

Patient ID:				Bold Question = Required	
DEMOGRAPHICS <i>Demographics Tab</i>					
Gender		<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown			
Date of Birth: ____/____/____			Age: _____		
Zip Code: _____ - _____		<input type="checkbox"/> Homeless			
Payment Source	<input type="checkbox"/> Medicare Title 18		<input type="checkbox"/> Medicaid Title 19		<input type="checkbox"/> Medicare – Private/ HMO/ PPO/ Other
	<input type="checkbox"/> Medicaid – Private/ HMO/ PPO/ Other		<input type="checkbox"/> Private/ HMO/ PPO/ Other		<input type="checkbox"/> VA/ CHAMPVA/ Tricare
	<input type="checkbox"/> Self Pay/ No Insurance		<input type="checkbox"/> Other/ Not Documented/ UTD		
RACE AND ETHNICITY					
Race (Select all that apply):	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Black or African American		
	<input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian or Pacific Islander		
	[if Asian selected]		[if native Hawaiian or pacific islander selected]		
	<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian		<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> UTD		
Hispanic Ethnicity:		<input type="radio"/> Yes <input type="radio"/> No/UTD			
If Yes,		<input type="checkbox"/> Mexican, Mexican American, Chicano/a		<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban	
		<input type="checkbox"/> Another Hispanic, Latino or Spanish Origin			
ADMIN <i>Admin Tab</i>					
Final clinical diagnosis related to stroke		<input type="radio"/> Ischemic Stroke <input type="radio"/> Transient Ischemic Attack (<24 hours) <input type="radio"/> Subarachnoid Hemorrhage		<input type="radio"/> Intracerebral Hemorrhage <input type="radio"/> Stroke not otherwise specified <input type="radio"/> No stroke related diagnosis <input type="radio"/> Elective Carotid Intervention only	
If not Stroke Related Diagnosis:		<input type="radio"/> Migraine <input type="radio"/> Seizure <input type="radio"/> Delirium		<input type="radio"/> Electrolyte or metabolic imbalance <input type="radio"/> Functional disorder <input type="radio"/> Other <input type="radio"/> Uncertain	
Was the Stroke etiology documented in the patient medical record:				<input type="radio"/> Yes <input type="radio"/> No	
Select documented stroke etiology (select all that apply):		<input type="radio"/> 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis) <input type="radio"/> 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI) <input type="radio"/> 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm) <input type="radio"/> 4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders. <input type="radio"/> Dissection <input type="radio"/> Hypercoagulability <input type="radio"/> Other <input type="radio"/> 5: Cryptogenic stroke (stroke of undetermined etiology) <input type="radio"/> Multiple potential etiologies identified <input type="radio"/> Stroke of undetermined etiology <input type="radio"/> Unspecified			
When is the earliest documentation of comfort measures only?		<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented/UTD			
Arrival Date/Time: ____/____/____:____		<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown		Admit Date: ____/____/____	

Not Admitted:	<input type="radio"/> Yes, not admitted <input type="radio"/> No, patient admitted as in patient	Reason Not Admitted:	<input type="radio"/> Transferred from your ED to another acute care hospital <input type="radio"/> Discharged directly from ED to home or other location that is not an acute care hospital <input type="radio"/> Left from ED AMA <input type="radio"/> Died in ED <input type="radio"/> Discharged from observation status without an inpatient admission <input type="radio"/> other
If patient transferred from your ED to another hospital, specify hospital name	[Select hospital name from picker list] <input type="checkbox"/> Hospital not on list <input type="checkbox"/> Hospital not documented		
Select reason(s) for why patient transferred	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented		
Discharge Date:	____/____/____:____		<input type="checkbox"/> MM/DD/YYYY only
Documented reason for delay in transfer to referral facility?	<input type="radio"/> Yes <input type="radio"/> No/ND		
Specific reason for delay documented in transfer patient (check all that apply):	<input type="checkbox"/> Social/religious <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care team unable to determine eligibility <input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Investigational or experimental protocol for reperfusion <input type="checkbox"/> Delay in stroke diagnosis * <input type="checkbox"/> In-hospital time delay * <input type="checkbox"/> Equipment-related delay * <input type="checkbox"/> Need for additional imaging* <input type="checkbox"/> Catheter lab not available* <input type="checkbox"/> Other *		
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	<input type="checkbox"/> 1 – Home <input type="checkbox"/> 2 – Hospice – Home <input type="checkbox"/> 3 – Hospice – Health Care Facility <input type="checkbox"/> 4 – Acute Care Facility <input type="checkbox"/> 5 – Other Health Care Facility <input type="checkbox"/> 6 – Expired <input type="checkbox"/> 7 – Left Against Medical Advice / AMA <input type="checkbox"/> 8 – Not Documented or Unable to Determine (UTD)		
If Other Health Care Facility	<input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Long Term Care Hospital (LTCH)		<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Other
DIAGNOSIS CODE			
<i>Clinical Codes Tab</i>			
ICD-9CM or ICD-10-CM Principal Diagnosis Code ICD-9CM or ICD-10-CM Other Diagnosis Codes ICD-9-CM or ICD-10-PCS Principal Procedure Code ICD-9-CM or ICD-10-PCS Other Procedure Codes ICD-9-CM Discharge Diagnosis Related to Stroke ICD-10-CM Discharge Diagnosis Related to Stroke No Stroke or TIA Related ICD-9-CM Code Present No Stroke or TIA Related ICD-10-CM Code Present	_____ _____ _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____		
ARRIVAL AND ADMISSION INFORMATION			
<i>Admission Tab</i>			

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)?		<input type="radio"/> Yes	<input type="radio"/> No
Was this patient admitted for the sole purpose of performance of elective carotid intervention?		<input type="radio"/> Yes	<input type="radio"/> No
Patient location when stroke symptoms discovered	<input type="radio"/> Not in a healthcare setting <input type="radio"/> Another acute care facility <input type="radio"/> Chronic health care facility	<input type="radio"/> Outpatient healthcare setting <input type="radio"/> Stroke occurred after hospital arrival (in ED/Obs/inpatient) <input type="radio"/> ND or Cannot be determined	
How patient arrived at your hospital	<input type="radio"/> EMS from home/scene <input type="radio"/> Mobile Stroke Unit <input type="radio"/> Private Transportation/Taxi/Other from home/scene	<input type="radio"/> Transfer from another hospital <input type="radio"/> ND or Unknown	
Referring hospital discharge Date/ Time	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown		
If transferred from another hospital, specify hospital name	[Select hospital name from picker list] <input type="checkbox"/> Hospital not on list <input type="checkbox"/> Hospital not documented		
Referring hospital arrival date/ time	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown		
If patient transferred to your hospital, select transfer reason(s)	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (e.g. Drip and Ship) <input type="checkbox"/> Evaluation for Endovascular thrombectomy <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented		
Was the patient an ED patient at the facility?	<input type="radio"/> Yes <input type="radio"/> No		
Was the patient a direct admission to the hospital?	<input type="radio"/> Yes <input type="radio"/> No		
Where patient first received care at your hospital	<input type="radio"/> Emergency Department / Urgent Care <input type="radio"/> Direct Admit, not through ED <input type="radio"/> Imaging suite <input type="radio"/> ND or Cannot be determined		
Advanced Notification by EMS or MSU?	<input type="radio"/> Yes <input type="radio"/> No/ND		
Initial Admitting Service	<input type="radio"/> Neurology <input type="radio"/> Neurosurgery <input type="radio"/> Neurocritical Care	<input type="radio"/> Medicine <input type="radio"/> Surgery <input type="radio"/> Other: _____	
In which settings were care delivered? Select all that apply.	<input type="checkbox"/> Neuro/ Neurosurgery ICU <input type="checkbox"/> Other ICU <input type="checkbox"/> Stroke Unit (Non-ICU)	<input type="checkbox"/> General Care Floor <input type="checkbox"/> Observation <input type="checkbox"/> Other: _____	
If the patient was not cared for in a dedicated stroke unit, was a formal inpatient consultation from a stroke expert obtained?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND		
Physician / Provider NPI:			
MEDICAL HISTORY			
Previously known medical hx of:	<input type="checkbox"/> None <input type="checkbox"/> Atrial Fib/Flutter <input type="checkbox"/> Current Pregnancy (up to 6 weeks post-partum) <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> ND Duration: <input type="radio"/> < 5 years <input type="radio"/> 5 - < 10 years <input type="radio"/> 10 - < 20 years <input type="radio"/> >= 20 years <input type="radio"/> Unknown	<input type="checkbox"/> CAD/ Prior MI <input type="checkbox"/> DVT/ PE <input type="checkbox"/> Drugs/ Alcohol Abuse <input type="checkbox"/> Familial Hypercholesterolemia <input type="checkbox"/> HRT <input type="checkbox"/> Migraine <input type="checkbox"/> Previous TIA <input type="checkbox"/> Renal Insufficiency – Chronic <input type="checkbox"/> Smoker	<input type="checkbox"/> Carotid Stenosis <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Family History of Stroke <input type="checkbox"/> Hx of Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other Infectious Respiratory Pathogen <input type="checkbox"/> Obesity Overweight <input type="checkbox"/> Prosthetic Heart Valve

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

DIAGNOSIS & EVALUATION

Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)	<input type="radio"/> Less than 10 minutes <input type="radio"/> 10 – 59 minutes <input type="radio"/> > = 60 minutes <input type="radio"/> ND
Had stroke symptoms resolved at time of presentation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND
Initial NIH Stroke Scale	<input type="radio"/> Yes <input type="radio"/> No/ND
If yes:	<input type="radio"/> Actual <input type="radio"/> Estimate from record <input type="radio"/> ND

Total Score: _____ (refer to web program for questions)

^What is the first NIHSS score obtained prior to or after hospital arrival? _____ UTD

^Was the initial NIHSS score after hospital arrival less than 6? Yes No

^Is there documentation that an initial NIHSS score was done at this hospital Yes No

^What is the date and time that the NIHSS score was first performed at this hospital? _____:_____ MM/DD/YYYY only
 Unknown

NIHSS score obtained from transferring facility: _____ ND

Initial exam findings (Select all that apply)

<input type="checkbox"/> Weakness/Paresis	<input type="checkbox"/> Altered Level of Consciousness	<input type="checkbox"/> Aphasia/Language Disturbance
<input type="checkbox"/> Other neurological signs/symptoms	<input type="checkbox"/> No neurological signs/symptoms	<input type="checkbox"/> ND

Ambulatory status on admission

Able to ambulate independently (no help from another person) w/ or w/o device
 With assistance (from person)
 Unable to ambulate
 ND

HEMORRHAGIC STROKE SCALES

^First Glasgow Coma Scale (GCS)	Eye _____	Verbal _____	<input type="checkbox"/> Intubated	Motor _____	Total GCS _____ <input type="checkbox"/> ND
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SUBARACHNOID HEMORRHAGE (SAH)

^Is there documentation any time during the hospital stay that the hemorrhage was non-aneurysmal or due to head trauma? Yes No

^Was an initial Hunt and Hess scale done at this hospital? Yes No

^If yes, Hunt and Hess score: _____

^What is the date and time that the Hunt and Hess Scale was first performed at this hospital?	____/____/____:____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
^WFNS SAH Grading Scale _____		
INTRACEREBRAL HEMORRHAGE (ICH)		
^Was an initial ICH score done at this hospital?	<input type="radio"/> Yes <input type="radio"/> No	
^If yes, ICH score:	_____	
^What is the date and time that the ICH score was first performed at this hospital?	____/____/____:____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
^^FUNC Score (ICH)	_____	
MEDICATION PRIOR TO ADMISSION		
No medications prior to admission <input type="checkbox"/>		
Antiplatelet or Anticoagulant Medication(s): <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		
<input type="checkbox"/> Antiplatelet Medication <input type="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> prasugrel (Effient) <input type="radio"/> ticagrelor (Brilinta) <input type="radio"/> ticlopidine (Ticlid) <input type="radio"/> Other Antiplatelet	<input type="checkbox"/> Anticoagulant Medication <input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> desirudin (Iprivask) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra) <input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> unfractionated heparin IV <input type="radio"/> warfarin (Coumadin) <input type="radio"/> other Anticoagulant	
Antihypertensive	<input type="radio"/> Yes <input type="radio"/> No/ND	
Cholesterol-Reducer	<input type="radio"/> Yes <input type="radio"/> No/ND	
Anti-hyperglycemic medications:	<input type="radio"/> Yes <input type="radio"/> No/ND	
If yes, select medications (select all that apply)	<input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> SGLT2 inhibitor <input type="checkbox"/> Other injectable/subcutaneous agent <input type="checkbox"/> GLP-1 receptor agonist <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Insulin <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> Metformin <input type="checkbox"/> Other oral agent	
Antidepressant medication	<input type="radio"/> Yes <input type="radio"/> No/ND	
VACCINATIONS & TESTING		
COVID-19 Vaccination:	<input type="radio"/> COVID-19 vaccine was given during this hospitalization <input type="radio"/> COVID-19 vaccine was received prior to admission, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of COVID-19 vaccine <input type="radio"/> Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD	
COVID-19 Vaccination date:	____/____/____	<input type="radio"/> Not Documented
Is there documentation that this patient was included in a COVID-19 vaccine trial?	<input type="radio"/> Yes <input type="radio"/> No/ND	
Influenza Vaccination:	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/sensitivity to influenza vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD	
SYMPTOM TIMELINE		
Date/Time Patient last known to be well?	<input type="checkbox"/> Time of Discovery	Date/Time of discovery of stroke symptoms?

____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	same as Last Known well	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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Comments: _____

BRAIN IMAGING

Brain imaging completed at your hospital for this episode of care?	<input type="radio"/> Yes <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="radio"/> No/ND <input type="checkbox"/> ONC	Date/Time Brain Imaging First Initiated at your hospital:	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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Interpretation of first brain image after symptom onset, done at any facility:	<input type="radio"/> Acute Hemorrhage <input type="radio"/> No Acute Hemorrhage <input type="radio"/> Not Available
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Was acute Vascular or perfusion imaging (e.g. CTA, MRA, DSA) performed at your hospital?	<input type="radio"/> Yes <input type="radio"/> No	Date/Time 1 st vessel or perfusion imaging initiated at your hospital:	____/____/____:____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
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If yes, type of vascular imaging (select all that apply)	<input type="checkbox"/> CTA <input type="checkbox"/> CT Perfusion <input type="checkbox"/> MRA	<input type="checkbox"/> MR Perfusion <input type="checkbox"/> DSA (catheter angiography) <input type="checkbox"/> Image type not documented
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Was a target lesion (large vessel occlusion) visualized?	<input type="radio"/> Yes <input type="radio"/> No/ND
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If yes, select site of large vessel occlusion (select all that apply):	<input type="checkbox"/> ICA <input type="checkbox"/> Intracranial ICA <input type="checkbox"/> Cervical ICA <input type="checkbox"/> Other/UTD	<input type="checkbox"/> MCA <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> Other/UTD	<input type="checkbox"/> Basilar <input type="checkbox"/> Other cerebral artery branch <input type="checkbox"/> Vertebral Artery
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ADDITIONAL TIME TRACKER

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

	<input type="radio"/> N/A		
Additional Comments:			
IV THROMBOLYTIC THERAPY			
IV thrombolytic initiated at this hospital?	<input type="radio"/> Yes <input type="radio"/> No	Date/Time IV thrombolytic initiated: ____/____/____ : ____	
Thrombolytic used:	<input type="radio"/> Alteplase (Class 1 evidence) Alteplase, total dose: _____(mg) <input type="checkbox"/> Alteplase dose ND	<input type="radio"/> Tenecteplase (Class 2b evidence) Tenecteplase, total dose: _____(mg) <input type="checkbox"/> Tenecteplase dose ND	
Reason for selecting tenecteplase instead of alteplase:	<input type="radio"/> Large Vessel Occlusion (LVO) with potential thrombectomy <input type="radio"/> Mild Stroke <input type="radio"/> Other: _____		
If IV thrombolytic administered beyond 4.5-hour, was imaging used to identify eligibility?	<input type="radio"/> Yes, Diffusion-FLAIR mismatch <input type="radio"/> Yes, Core-Perfusion mismatch <input type="radio"/> None <input type="radio"/> Other: _____		
Documented exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?	<input type="radio"/> Yes <input type="radio"/> No		
Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window?	<input type="radio"/> Yes <input type="radio"/> No		
SHOW ALL			
<i>If yes, documented exclusions for 0 -3-hour treatment window or 3 – 4.5 treatment window, select reason for exclusion.</i>			
For discharges on or after 1 April 2016			
<i>Exclusion Criteria (contraindications) 0-3 hr treatment window. Select all that apply:</i>			
<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Acute bleeding diathesis (low platelet count, increased PTT, INR >= 1.7 or use of NOAC) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere) <input type="checkbox"/> C8: Arterial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L)			
<i>Relative Exclusion Criteria (Warnings) 0-3 hr treatment window. Select all that apply:</i>			
<input type="checkbox"/> W1: Care-team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Patient/family refusal <input type="checkbox"/> W7: Stroke severity too mild (non-disabling) <input type="checkbox"/> W8: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W9: Seizure at onset with postictal residual neurological impairments <input type="checkbox"/> W10: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)			
<i>Exclusion Criteria (contraindications) 3-4.5 hr treatment window. Select all that apply:</i>			
<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous			

	<p style="text-align: center;">3 months</p> <ul style="list-style-type: none"> <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Acute bleeding diathesis (low platelet count, increased PTT, INR ≥ 1.7 or use of NOAC) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrates multi-lobar infarction (hypodensity >1/3 cerebral hemisphere) <input type="checkbox"/> C8: Arterial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration <50 mg/dL (2.7 mmol/L) <p>Relative Exclusion Criteria (Warnings) 3-4.5 hr treatment window. Select all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> W1: Care-team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombectomy at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe co-morbid illness or CMO on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Patient/family refusal <input type="checkbox"/> W7: Stroke severity too mild (non-disabling) <input type="checkbox"/> W8: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W9: Seizure at onset with postictal residual neurological impairments <input type="checkbox"/> W10: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days) <p>Additional Relative Exclusion Criteria 3-4.5 hr treatment window. Select all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> AW1: Age > 80 <input type="checkbox"/> AW2: History of both diabetes and prior ischemic stroke <input type="checkbox"/> AW3: Taking an oral anticoagulant regardless of INR <input type="checkbox"/> AW4: Severe Stroke (NIHSS > 25) <p>Other Reasons (Hospital-related or other factors) 0-3-hour treatment window.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> In-hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Rapid or Early Improvement <input type="checkbox"/> Advanced Age <input type="checkbox"/> Stroke too severe <input type="checkbox"/> Other – requires specific reason to be entered in the PMT when this option is selected. <p>Other Reasons (Hospital-related or other factors) 3-4.5-hour treatment window.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> In-hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Rapid or Early Improvement <input type="checkbox"/> Other – requires specific reason to be entered in the PMT when this option is selected 									
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">If IV thrombolytic was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</td> <td style="width: 10%; text-align: center;">○ Yes</td> <td style="width: 10%; text-align: center;">○ No</td> </tr> <tr> <td>If IV thrombolytic was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</td> <td style="text-align: center;">○ Yes</td> <td style="text-align: center;">○ No</td> </tr> <tr> <td>If IV thrombolytic was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:</td> <td style="text-align: center;">○ Yes</td> <td style="text-align: center;">○ No</td> </tr> </table>	If IV thrombolytic was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No	If IV thrombolytic was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No	If IV thrombolytic was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No
If IV thrombolytic was initiated greater than 60 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No								
If IV thrombolytic was initiated greater than 45 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No								
If IV thrombolytic was initiated greater than 30 minutes after hospital arrival, were Eligibility or Medical reason(s) documented as the cause for delay:	○ Yes	○ No								
<p>Eligibility Reason(s):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Social/Religious <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care-team unable to determine eligibility <input type="checkbox"/> Specify eligibility reason: _____ 									

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

ENDOVASCULAR THERAPY

Is there documentation of a suspected LVO in the medical record?	<input type="radio"/> Yes <input type="radio"/> No
Is there documentation in the medical record that the patient is eligible for MER therapy or a mechanical thrombectomy procedure?	<input type="radio"/> Yes <input type="radio"/> No
Catheter-based stroke treatment at this hospital?	<input type="radio"/> Yes <input type="radio"/> No
IA alteplase or MER Initiation Date/Time	____/____/____ : ____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Catheter-based stroke treatment at outside hospital?	<input type="radio"/> Yes <input type="radio"/> No

Note, if your hospital is collecting data for the Comprehensive Stroke Center and/or Mechanical Endovascular Reperfusion measure set, please ensure you complete additional data entry on the Advanced Stroke Care.

COMPLICATIONS

Complications of Reperfusion Therapy (Thrombolytic or MER)	<input type="checkbox"/> Symptomatic Intracranial hemorrhage <36 hours <input type="checkbox"/> Life threatening, serious systemic hemorrhage <36 hours <input type="checkbox"/> UTD	<input type="checkbox"/> Other serious complications <input type="checkbox"/> No serious complications
If bleeding complications occur in patient after IV alteplase:	<input type="radio"/> Symptomatic hemorrhage detected prior to patient transfer <input type="radio"/> Symptomatic hemorrhage detected only after patient transfer	<input type="radio"/> Unable to determine <input type="radio"/> N/A

OTHER IN-HOSPITAL TREATMENT AND SCREENING

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

VTE Interventions	<input type="checkbox"/> 1- Low dose unfractionated heparin (LDUH) <input type="checkbox"/> 2- Low molecular weight heparin (LMWH) <input type="checkbox"/> 3- Intermittent pneumatic compression devices (IPC) <input type="checkbox"/> 4- Graduated compression stockings (GCS) <input type="checkbox"/> 5- Factor Xa Inhibitor <input type="checkbox"/> 6- Warfarin	<input type="checkbox"/> 7- Venous foot pumps (VFP) <input type="checkbox"/> 8-Oral Factor Xa Inhibitor <input type="checkbox"/> 9- Aspirin <input type="checkbox"/> A- None of the above or ND	
What date was the initial VTE prophylaxis administered after hospital admission?		____/____/____ <input type="checkbox"/> Unknown	
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?		<input type="radio"/> Yes <input type="radio"/> No	
For discharges on or after 01/01/2013: Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?		<input type="radio"/> Yes <input type="radio"/> No	
Other Therapeutic Anticoagulation	<input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> argatroba <input type="checkbox"/> dabigatran (Pradaxa)	<input type="checkbox"/> desirrudin (Iprivask) <input type="checkbox"/> endoxaban (Savaysa) <input type="checkbox"/> lepirudin (Refludan)	
		<input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> other anticoagulant	
Was DVT or PE documented?		<input type="radio"/> Yes <input type="radio"/> No/ND	
Was antithrombotic therapy administered by the end of hospital day 2?		<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC	
Active bacterial or viral infection at admission or during hospitalization:	<input type="checkbox"/> None <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> MERS <input type="checkbox"/> Other Emerging Infectious Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal Cold <input type="checkbox"/> Other Viral Infection		
MEASUREMENTS (first measurement upon presentation to your hospital)			
Total Chol: _____ mg/dl	Triglycerides: _____ mg/dl	HDL: _____ mg/dl	LDL: _____ mg/dl <input type="checkbox"/> Lipids: NC <input type="checkbox"/> Lipids: ND
A ₁ C: _____ % A ₁ C <input type="checkbox"/> ND	Blood Glucose (required if patient received IV alteplase): _____ mg/dl <input type="checkbox"/> ND <input type="checkbox"/> Too Low <input type="checkbox"/> Too High		
Serum Creatine: _____ <input type="checkbox"/> ND	^What is the first platelet count obtained prior to or after hospital arrival? _____		
INR: _____ <input type="checkbox"/> ND <input type="checkbox"/> NC			
^Is there documentation in the medical record that the INR value performed closest to hospital arrival was greater than 1.4?			<input type="radio"/> Yes <input type="radio"/> No
Vital Signs:	Heart Rate (beats per minute): _____ bpm ^What is the first blood pressure obtained prior to or after hospital arrival? (required if patient received IV alteplase) _____ / _____ <input type="checkbox"/> Vital signs UTD		
Height: _____	<input type="radio"/> in <input type="radio"/> cm <input type="radio"/> ND		
Weight: _____	<input type="radio"/> lbs <input type="radio"/> kg <input type="radio"/> ND		
Waist Circumference: _____	<input type="radio"/> in	<input type="radio"/> cm	<input type="radio"/> ND
BMI: _____	<input type="checkbox"/> ND		

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

		<input type="checkbox"/> Equipment-related delay * <input type="checkbox"/> Need for additional imaging* <input type="checkbox"/> Catheter lab not available * <input type="checkbox"/> Other *	
^What is the location of the clot in the cerebral circulation?		<input type="radio"/> Proximal cerebral occlusion <input type="radio"/> Distal cerebral occlusion <input type="radio"/> Neither proximal or distal, OR unable to determine (UTD) from the medical record documentation	
^What cerebral artery is occluded?		<input type="radio"/> Anterior cerebral artery (ACA) <input type="radio"/> A1 ACA <input type="radio"/> Anterior communicating artery <input type="radio"/> Internal carotid artery (ICA) <input type="radio"/> ICA terminus (T-lesion; T occlusion) <input type="radio"/> Middle cerebral artery (MCA) <input type="radio"/> M1 MCA <input type="radio"/> M2 MCA <input type="radio"/> M3/M4 MCA <input type="radio"/> Vertebral artery (VA) <input type="radio"/> Basilar artery (BA) <input type="radio"/> Posterior cerebral artery (PCA) <input type="radio"/> Other cerebral artery branch/segment <input type="radio"/> The clinical location of the primary occluded vessel was not documented, OR unable to determine (UTD) from the medical record documentation.	
^Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade		<input type="radio"/> Grade 0 <input type="radio"/> Grade 1 <input type="radio"/> Grade 2a <input type="radio"/> Grade 2b <input type="radio"/> Grade 3 <input type="radio"/> ND	
^Is there a documented TICI reperfusion grade post-treatment?	<input type="radio"/> 1 - A TICI reperfusion grade greater than or equal to (\geq) 2B was documented posttreatment	<input type="radio"/> 2 - A TICI reperfusion grade less than ($<$) 2B was documented post-treatment	<input type="radio"/> 3 - A TICI reperfusion grade was not done post-treatment, OR Unable to determine (UTD) from the medical record documentation
^What was the date and time that a TICI was first documented during the mechanical thrombectomy procedure?		____/____/____ : ____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
COMPLICATIONS			
^Was there a positive finding on brain imaging of parenchymal hematoma, SAH, and/or IVH following IV or IA alteplase, or mechanical endovascular reperfusion therapy initiation?		<input type="radio"/> Yes <input type="radio"/> No	
^Date/Time of positive brain image :		____/____/____ : ____	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
^^Results of positive brain image		<input type="checkbox"/> PH2 (Parenchymal Hematoma Type 2) <input type="checkbox"/> IVH (Intraventricular Hemorrhage) <input type="checkbox"/> SAH (Subarachnoid Hemorrhage) <input type="checkbox"/> RIH (Remote site of intraparenchymal hemorrhage outside the area of infarction) <input type="checkbox"/> Other positive finding not listed above <input type="checkbox"/> Not documented	
^What is the last NIHSS score documented prior to initiation of alteplase at this hospital?		_____	
This score obtained from:		<input type="radio"/> Baseline NIHSS <input type="radio"/> Subsequent NIHSS	
^What is the highest NIHSS score documented within 36 hours following initiation of IV alteplase?		_____	
^What is the last NIHSS score documented prior to initiation of IA alteplase or MER at this hospital?		_____	
This score obtained from:		<input type="radio"/> Baseline NIHSS <input type="radio"/> Subsequent NIHSS	
^What is the highest NIHSS score documented within 36 hours following IA alteplase or MER initiation?		_____	
^Is there documentation that a procoagulant reversal agent was		<input type="radio"/> Yes <input type="radio"/> No	

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

HEMORRHAGIC STROKE TREATMENT

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

DISCHARGE INFORMATION *Discharge Tab*

GWTG Ischemic Stroke-Only Estimated Mortality Rate	[Calculated in the PMT]
GWTG Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke NOS)	[Calculated in the PMT]
Modified Rankin Scale at Discharge	<input type="radio"/> Yes <input type="radio"/> No/ND
If Yes:	<input type="radio"/> Actual <input type="radio"/> Estimated from record <input type="radio"/> ND
Total Score:	_____
Ambulatory status at discharge	<input type="radio"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="radio"/> With assistance (from person) <input type="radio"/> Unable to ambulate <input type="radio"/> ND
Discharge Blood Pressure (Measurement closest to discharge)	_____/____ mmHg (Systolic/Diastolic) <input type="checkbox"/> ND

DISCHARGE TREATMENTS

Antithrombotic Therapy approved in stroke	Prescribed? <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC
	If yes,
	<input type="checkbox"/> Antiplatelet <input type="checkbox"/> Anticoagulant
	<input type="radio"/> aspirin <input type="radio"/> aspirin/dipyridamole (Aggrenox) <input type="radio"/> clopidogrel (Plavix) <input type="radio"/> ticlopidine (Ticlid) <input type="radio"/> apixaban (Eliquis) <input type="radio"/> argatroban <input type="radio"/> dabigatran (Pradaxa) <input type="radio"/> endoxaban (Savaysa) <input type="radio"/> fondaparinux (Arixtra) <input type="radio"/> full dose LMW heparin <input type="radio"/> lepirudin (Refludan) <input type="radio"/> rivaroxaban (Xarelto) <input type="radio"/> Unfractionated heparin IV <input type="radio"/> warfarin

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

New Diagnosis of Diabetes?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND	
Basis for Diagnosis (Select all that apply)		<input type="checkbox"/> HbA1c <input type="checkbox"/> Oral Glucose Tolerance	<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Test Other
Anti-hyperglycemic medications:	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Class:	Medication:
		Class:	Medication:
		Class:	Medication:
		Class:	Medication:
Was there a documented reason for not prescribing a medication with proven CVD benefit?		<input type="radio"/> Yes <input type="radio"/> No/ND	
Follow-up appointment scheduled for diabetes management?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Date of scheduled diabetes follow-up appointment:	____ / ____ / ____ <input type="radio"/> Unknown		
Anti-Smoking Tx	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Smoking Cessation Therapies Prescribed (select all that apply)	<input type="checkbox"/> Counseling <input type="checkbox"/> Over the Counter Nicotine Replacement Therapy <input type="checkbox"/> Prescription Medications <input type="checkbox"/> Other <input type="checkbox"/> Treatment not specified		
Was the patient prescribed any antidepressant class of medication at discharge?	<input type="radio"/> Yes, SSRI <input type="radio"/> Yes, any other antidepressant class <input type="radio"/> No/ND		
OTHER LIFESTYLE INTERVENTIONS			
Reducing weight and/or increasing activity recommendations	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
TLC Diet or Equivalent	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Antihypertensive Diet	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
Was Diabetic Teaching Provided?	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> NC		
STROKE EDUCATION			
Patient and/or caregiver received education and/or resource materials regarding all the following:			
Check all as Yes: <input type="checkbox"/>			
Risk Factors for Stroke	<input type="radio"/> Yes <input type="radio"/> No	Stroke Warning Signs and Symptoms	<input type="radio"/> Yes <input type="radio"/> No
How to Activate EMS for Stroke	<input type="radio"/> Yes <input type="radio"/> No	Need for Follow-Up After Discharge	<input type="radio"/> Yes <input type="radio"/> No
Their Prescribed medications	<input type="radio"/> Yes <input type="radio"/> No		
STROKE REHABILITATION			
Patient assessed for and/or received rehabilitation services during this hospitalization?		<input type="radio"/> Yes <input type="radio"/> No	
Check all rehab services that patient received or was assessed for:	<input type="checkbox"/> Patient received rehabilitation services during hospitalization <input type="checkbox"/> Patient transferred to rehabilitation facility <input type="checkbox"/> Patient referred to rehabilitation services following discharge <input type="checkbox"/> Patient ineligible to receive rehabilitation services because symptoms resolved <input type="checkbox"/> Patient ineligible to receive rehabilitation services due to impairment (i.e. poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)		

HEALTH RELATED SOCIAL NEEDS ASSESSMENT																
During this admission, was a standardized health related social needs form or assessment completed?	<input type="radio"/> Yes <input type="radio"/> No/ND															
If Yes, identify the areas of unmet social need. Select all that apply.	<table border="0"> <tr> <td><input type="checkbox"/> Living Situation/ Housing</td> <td><input type="checkbox"/> Employment</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> Education</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Utilities</td> <td><input type="checkbox"/> Mental Health</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Personal Safety</td> <td><input type="checkbox"/> Substance Use</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Financial Strain</td> <td><input type="checkbox"/> Transportation Barriers</td> <td></td> </tr> </table>	<input type="checkbox"/> Living Situation/ Housing	<input type="checkbox"/> Employment		<input type="checkbox"/> Food	<input type="checkbox"/> Education		<input type="checkbox"/> Utilities	<input type="checkbox"/> Mental Health	<input type="checkbox"/> None	<input type="checkbox"/> Personal Safety	<input type="checkbox"/> Substance Use		<input type="checkbox"/> Financial Strain	<input type="checkbox"/> Transportation Barriers	
<input type="checkbox"/> Living Situation/ Housing	<input type="checkbox"/> Employment															
<input type="checkbox"/> Food	<input type="checkbox"/> Education															
<input type="checkbox"/> Utilities	<input type="checkbox"/> Mental Health	<input type="checkbox"/> None														
<input type="checkbox"/> Personal Safety	<input type="checkbox"/> Substance Use															
<input type="checkbox"/> Financial Strain	<input type="checkbox"/> Transportation Barriers															

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

OPTIONAL FIELDS – Please do not enter any patient identifiers in this section					Optional Fields Tab
Field 1	Field 2	Field 3	Field 4	Field 5	
Field 6	Field 7	Field 8	Field 9	Field 10	
Field 11			Field 12		
Field 13	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown	Field 14	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY <input type="checkbox"/> Unknown
Additional Comments:					

Administrative			
PMT used concurrently or retrospectively or combination?	<input type="radio"/> Concurrently	<input type="radio"/> Retrospectively	<input type="radio"/> Combination
Was a stroke admission order set used in this patient?	<input type="radio"/> Yes	<input type="radio"/> No	
Was a stroke discharge checklist used in this patient?	<input type="radio"/> Yes	<input type="radio"/> No	
Patient adherence contract/compact used?	<input type="radio"/> Yes	<input type="radio"/> No	

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

What is the date/time the patient departed from the emergency department?	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
For discharges on or after 07/01/2012: What was the patient's discharge code from the outpatient setting?	<input type="checkbox"/>	

Core Measure Tab

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

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

History & Last Known Well

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

Thrombolytics

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

Early Antithrombotics

Was antithrombotic therapy administered by the end of hospital day 2?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Labs

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

Discharge Information

Discharge Date/Time	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown
Was antithrombotic therapy prescribed at hospital discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not prescribing antithrombotic therapy at hospital discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was anticoagulation therapy prescribed at hospital discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not prescribing anticoagulation therapy at hospital discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was a statin medication prescribed at discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Stroke Core Measure Additional Comments:

CSTK Additional Comments:

END OF FORM