



Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Hospital: \_\_\_\_\_

**Emergency Contact**

First Name   
Last Name   
Address type  Home  Business  Other  
Street Address   
Suburb   
Post Code  State   
Country   
Phone Number  Mobile Number   
Relationship to participant


**Alternate Contact**

First Name   
Last Name   
Address type  Home  Business  Other  
Street Address   
Suburb   
Post Code  State   
Country   
Phone Number  Mobile Number   
Relationship to participant

**General Practitioner**

GP First Name   
GP Last Name   
Street Address   
Suburb   
Post Code  State   
Country   
GP Telephone Number   
GP Fax Number

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Hospital: \_\_\_\_\_

Admission Information	
Date of arrival at Emergency Department*	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>(dd/mm/yyyy)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
Time of arrival at Emergency Department*	<input type="text"/> : <input type="text"/> <small>(24-hour clock)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
Date of stroke onset*	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>(dd/mm/yyyy)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
Time of stroke onset*	<input type="text"/> : <input type="text"/> <small>(24-hour clock)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
Date of admission*	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>(dd/mm/yyyy)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
Was the patient transferred from another hospital?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did this stroke occur while the patient was in hospital?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Able to walk independently on admission?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<small>(i.e. may include walking aid, but without assistance from another person)</small>	
Is there documented evidence of a previous stroke?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<small>(i.e. focal neurological signs persisting for more than 24 hours)</small>	
Clinical Information	
Was the patient treated in a Stroke Unit at any time during their stay?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Type of stroke*	<input type="checkbox"/> TIA <input type="checkbox"/> Ischaemic <input type="checkbox"/> Haemorrhagic <input type="checkbox"/> Undetermined
If an ischaemic stroke, did the patient receive intravenous thrombolysis (tPA)?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cause of stroke *	<input type="checkbox"/> Known <input type="checkbox"/> Unknown
ICD10 code – Diagnosis	<input type="text"/>
Separation (Discharge) Information	
Patient Deceased <input type="checkbox"/> No <input type="checkbox"/> Yes, date of death: <input type="text"/> / <input type="text"/> / <input type="text"/> <small>(dd/mm/yyyy)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate	
Discharged Alive 	
a) Date of discharge*	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>(dd/mm/yyyy)</small> <input type="checkbox"/> Accurate <input type="checkbox"/> Estimate
b) Discharge destination/mode*	<input type="checkbox"/> Hospital <input type="checkbox"/> Home with support <input type="checkbox"/> Rehabilitation (Inpatient) <input type="checkbox"/> Home without support <input type="checkbox"/> Low level Residential Care <input type="checkbox"/> Transitional care services <input type="checkbox"/> High level Residential Care <input type="checkbox"/> Died in hospital <input type="checkbox"/> Other: _____
c) Discharged with antihypertensive agents*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
d) Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient and/or family (if patient has severe aphasia or cognitive impairments)?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown
Opt-Out Request	
Place <input checked="" type="checkbox"/> in appropriate boxes	
<input type="checkbox"/> Medical information <input type="checkbox"/> Personal information <input type="checkbox"/> Do not wish to be contacted for <i>follow-up</i>	

Form completed by:

Date: / /  Contact Number