	Required
Advanced	**Date/Time EVD placed**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Was the patient diagnosed with ventriculitis during this hospitalization?**	○ Yes ○ No	Required
Advanced	**^Is there documentation that nimodipine was administered at this hospital within 24 hours of arrival?**	○ Yes ○ No	Required
Advanced	**^What is the date and time that nimodipine was first administered to this patient at this hospital?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	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	Required
Advanced	**Specify reason(s) for not administering nimodipine treatment**	☐ Nimodipine Allergy ☐ Hypotension or on pressor ☐ Route of administration unavailable ☐ Other	Required
Advanced	**Was nimodipine continued until discharge?**	○ Yes ○ No	Required
Advanced	**Date and time that nimodipine was discontinued**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Documented reason(s) for not continuing nimodipine treatment**	○ Yes ○ No	Required
Advanced	**^^Surgical treatment for ICH at this hospital?**	○ Yes ○ No	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
			Required

Advanced	**If surgical treatment for ICH at this hospital is yes, what was the procedure date/ time?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Was an AVM repair attempted during this episode of care at this hospital?**	○ Yes ○ No	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	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	Required
Advanced	**Documentation of a neurological or other medical reason for prescribing corticosteroids:**	○ Yes ○ No	Required
Advanced	**Was the patient administered a platelet transfusion at your hospital?**	○ Yes ○ No	Required
Advanced	**Acceptable reason for administering platelet transfusion?**	○ Yes ○ No	Required
Advanced	**Initial Platelet Transfusion Date/Time**	_____ / _____ / _____	____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Was a cerebral aneurysm repair attempted during this episode of care at this hospital?**	○ Yes ○ No	Required
Advanced	**Documented reason for not attempting aneurysm repair**	○ Yes ○ No	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) _____	Required
Advanced	**Location of the cerebral aneurysm**	○ Anterior circulation ○ Posterior circulation ○ ND	None
Advanced	**Size of the aneurysm (mm):**	_____	None
Advanced	**Was the aneurysm ruptured prior to repair procedure?**	○ Yes ○ No ○ Not Documented	Required
Advanced	**Was a Fisher Scale grade documented prior to the aneurysm repair procedure?**	○ Yes ○ No/ND	None
Advanced	**What type of Fisher Scale was used?**	○ Modified Fisher ○ Fisher	None
Advanced	**Modified Fisher Scale grade prior to repair:**	○ Grade 0: No SAH or IVH ○ Grade 1: Focal or diffuse, thin SAH, no IVH ○ Grade 2: Focal or diffuse, thin SAH, w/IVH ○ Grade 3: Focal or diffuse, thick SAH, no IVH ○ Grade 4: Focal of diffuse, thick SAH, w/IVH	None

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	None
Advanced	**Date/time repair procedure initiated:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Date/time repair procedure completed**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Advanced	**Documented reason for delay in aneurysm repair**	○ Yes ○ No/ND	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*	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) _____	Required
Discharge	**Get With The Guidelines® - Ischemic Stroke-Only Estimated Mortality Rate**	[Calculated in the IRP]	None
Discharge	**Get With The Guidelines® - Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke not otherwise specified)**	[Calculated in the IRP]	None
Discharge	**Was a Modified Rankin Scale (mRS) performed at discharge?**	○ Yes ○ No/ND	Required
Discharge	**Method used to obtain Modified Rankin Scale at Discharge:**	○ Actual ○ Estimated from the record ○ ND	Required (PSS)
Discharge	**Modified Rankin at Discharge, Total Score:**	_____	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	Required (PSS)

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	Required
Discharge	**Blood Pressure (Systolic) - Discharge:**	_____	Required
Discharge	**Blood Pressure (Diastolic) - Discharge:**	_____	Required
Discharge	**Discharge Blood Pressure Not Documented**	☐	None
Discharge	**Did the patient receive any antihypertensive medication on the day of or the day prior to discharge?**	○ Yes ○ No/ND	Required
Discharge	**Were there two or more systolic blood pressure readings < 130 within 24 hours prior to the time of discharge?**	○ Yes ○ No/ND	Required
Discharge	**Antithrombotic Medication(s) Prescribed at Discharge:**	○ Yes ○ No/ND ○ NC	Required
Discharge	**Antithrombotic Class**	☐ Antiplatelet ☐ Anticoagulation	Required
Discharge	**Antithrombotics Medication**	Antiplatelet: ☐ aspirin ☐ aspirin/dipyridamole (Aggrenox) ☐ clopidogrel (Plavix) ☐ prasugrel (Effient) ☐ ticagrelor (Brilinta) ☐ ticlopidine (Ticlid) ☐ Other Antiplatelet	Required
Discharge	**Antithrombotics Medication**	Anticoagulation: ☐ apixaban (Eliquis) ☐ argatroban ☐ dabigatran (Pradaxa) ☐ desirudin (Iprivask) ☐ edoxaban (Savaysa) ☐ fondaparinux (Arixtra) ☐ full dose LMW heparin ☐ lepirudin (Refludan) ☐ rivaroxaban (Xarelto) ☐ unfractionated heparin IV ☐ warfarin (Coumadin) ☐ other Anticoagulant	Required
Discharge	**Antithrombotic Dosage**	_____	None
Discharge	**Antithrombotic Frequency**	_____	None
Discharge	**Documented reason for not prescribing an antithrombotic approved in stroke**	○ Yes ○ No/ND	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	Required

Discharge	**Persistent or Paroxysmal Atrial Fibrillation/Flutter:**	○ Yes ○ No	Required
Discharge	**If Atrial Fibrillation/Flutter or history of PAF documented, was patient discharged on anticoagulation?**	○ Yes ○ No/ND ○ NC	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 ☐ Other	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	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	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)	Required
Discharge	**Statin Total Daily Dose**	_____	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	Required
Discharge	**Documented reason for not prescribing a statin medication at discharge?**	○ Yes ○ No	Required
Discharge	**Follow-up for lipid management**	○ Yes ○ No ○ NC	Required

Discharge	**LP(a) treatment plan**	☐ None ☐ Lipoprotein apheresis ☐ Patient education on LP(a) ☐ Referred to lipid management ☐ Risk factor management ☐ Other _____	Required
Discharge	**New Diagnosis of Diabetes**	○ Yes ○ No ○ ND	Required
Discharge	**Basis for Diabetes Diagnosis (Select all that apply):**	☐ HbA1c ☐ Fasting Blood Sugar ☐ Oral Glucose Tolerance ☐ Test Other	Required
Discharge	**GLP-1 Receptor Agonist prescribed at discharge**	○ Yes ○ No ○ NC	
Discharge	**SGLT2 prescribed at discharge**	○ Yes ○ No ○ NC	
Discharge	**Antihyperglycemic Medication(s) (regardless of indication) Prescribed at Discharge:**	○ Yes ○ No ○ NC	Required
Discharge	**Antihyperglycemic Class (regardless of indication)**	☐ Biguanide ☐ DPP-4 Inhibitor ☐ GLP-1 receptor agonist ☐ Insulin ☐ SGLT2 Inhibitor ☐ Sulfonylurea ☐ Thiazolidinedione ☐ Other subcutaneous/injectable agents ☐ Other oral agents	Required
Discharge	**Antihyperglycemic Medication (regardless of indication)**	_____	Required
Discharge	**Was there a documented reason for not prescribing a medication with proven CVD benefit?**	○ Yes ○ No/ND	Required
Discharge	**Follow-up appointment scheduled for diabetes management?**	○ Yes ○ No/ND ○ NC	Required
Discharge	**Date of diabetes management follow-up visit:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Discharge	**Anti-Smoking Treatment:**	○ Yes ○ No/ND ○ NC	Required
Discharge	**Smoking Cessation Therapies Prescribed**	☐ Counseling ☐ Over the Counter Nicotine Replacement Therapy ☐ Prescription Medications ☐ Other ☐ Treatment not specified	None Stroke Required MiddleEast

Discharge	**Was the patient prescribed any antidepressant class of medication at discharge?**	○ Yes, SSRI ○ Yes, any other antidepressant class ○ No/ND	None
Discharge	**Reducing weight and/or increasing activity recommendations:**	○ Yes ○ No/ND ○ NC	Required
Discharge	**TLC Diet or Equivalent:**	○ Yes ○ No/ND ○ NC	Required
Discharge	**Anti-hypertensive Diet:**	○ Yes ○ No/ND ○ NC	Warning
Discharge	**Was Diabetes Teaching Provided?**	○ Yes ○ No/ND ○ NC	None
Discharge	**Check all Stroke Education as Yes:**	☐	None
Discharge	**Risk Factors for Stroke**	○ Yes ○ No	Required
Discharge	**Stroke Warning Signs and Symptoms**	○ Yes ○ No	Required
Discharge	**How to Activate EMS for Stroke**	○ Yes ○ No	Required
Discharge	**Need for Follow-Up After Discharge**	○ Yes ○ No	Required
Discharge	**Their Prescribed Medications**	○ Yes ○ No	Required
Discharge	**Patient assessed for and/or received rehabilitation services during this hospitalization?**	○ Yes ○ No	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)	Warning
Discharge	**During this admission, was a standardized health related social needs form or assessment completed?**	○ Yes ○ No/ND	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	Required
Discharge	**If unmet social need(s) identified, were resources provided to the patient?**	○ Yes ○ No	Required
Discharge	**If yes, what resources were provided?**	☐ Access to a Community Health Worker ☐ Access to a Social Worker ☐ Access to another Case Worker/Support Specialist ☐ Resources for a digital-based community platform (e.g., findhelp.org) ☐ Other	Required
Discharge	**Cardiac ultrasound/echocardiography**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Required
Discharge	**Extended implantable cardiac rhythm monitoring**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Required
Discharge	**Carotid imaging**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Required
Discharge	**Hypercoagulability testing**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Required
Discharge	**Carotid revascularization**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	Required
Discharge	**Intracranial vascular imaging**	○ Performed during this admission or in the 3 months prior ○ Planned post discharge ○ Not performed or planned	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	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	Required
Optional	**PMT used concurrently or retrospectively or combination?**	○ Concurrently ○ Retrospectively ○ Combination	None
Optional	**Was a stroke admission order set used in this patient?**	○ Yes ○ No	None

Optional	**Was a stroke discharge checklist used in this patient?**	○ Yes ○ No	None
Optional	**Patient adherence contract/compact used?**	○ Yes ○ No	None
Certification	**Check if patient is part of a sample:**	☐	None
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	Required
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	Required
Certification	**Is there documentation that the date and time of last known well was witnessed or reported?**	○ Yes ○ No	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	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	Required
Certification	**Is there documentation that IV alteplase was initiated at this hospital?**	○ Yes ○ No	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	Required
Certification	**Did the patient receive IV or IA alteplase at this hospital or within 24 hours prior to arrival?**	○ Yes ○ No	Required
Certification	**Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV alteplase?**	○ Yes ○ No	Required
Certification	**Was antithrombotic therapy administered by the end of hospital day 2? (STK)**	○ Yes ○ No	Required
Certification	**Discharge Date/Time (JC)**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ UTD	Required
Certification	**Was antithrombotic therapy prescribed at hospital discharge?**	○ Yes ○ No	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	Required

Certification	**Was anticoagulation therapy prescribed at hospital discharge?**	○ Yes ○ No	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	Required
Certification	**Was a statin medication prescribed at discharge?**	○ Yes ○ No	Required
Outpatient	**Hospital MRN**	_____	None
Outpatient	**Other MRN**	_____	None
Outpatient	**External Tracking ID**	_____	None
Outpatient	**Encounter Date**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Outpatient	**E/M Code**	_____	Required
Outpatient	**Arrival Date/Time (OP STK)**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Outpatient	**Birth Date (OP STK)**	_____ / _____ / _____	Required
Outpatient	**Sex (OP STK)**	○ Female ○ Male	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	Required
Outpatient	**Hispanic Ethnicity (OP STK)**	○ Yes ○ No	Required
Outpatient	**Patient Zip Code (OP STK)**	_____	Required
Outpatient	**Zip Code Extension (OP STK)**	_____	None
Outpatient	**Homeless (OP STK)**	☐	None
Outpatient	**What is the patient's source of payment for this outpatient encounter?**	○ Medicare ○ Non-Medicare	Required
Outpatient	**What is the date/time the patient departed from the emergency department?**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	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)	Required
Outpatient	**Was a Head CT or MRI scan ordered by the physician during the emergency department visit?**	○ Yes ○ No	Required
Outpatient	**Is there documentation that the date and time of last known well was witnessed or reported? (Outpatient)**	○ Yes ○ No	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	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	Required
Outpatient	**Clinical Service**	▽ _____	None
	SPECIAL INITIATIVES		
	Telestroke		
Telestroke	**If Yes, telestroke consult performed, select all applicable delivery methods.**	☐ Interactive Video ☐ Teleradiology ☐ Telephone Call ☐ ND	None
Telestroke	**What was the type of Telestroke provider?**	○ Hospital Based (In-State) ○ Hospital Based (Out-of-State) ○ Private Provider (Independent)	Required
Telestroke	**Who provided Telestroke Service?**	_____	None
Telestroke	**Did the Telestroke consultant recommend transfer?**	○ Yes ○ No ○ ND	None
Telestroke	**Patient transfer status after Telestroke consult (JC or equivalent):**	○ Not Transferred ○ Transferred to ○ Transferred to TSC ○ Transferred to CSC ○ Transferred to Unknown	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	Required
Telestroke	**Did Telestroke consultation result in thrombolytic administration at the referring site?**	○ Yes ○ No ○ ND	Required

	Telestroke Time Tracker		
Telestroke	**Date/Time of End of Neurologist Videoconference**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Telestroke	**Date/Time of first Telestroke consultation request:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Telestroke	**Date/Time Telestroke Response:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Telestroke	**Date/Time start of Telestroke video session:**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	Required
Telestroke	**Date/Time Decision to Administer Thrombolytic (By Telestroke):**	_____ / _____ / _____ | ____:____ ○ MM/DD/YYYY only ○ Unknown	None
Telestroke	**Additional Comments:**	_____	None