Patient number ☐☐☐☐☐☐

(Staff only)

Collecting data form of quality of service: Stroke

Instructions

1. Please put X mark in the box ☐ in front of the statement and/or fill in the blank truthfully.

A: Stroke patient data	
	ID Card .....
A1	First name – Last name .....
A2	HN: .....
A3	Age ☐☐☐ years
A4	Sex ☐ 1. Male ☐ 2. Female
A5	Healthcare coverage ☐ 1. National coverage ☐ 2. Social security ☐ 3. Self-pay ☐ 4. Original affiliation ☐ 5. Others.....
A6	Referral from other healthcare facility ☐ 1. Yes, Province..... Hospital..... ☐ 2. No
A7	History of illness/risk factors/comorbidities
A7.1	Diabetes mellitus ☐ 1. No ☐ 2. Yes → ☐☐ years ☐☐ months ☐ 3. Not checked
A7.2	Hypertension (over 140/80, or 130/80 if there is DM or stroke) ☐ 1. No ☐ 2. Yes → ☐☐ years ☐☐ months ☐ 3. Not checked
A7.3	Hyperlipidemia ☐ 1. No ☐ 2. Yes → ☐☐ years ☐☐ months ☐ 3. Not checked
A7.4	Atrial fibrillation and/or atrial flutter ☐ 1. No ☐ 2. Yes → ☐☐ years ☐☐ months ☐ 3. Not checked
A7.5	Previous stroke ☐ 1. No ☐ 2. Yes → Type ☐ 2.1 Ischemic ☐ 2.2 Hemorrhagic ☐3. Unknown
A7.6	Smoking? ☐ 1. No ☐ 2. Yes → still smokes in the past 6 months ☐ 2.1 No ☐ 2.2 Yes → Amount ☐☐ cigarettes/day
A7.7	Alcohol use? ☐ 1. No ☐ 2. Yes → still drinks in the past 6 months ☐ 2.1 No ☐ 2.2 Yes → Amount ☐☐ times/month
B: Clinical data	
B1.1	Ward on admission ☐ Stroke unit ☐ Others, specify.....
B1.2	Ward on transfer ☐ Stroke unit ☐ Others, specify.....
B2.1	Date of the symptom (stroke) ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐
B2.2	Service ☐ IPD ☐ OPD
B3.1	Date when the patient arrived OPD/ER ☐☐ /☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐
B3.2	Date of admission ☐☐ /☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐
B4	Date of discharge ☐☐ /☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐
	Follow Up after discharge ☐ Yes. Date of Follow Up ☐☐/☐☐/20☐☐ ☐ No. due to.....

B: Clinical data (Cont.)			
B4.1	Referral to another hospital ☐ 1. No ☐ 2. Yes, Province ..... Hospital ..... Date ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐ due to		
B5	First diagnosis ☐ 1. Acute ischemic stroke ☐ 2. Acute hemorrhagic stroke ☐ 3. Transient ischemic attack ☐ 4. Subarachnoid hemorrhage ☐ 5. Cerebral venous thrombosis	B6	Final diagnosis ☐ 1. Acute ischemic stroke ☐ 2. Acute hemorrhagic stroke ☐ 3. Transient ischemic attack ☐ 4. Subarachnoid hemorrhage ☐ 5. Cerebral venous thrombosis
B7	Glasgow Coma Scale (GCS) score on admission Total (3-15): ☐☐ ☐ N/A	B8	Glasgow Coma Scale (GCS) score on discharge Total (3-15): ☐☐ ☐ N/A
B9	Barthel index (0-100) on admission ☐☐☐	B10	Barthel index (0-100) on discharge ☐☐☐
B11	mRS on admission (0-5) ☐	B12	mRS on discharge (0-6) ☐
B13	NIHSS score (0-42) on admission ☐☐	B14	NIHSS score (0-42) on discharge ☐☐
B15	Blood sugar result ☐☐☐ mg % Date tested ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐ or ☐ tested from outside		
B15.1	Testing method ☐ 1. Dextrostick ☐ 2. Central lab		
B15.2	Fasting ☐ 1. Fasting ☐ 2. Non-fasting		
B16	Thrombolytic agent ☐ 1. Not received ☐ 2. Received → Date received antithrombolytic ☐☐ /☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐		
B16.1	Type of the medication ☐ 1. rtPA ☐ 2. Other (specify).....		
B16.2	Route ☐ 1. Intravenous Drug amount ☐☐.☐☐ milligram ☐ 2. Intra-arterial Drug amount ☐☐.☐☐ milligram		
B17	Endovascular treatment ☐ 1. Not received ☐ 2. Received → Groin puncture date ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐		
B18	Lipid level LDL.....mg/dl		
B19	Was the patient put on a ventilator? ☐ 1. Yes ☐ 2. No		
C: Indicators in ischemic stroke patient care			
C2	Was the patient readmitted due to recurrent ischemic stroke within 28 days without planning in advance? ☐ 1. Yes, specify number of days ..... (from the previous discharge date) ☐ 2. No Specify Recurrent Stroke/Complication/Other		
C3	Did the patient have EKG? ☐ 1. Tested on Date ☐☐/☐☐/20☐☐ Time (hh.mm) ☐☐:☐☐ ☐ 2. Tested from outside prior to admission ☐ 3. No		

C: Indicators in ischemic stroke patient care (Cont.)	
C4	Did the patient have EKG monitoring 24 hours after admission? ☐1. Yes ☐ 2. No
C5	Did the patient have CT brain and/or MRI/MRA brain within 24 hours? ☐ 1. Tested after admission ☐ 2. Tested from outside after admission Date ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐ ☐ 3. Tested prior to admission ☐ 4. No
C6	Symptomatic carotid stenosis ☐ 1. No ☐ 2. 50% - 70% ☐ 3. > 70%
C7	Did the patient receive antiplatelet (aspirin) for the treatment within 48 hours after symptom onset? ☐ 1. Yes, Date ☐☐/☐☐/20☐☐ Time (hh:mm) ☐☐:☐☐ ☐ 2. Yes, from home/other healthcare facilities ☐ 3. No due to .....
C8	Did the patient have fever ≥ 37.5°C during admission? ☐ 1. Yes ☐ 2. No (if answered, skip to C9)
C8.1	Did the patient receive tepid sponge or fever reduction? ☐ 1. Yes ☐ 2. No
C8.2	Did the patient receive laboratory investigations and/or treatment of cause of fever? ☐ 1. Yes ☐ 2. No
C9	Did the patient receive care by using Care Map/Path Way? ☐ 1. Yes ☐ 2. No
C10	Did the patient receive care in Stroke Unit? ☐ 1. Yes ☐ 2. No
C11	Did the patient receive swallowing evaluation within 72 hours after admission? ☐ 1. Yes ☐ 2. No due to .....
C12	Did the patient receive care regarding rehabilitation and/or Physical therapy/Evaluated/ Occupational therapy/Speech-Language therapy within 72 hours after admission? ☐ 1. Yes ☐ 2. Referred for physical therapy at another hospital ☐ 3. No due to .....
C13	Did the patient have the following complications?
C13.1	Pneumonia ☐ 1. Yes, found within ..... hours ☐ 2. No
C13.2	Urinary tract infection ☐ 1. Yes, found within ..... hours ☐ 2. No
C13.3	Pressure sore/skin break ☐ 1. Yes, found within ..... hours ☐ 2. No
C13.4	Deep vein thrombosis (DVT) ☐ 1. Yes, found within ..... hours ☐ 2. No
C14	Did the patient have falls? ☐ 1. Yes ☐ 2. No
C15	Did the patient receive instructions in the following topics?
C15.1	Secondary prevention ☐ 1. Yes ☐ 2. No
C15.2	Symptoms or abnormalities indicating possible recurrence ☐ 1. Yes ☐ 2. No
C15.3	Action when recurrence is suspected ☐ 1. Yes ☐ 2. No
C16	Did the patient receive therapy/advice about smoking cessation or avoid cigarette smoke? ☐ 1. Yes ☐ 2. No due to .....

C: Indicators in ischemic stroke patient care (Cont.)	
C17	Was antihypertensive medication prescribed to the patient before discharge from the hospital? ☐ 1. Yes ☐ 2. No
C18	Did the discharged ischemic stroke patient receive medication for secondary prevention on discharge? ☐ 1. Antiplatelet (such as aspirin, ticlopidine, clopidogrel, aspirin+dipyridamole, glostazol, trifusal), specify..... ☐ 2. Anticoagulant (such as warfarin, dabigatran, apixaban, rivaroxaban), specify ..... due to ..... ☐ 3. No due to .....
C19	Did the patient receive statin on discharge? ☐ 1. Yes ☐ 2. No due to .....
C20	Did the patient die during the hospital admission? 1. Yes, on Date ☐☐ /☐☐/20☐☐ ☐ 2. No
C21	Total expense ..... Currency Unit .....
D: Intracerebral **Hemorrhage**	
D1	Procedures performed to identify cause ☐ CTA ☐ MRA ☐ DSA ☐ None
D2	Was neurosurgery performed? ☐ 1. No ☐ 2. Yes, select the type: Intracranial hematoma evacuation, External ventricular drainage, Decompresive craniectomy, Referred to another centre
D3	The reason for bleeding was ☐ Arterial hypertension ☐ Aneurysm ☐ Arterio-venous malformation ☐ Anticoagulation therapy ☐ Amyloid angiopathy ☐ Other
E: Subarachnoid hemorrhage	
E1	The reason for bleeding was known ☐ 1. Yes ☐ 2. No
E2	Intervention ☐ Endovascular (coiling) ☐ Neurosurgical (clipping) ☐ Other neurosurgical treatment (decompression, drainage) ☐ Patient referred to another hospital for intervention
F: Cerebral venous thrombosis	
F1	Treatment ☐ Anticoagulation ☐ Endovascular intervention - thrombectomy ☐ Endovascular intervention - local thrombolysis ☐ Neurosurgical treatment (Decompressive craniectomy)

Signature....., Data Recorder

Date ☐☐/☐☐/20☐☐