AuSCR
EMERGENCY DEPARTMENT (ED) MODULE DATA COLLECTION FORM

Australian Stroke Clinical Registry

For any queries contact the AuSCR Office **Phone**: 1800 673 053 **Email**: admin@auscr.com.au

Hospital Name: _____

Auditor Name: _____

AFFIX PATIENT IDENTIFICATION STICKER HERE

PATIENT DEMOGRAPHICS

Patient details

Title ☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐

Hospital MRN ☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Intersex or indeterminate ☐ Not stated/inadequately described

Country of birth ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Is the patient of Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Indigenous not otherwise described
- ☐ Missing/Not stated

Contact information

Post Code ☐☐☐☐ State ☐☐☐

ADMISSION AND TRANSFER INFORMATION

Admission details

Onset date ☐☐/☐☐/☐☐☐☐ ☐ Unknown ☐ Accurate ☐ Estimate

Onset time ☐☐:☐☐ (24-hour clock)

Time accuracy: ☐ Known time of onset ☐ If uncertain time of stroke, then time last seen well ☐ If wake up stroke, then time last seen well ☐ Time unknown

Date of discovery ☐☐/☐☐/☐☐☐☐ ☐ Unknown ☐ Accurate ☐ Estimate

Time of discovery ☐☐:☐☐ (24-hour clock) ☐ Time unknown

Time accuracy: ☐ Accurate ☐ Estimate

Date of arrival at Emergency Department ☐☐/☐☐/☐☐☐☐ ☐ Accurate ☐ Estimate

Time of arrival at Emergency Department ☐☐:☐☐ (24-hour clock) ☐ Time unknown

Time accuracy: ☐ Accurate ☐ Estimate

Did the patient arrive by ambulance? ☐ Yes ☐ No ☐ Unknown

Prehospital notification by paramedics? ☐ Yes ☐ No ☐ Unknown

Date of transfer ☐☐/☐☐/☐☐☐☐ ☐Not documented

Time of transfer ☐☐:☐☐ (24-hour clock) ☐Not documented

What was the reason for transfer?

Need for IV tPA	☐ Yes	☐ No
Need for stroke unit care	☐ Yes	☐ No
Need for brain imaging only	☐ Yes	☐ No
Need for ICU	☐ Yes	☐ No
Need for specialist medical assessment	☐ Yes	☐ No
Need for surgical interventions	☐ Yes	☐ No
Need for diagnostic tests	☐ Yes	☐ No
Need for endovascular therapy	☐ Yes	☐ No
Unknown	☐ Yes	☐ No
Other	☐☐☐☐☐☐☐☐☐☐	

PRE STROKE HISTORY

Dependency prior to admission

Functional status prior to stroke (mRS) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

If Unknown, use the following questions to determine mRS:

(a) Can the patient walk on their own (i.e. without the assistance of another person, but may include walking aid)?	☐ Yes – go to (c)	☐ No – go to (b)
(b) If the patient can't walk on their own can they walk if someone is helping them?	☐ Yes – mRS = 4	☐ No – mRS = 5
(c) If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)?	☐ Yes – mRS = 3	☐ No – go to (d)
(d) If the patient can perform simple personal activities do they need help with more complex usual activities (driving, golf, finances, household bills, work tasks)?	☐ Yes – mRS = 2	☐ No – go to (e)
(e) If the patient has no disability do they have any symptoms?	☐ Yes – mRS = 1	☐ No – mRS = 0

ACUTE CLINICAL DATA

What was the triage category for this patient (ATS 1 to 5)? ATS ☐

NIHSS (National Institutes of Health Stroke Scale) at baseline ☐☐ ☐ Unknown (99)

Did the patient have a brain scan after the stroke? ☐ Yes ☐ No

Date of first brain scan after the stroke ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Time of first brain scan after the stroke ☐☐:☐☐ (24-hour clock) ☐ Not documented

Was advanced imaging performed?

CT angiography	☐
CT perfusion	☐
Diffusion weighted imaging	☐
MR angiography	☐
Perfusion weighted imaging	☐
No	☐

Type of stroke ☐ TIA ☐ Ischaemic ☐ Haemorrhagic ☐ Undetermined

TELEMEDICINE AND REPERFUSION

Was a stroke telemedicine consultation conducted? ☐ Yes ☐ No ☐ Unknown

Date ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Time ☐☐:☐☐ (24-hour clock) ☐ Unknown

Telemedicine setting and reason

Did the patient receive intravenous thrombolysis (tPA)? ☐ Yes ☐ No ☐ Unknown

Date of delivery ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Time of delivery ☐☐:☐☐ (24-hour clock) ☐ Unknown

Drug used ☐ tPA ☐ Other

Was there a serious adverse event related to thrombolysis? ☐ Yes ☐ No

Type of adverse event:

Intracranial haemorrhage	☐ Yes	☐ No
Extracranial haemorrhage	☐ Yes	☐ No
Angioedema	☐ Yes	☐ No
Other	☐ Yes	☐ No

OTHER CLINICAL INFORMATION

Swallowing

Was a formal swallow screen performed (i.e. not a test of gag reflex)? ☐ Yes ☐ No ☐ Not documented

Was the swallow screen or swallowing assessment performed before the patient was given:

Oral medications?	☐ Yes	☐ No	☐ Not documented
Oral food or fluids?	☐ Yes	☐ No	☐ Not documented

Note: if no oral medications/oral food or fluids given before discharge, select "Yes"

Mobilisation

Was the patient able to walk independently on admission? ☐ Yes ☐ No ☐ Unknown

(i.e. may include walking aid, but without assistance from another person)

DISCHARGE INFORMATION

What was the discharge destination?

- ☐ Discharge/transfer to (an)other acute hospital
- ☐ Discharge/transfer to a residential aged care service, unless this is the usual place of residence:
  - ☐ Low level residential care
  - ☐ High level residential care
- ☐ Statistical discharge – type change
- ☐ Left against medical advice/discharge at own risk
- ☐ Died
- ☐ Other
- ☐ Usual residence (e.g. home) with supports
- ☐ Usual residence (e.g. home) without supports
- ☐ Inpatient rehabilitation
- ☐ Transitional care services

Form completed by: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date: ☐☐ / ☐☐ / ☐☐☐☐ Contact Number ☐☐☐☐☐☐☐☐☐☐