GWTG-Stroke Case Record Form (CRF)

Active Form Groups: Stroke, Diabetes, Endovascular Therapy **August 2023**

Patient ID			
DEMOGRAPHICS			
Sex	O Male	O Female	O Unknown
Patient Gender Identity	O Male O Female O Female-to-Male (FTM)/Transgender Male/Trans Man O Male-to-Female (MTF)/Transgender Female/Trans Woman O Genderqueer, neither exclusively male nor female O Additional gender category or other: ______________ O Did not disclose		
Patient-Identified Sexual Orientation	O Straight or heterosexual O Lesbian or gay O Bisexual O Queer, pansexual, and/or questioning O Something else, please specify: ______________ O Don't know O Declined to answer		
Date of Birth:	____/____/________	Age:	__________
Zip Code:	_____________ - __________	☐ Homeless	
Payment Source	☐ Medicare Title 18 ☐ Medicaid – Private/ HMO/ PPO/ Other ☐ Self Pay/ No Insurance	☐ Medicaid Title 19 ☐ Private/ HMO/ PPO/ Other ☐ Other/ Not Documented/ UTD	☐ Medicare – Private/ HMO/ PPO/ Other ☐ VA/ CHAMPVA/ Tricare
Race and Ethnicity			
Race (Select all that apply):	☐ American Indian/Alaska Native ☐ White ☐ Native Hawaiian or Pacific Islander [if native Hawaiian or Pacific Islander selected] ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ UTD	☐ Black or African American ☐ Asian [if Asian selected] ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	
Hispanic Ethnicity:	O Yes	O No/UTD	
If Yes,	O Mexican, Mexican American, Chicano/a O Another Hispanic, Latino or Spanish Origin	O Puerto Rican O Cuban	
ADMIN			
Final clinical diagnosis related to stroke	O Ischemic Stroke O Transient Ischemic Attack (<24 hours) O Subarachnoid Hemorrhage	O Intracerebral Hemorrhage O Stroke not otherwise specified O No stroke related diagnosis O Elective Carotid Intervention only	
If no Stroke Related Diagnosis:	O Migraine O Seizure O Delirium	O Electrolyte or metabolic imbalance O Functional disorder O Other O Uncertain	

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Was the Stroke etiology documented in the patient medical record:	O Yes	O No

Select documented stroke etiology (select all that apply):	O 1: Large-artery atherosclerosis (e.g., carotid or basilar stenosis)
	O 2: Cardioembolism (e.g., atrial fibrillation/flutter, prosthetic heart valve, recent MI)
	O 3: Small-vessel occlusion (e.g., subcortical or brain stem lacunar infarction <1.5 cm)
	O 4: Stroke of other determined etiology (e.g., dissection, vasculopathy, hypercoagulable or hematologic disorders.
	  O Dissection
	  O Hypercoagulability
	  O Other
	O 5: Cryptogenic stroke (stroke of undetermined etiology)
	  O Multiple potential etiologies identified
	  O Stroke of undetermined etiology
	  O Unspecified

When is the earliest documentation of comfort measures only?	O Day 0 or 1	O Day 2 or after	O Timing unclear	O Not Documented/UTD

Arrival Date/Time:	___/____/_________:___	☐ MM/DD/YYYY only ☐ Unknown

Was this patient a Stroke Alert (Code Stroke) at your facility?	O Yes	O No	O ND
Location of Stroke alert (Code Stroke)	O Emergency Department O MSU	O EMS O Outpatient Procedure	O Inpatient O Other ___________
Date/Time Stroke Alert (Code Stroke) Received	O ___/____/_____ ____:____	O MM/DD/YYYY only	O Unknown

Not Admitted:	O Yes, not admitted O No, patient admitted as in patient	Reason Not Admitted:	O Transferred from your ED to another acute care hospital O Discharged directly from ED to home or other location that is not an acute care hospital O Left from ED AMA O Died in ED O Discharged from observation status without an inpatient admission O other

Admit Date	____/____/______

If patient transferred from your ED to another hospital, specify hospital name	[Select hospital name from picker list] ☐ Hospital not on list ☐ Hospital not documented
Select reason(s) for why patient transferred	☐ Evaluation for IV alteplase up to 4.5 hours ☐ Post Management of IV alteplase (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

Discharge Date/Time:	___/____/_________:___	☐ MM/DD/YYYY only

Documented reason for delay in transfer to referral facility?	O Yes O No/ND
Specific reason for delay documented in transfer patient (check all that apply):	☐ Social/religious ☐ Initial refusal ☐ Care team unable to determine eligibility

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

	☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Investigational or experimental protocol for reperfusion ☐ Bed availability at receiving center* ☐ Delay in stroke diagnosis * ☐ Delay in transport arrival* ☐ In-hospital time delay * ☐ Equipment-related delay * ☐ Need for additional imaging* ☐ Catheter lab not available* ☐ Other *
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)
If Other Health Care Facility	○ Inpatient Rehabilitation Facility (IRF) ○ Intermediate Care facility (ICF) ○ Long Term Care Hospital (LTCH) ○ Skilled Nursing Facility (SNF) ○ Other

CLINICAL CODES

ICD-10-CM Principal Diagnosis Code	____________________
ICD-10-CM Other Diagnosis Codes	____________________
ICD-10-CM Discharge Diagnosis Related to Stroke	____________________
No Stroke or TIA Related ICD-10-CM Code Present	☐

Arrival and Admission Information

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
If yes, Type of Clinical Trial(s) (select all that apply):	☐ Antithrombotics ☐ Anticoagulation for AFib/Aflutter ☐ Intensive Statin Therapy ☐ Endovascular Therapy	☐ VTE Prophylaxis ☐ Smoking Cessation ☐ Thrombolytic administration ☐ Other
Was this patient admitted for the sole purpose of performance of elective carotid intervention?	○ Yes	○ No
Point of Origin for Admission or Visit	○ Clinic ○ Emergency Room ○ Transfer from a hospital (different facility) ○ Transfer from ambulatory surgery center ○ Transfer from Hospice and is under a hospital Plan of Care or enrolled in Hospice program ○ Information not available ○ Transfer from a Critical Access Hospital	○ Court/Law Enforcement ○ Non-health care facility point of origin ○ Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) ○ Transfer from another health care facility ○ Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer ○ HMO referral

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

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
How patient arrived at your hospital	○ EMS from home/scene ○ Mobile Stroke Unit ○ Private Transportation/Taxi/Other from home/scene ○ Transfer from another hospital ○ ND or Unknown
Referring hospital discharge Date/ Time	___/____/______ ___:___ ☐ MM/DD/YYYY only ☐ Unknown
If transferred from another hospital, specify hospital name	[Select hospital name from picker list] ☐ Hospital not on list ☐ Hospital not documented
Referring hospital arrival date/ time	___/____/______ ___:___ ☐ MM/DD/YYYY only ☐ Unknown
If patient transferred to your hospital, select transfer reason(s)	☐ Evaluation for IV alteplase up to 4.5 hours ☐ Post Management of IV alteplase (e.g. Drip and Ship) ☐ Evaluation for Endovascular thrombectomy ☐ Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) ☐ Patient/family request ☐ Other advanced care (not stroke related) ☐ Not documented
Where patient first received care at your hospital	☐ Emergency Department / Urgent Care ☐ Direct Admit, not through ED ☐ Imaging suite ☐ ND or Cannot be determined
Advanced Notification by EMS or MSU?	○ Yes ○ No/ND
Initial Admitting Service	○ Medicine ○ Neurology ○ Surgery ○ Neurocritical Care ○ Neurosurgery ○ Other: ________________
In which settings were care delivered? Select all that apply.	☐ Neuro/ Neurosurgery ICU ☐ Other ICU ☐ Stroke Unit (Non-ICU) ☐ General Care Floor ☐ Observation ☐ Other: ________________
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
ED Physician	
Stroke NP/PA	
Admitting Physician	
Attending Physician	
Neurologist	
Neurosurgeon	
Interventionalist	
Discharging	

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Provider	
Other Provider	
Telestroke	
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
Did the patient receive stroke consultation from a stroke expert at my hospital?	○ Yes ○ No/ND
Medical History	

Previously known medical hx of:	☐ No Previous Medical History
	
	☐ Atrial Fib/Flutter
	☐ CAD/ Prior MI
	☐ Carotid Stenosis
	☐ Current Pregnancy (up to 6 weeks post-partum)
	☐ DVT/PE
	☐ Dementia
	☐ Depression
	☐ Diabetes Mellitus
	  ○ Type I
	  ○ Type II
	  ○ ND
	  Duration:
	    ☐ < 5 years
	    ☐ 5 - < 10 years
	    ☐ 10 - < 20 years
	    ☐ >= 20 years
	    ☐ Unknown
	☐ Drugs/Alcohol Abuse
	☐ Dyslipidemia
	☐ E-Cigarette Use (Vaping)
	☐ Familial Hypercholesterolemia
	☐ Family History of Stroke
	☐ HF
	☐ HRT
	☐ Hx of Emerging Infectious Disease
	  ☐ MERS
	  ☐ SARS-COV-1
	  ☐ SARS-COV-2 (COVID-19)
	  ☐ Other Infectious Respiratory Pathogen
	☐ Hypertension
	☐ Migraine
	☐ Obesity/Overweight
	☐ Previous Stroke
	  ☐ Ischemic Stroke
	  ☐ ICH
	  ☐ SAH
	  ☐ Not Specified
	☐ Previous TIA
	☐ Prosthetic Heart Valve
	☐ PVD
	☐ Renal Insufficiency - Chronic
	☐ Sickle Cell
	☐ Sleep Apnea
	☐ Smoker

Ambulatory status prior to current event?	○ Able to ambulate independently (no help from another person) w/ or w/o device ○ With assistance (from person) ○ Unable to ambulate ○ ND
Pre-stroke Modified Rankin Score	○ 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
Diagnosis & Evaluation	

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Symptom Duration if diagnosis of Transient Ischemic Attack (less than 24 hours)	O Less than 10 minutes O 10 – 59 minutes O > = 60 minutes O ND
Had stroke symptoms resolved at time of presentation?	O Yes O No O ND
^Is there documentation that an initial NIHSS score was done at this hospital?	O Yes O No
Method used to obtain NIHSS	O Actual O Estimated from record O ND
^What is the date and time that the NIHSS score was first performed at this hospital?	___/____/______ ___:___ ☐ MM/DD/YYYY only ☐ Unknown
NIHSS Total Score:	_______________
Do you want to calculate the NIH Stroke Scale score?	O Yes (refer to web program for calculation questions) O No
NIHSS score obtained from transferring facility:	___________ O ND
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
Ambulatory status on admission	O Able to ambulate independently (no help from another person) w/ or w/o device O With assistance (from person) O Unable to ambulate O ND

Medications Prior to Admission	
No medications prior to admission	☐
Antiplatelet or Anticoagulant	O Yes O No/ND

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Medication(s) prior to admission:	
☐ Antiplatelet Medication ○ aspirin ○ aspirin/dipyridamole (Aggrenox) ○ clopidogrel (Plavix) ○ prasugrel (Effient) ○ ticagrelor (Brilinta) ○ ticlopidine (Ticlid) ○ Other Antiplatelet	☐ Anticoagulant Medication ○ 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

Antihypertensive Medication prior to admission:	○ Yes ○ No/ND			
Cholesterol-Reducer prior to admission	○ Yes ○ No/ND			
Cholesterol-Reducer type prior to admission	☐ Statin ☐ Niacin ☐ PCSK9 Inhibitor ☐ Not documented	☐ Fibrate ☐ Absorption Inhibitor ☐ Other cholesterol reducer type		
Anti-hyperglycemic medications prior to admission:	○ Yes ○ No/ND			
If yes, select medications (select all that apply)	☐ DPP-4 Inhibitors ☐ SGLT2 inhibitor ☐ Other injectable/ subcutaneous agent	☐ GLP-1 receptor agonist ☐ Sulfonylurea	☐ Insulin ☐ Thiazolidinedione	☐ Metformin ☐ Other oral agents
Antidepressant medication	○ Yes ○ No/ND			
Antidepressant type, prior to admission	○ SSRI	○ Other Antidepressant	○ ND	

Vaccinations & Testing				
COVID-19 Vaccination:	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD			
COVID-19 Vaccination Date:	___/___/_____	☐ MM/YYYY	☐ YYYY	☐Unknown
COVID-19 Vaccine Manufacturer:	○ AstraZeneca ○ Johnson & Johnson's / Janssen ○ Moderna ○ Novavax ○ Pfizer ○ Other ○ Not Documented			
Did the patient receive both doses of vaccine? (if applicable)	○ Yes	○ No	○ Not applicable	
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes	○ No/ND		

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

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

Symptom Timeline

Date/Time Patient last known to be well?	☐ Time of Discovery same as Last Known well	Date/Time of discovery of stroke symptoms?
___/____/______ ___:___ ☐ MM/DD/YYYY only ☐ Unknown		___/____/_________:__ __ ☐ MM/DD/YYYY only ☐ Unknown
Comments:		

Brain Imaging

Was brain or vascular imaging performed prior to transfer to your facility?	○ Yes ○ No/ND
If yes, type of imaging tests were performed? (select all that apply)	☐ CT ☐ CTA ☐ CT Perfusion ☐ MRA ☐ MR Perfusion ☐ MRI ☐ Image type not documented
Date/Time 1st vessel or perfusion imaging initiated at prior hospital:	___/____/____ ___:___ ☐ MM/DD/YYYY only ☐ Unknown

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

IV Thrombolytic Therapy

IV thrombolytic initiated at this hospital?	○ Yes ○ No	Date/Time IV thrombolytic initiated:	___/___/___ ____:_____ ☐ MM/DD/YYYY only Unknown
Thrombolytic used:	○ Alteplase (Class 1 evidence) Alteplase, total dose: _________(mg) ☐ Alteplase dose ND	○ Tenecteplase (Class 2b evidence) Tenecteplase, total dose: _________(mg) ☐ Tenecteplase dose ND	
Reason for selecting Tenecteplase instead of alteplase:	○ Large Vessel Occlusion (LVO) with potential thrombectomy ○ Mild Stroke ○ Other: ________________		

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

If IV thrombolytic administered beyond 4.5-hour, was imaging used to identify eligibility?	○ Yes, Diffusion-FLAIR mismatch ○ Yes, Core-Perfusion mismatch ○ None ○ Other: _______________

Documented exclusions or relative exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 0-3hr treatment window?	○ Yes	○ No
Documented exclusions or relative exclusions (Contraindications or Warnings) for not initiating IV thrombolytic in the 3-4.5 hr treatment window?	○ Yes	○ No

If yes, documented exclusions or relative exclusions for 0 -3-hour treatment window or 3 – 4.5 treatment window, select reason for exclusion.

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)*

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)*

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*

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)*

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*

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

- ☐ *AW3: Taking an oral anticoagulant regardless of INR*
- ☐ *AW4: Severe Stroke (NIHSS > 25)*

Other Reasons (Hospital-related or other factors) 0-3-hour treatment window.

- ☐ *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 – requires specific reason to be entered in the PMT when this option is selected.*

Other Reasons (Hospital-related or other factors) 3-4.5-hour treatment window.

- ☐ *Delay in Patient Arrival*
- ☐ *In-hospital Time Delay*
- ☐ *Delay in Stroke diagnosis*
- ☐ *No IV access*
- ☐ *Rapid or Early Improvement*
- ☐ *Other – requires specific reason to be entered in the PMT when this option is selected*

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

Eligibility Reason(s):	☐ Social/Religious ☐ Initial refusal ☐ Care-team unable to determine eligibility ☐ Specify eligibility reason: ________________________________
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: ______________________________
Hospital Related or Other Reason(s):	☐ Need for additional imaging ☐ Delay in stroke diagnosis ☐ In-hospital time delay ☐ Equipment-related delay ☐ Other ___________________________________
IV thrombolytic at an outside hospital or Mobile Stroke Unit?	○ Yes ○ No
If yes, select thrombolytic administered at outside hospital or Mobile Stroke Unit	○ Alteplase ○ Tenecteplase
Investigational or experimental protocol for thrombolysis?	○ Yes ○ No If yes, specify_________________________
Additional Comments Related to Thrombolytics:	

Endovascular Therapy		
Catheter-based stroke treatment at this hospital?	○ Yes	○ No
IA alteplase or MER Initiation Date/Time	___/___/_____ ___:____	○ MM/DD/YYYY only ○ Unknown

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Catheter-based stroke treatment at outside hospital?	○ Yes ○ No
Complications of Reperfusion Therapy	
Complications of Thrombolytic Therapy (Thrombolytic or MER)	☐ Symptomatic Intracranial hemorrhage <36 hours ☐ Life threatening, serious systemic hemorrhage <36 hours ☐ UTD ☐ Other serious complications ☐ No serious complications
If bleeding complications occur in patient after IV alteplase:	○ Symptomatic hemorrhage detected prior to patient transfer ○ Symptomatic hemorrhage detected only after patient transfer ○ Unable to determine ○ N/A
Other In-Hospital Treatment and Screening	
Patient NPO throughout the entire hospital stay?	○ Yes ○ No/ND
Was patient screened for dysphagia prior to any oral intake including water or medications?	○ Yes ○ No/ND ○ NC
If yes, Dysphagia screening results:	○ Pass ○ Fail ○ ND
Treatment for Hospital-Acquired Pneumonia	○ Yes ○ No ○ NC
VTE Interventions	☐ 1- Low dose unfractionated heparin (LDUH) ☐ 2- Low molecular weight heparin (LMWH) ☐ 3- Intermittent pneumatic compression devices (IPC) ☐ 4- Graduated compression stockings (GCS) ☐ 5- Factor Xa Inhibitor ☐ 6- Warfarin ☐ 7- Venous foot pumps (VFP) ☐ 8-Oral Factor Xa Inhibitor ☐ 9- Aspirin ☐ A- None of the above, ND, or UTD
What date was the initial VTE prophylaxis administered after hospital admission?	____/_____/________ ☐ Unknown
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?	○ Yes ○ No
Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?	○ Yes ○ No
Other Therapeutic Anticoagulation	☐ apixaban (Eliquis) ☐ argatroban ☐ dabigatran (Pradaxa) ☐ desirrudin (Iprivask) ☐ endoxaban (Savaysa) ☐ lepirudin (Refludan) ☐ rivaroxaban (Xaralto) ☐ unfractionated heparin IV ☐ other anticoagulant
Was DVT or PE documented?	○ Yes ○ No/ND
Was antithrombotic therapy administered by the end of hospital day 2?	○ Yes ○ No/ND ○ NC
If yes, select all that apply	☐ Antiplatelet ☐ Anticoagulant

Active bacterial or viral infection at admission or during hospitalization:	☐ None
	☐ Bacterial Infection
	☐ Emerging Infectious Disease
	  ☐ SARS-COV-1
	  ☐ SARS-COV-2 (COVID-19)
	  ☐ MERS
	  ☐ Other Emerging Infectious Disease
	☐ Influenza
	☐ Seasonal Cold
	☐ Other Viral Infection

MEASUREMENTS (first measurement upon presentation to your hospital)				
Total Chol: ________ mg/dl	Triglycerides: __________ mg/dl	HDL: __________ mg/dl	LDL: ___________ mg/dl	☐ Lipids: NC ☐ Lipids: ND

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

LP(a) Value: ________	LP(a) Unit: ○ nmol/L ○ mg/dl	LP(a): ☐ ND
A_1C: ________ % A_1C ☐ ND	Blood Glucose (required if patient received IV alteplase): ________ mg/dl	☐ ND ☐ Too Low ☐ Too High

Serum Creatinine:	________ ☐ ND
INR:	________ ☐ ND ☐ NC
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) __________/__________ ☐ Vital signs UTD

Height: _________	○in	○cm	☐ ND
Weight: _________	○lbs	○kg	☐ ND
Waist Circumference: _________	○in	○cm	☐ ND
BMI: _________	☐ ND		

ADDITIONAL TIME TRACKER

Date/Time Stroke Team Activated: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Stroke Team Arrived: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A
Date/Time of ED Physician Assessment: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Neurosurgical Services Consulted: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A
Date/Time Brain Imaging Ordered: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Brain Imaging Reported: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A
Date/Time IV Thrombolytic Ordered: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A		
Date/Time Lab Tests Ordered: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time Lab Tests Completed: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A
Date/Time ECG Ordered: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A	Date/Time ECG Completed: ___/___/_____ ___:____	Select one option ○ MM/DD/YYYY HH:MM ○ MM/DD/YYYY ○ Unknown ○ N/A
Date/Time Chest X-ray Ordered:	Select one option ○ MM/DD/YYYY HH:MM	Date/Time Chest X-ray Completed:	Select one option ○ MM/DD/YYYY

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

___/___/_____ ___:____	O MM/DD/YYYY O Unknown O N/A	___/___/_____ ___:____	HH:MM O MM/DD/YYYY O Unknown O N/A
Date/Time Neurointerventional Team Activation: ___/___/_____ ___:____	Select one option O MM/DD/YYYY HH:MM O MM/DD/YYYY O Unknown O N/A	Date/Time Patient Arrival in Neurointerventional Suite: ___/___/_____ ___:____	Select one option O MM/DD/YYYY HH:MM O MM/DD/YYYY O Unknown O N/A
Time Tracker Comments:			

Catheter-Based/Endovascular Stroke Treatment	
^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?	___/___/_____ ___:____ O MM/DD/YYYY only O Unknown
^^Was a mechanical endovascular reperfusion procedure attempted during this episode of care (at this hospital)?	O Yes O No
^^Are reasons for not performing mechanical endovascular reperfusion therapy documented?	O Yes O No
^^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 not favorable/hemorrhage transformation (ASPECTS score <6) ☐ 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 ☐ Equipment-related delay * ☐ No endovascular specialist available * ☐ Delay in stroke diagnosis * ☐ Vascular imaging not performed * ☐ Advanced Age * ☐ Other * * These reasons do not exclude from measure population
^^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
^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?	O Yes O No
^What is the date and time of the first pass of a clot retrieval device at this hospital?	___/___/_____ ___:__ O MM/DD/YYYY only O Unknown
^^Is a cause(s) for delay in performing mechanical endovascular reperfusion therapy documented?	O Yes O No
^^Reasons for delay (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

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

	disease ☐ Delay in stroke diagnosis * ☐ In-hospital time delay * ☐ Equipment-related delay * ☐ Need for additional imaging * ☐ Catheter lab not available * ☐ Other * ________________
^^Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade	○ Grade 0 ○ Grade 1 ○ Grade 2a ○ Grade 2b ○ Grade 3 ○ ND

^What was the date and time that TICI 2b/3 was first documented during the mechanical thrombectomy procedure?	___/___/_____ ___:____	○ MM/DD/YYYY only ○ Unknown
Date/Time end of endovascular procedure	___/___/_____ ___:____	○ MM/DD/YYYY only ○ Unknown

Complications		
^What is the last NIHSS score documented prior to initiation of IA alteplase or MER at this hospital?	____________	☐ ND
This score obtained from:	○ Baseline NIHSS	○ Subsequent NIHSS

Discharge Information	
GWTG Ischemic Stroke-Only Estimated Mortality Rate	[Calculated in the IRP]
GWTG Global Stroke Estimated Mortality Rate (Ischemic Stroke, SAH, ICH, Stroke NOS)	[Calculated in the IRP]

Modified Rankin Scale at Discharge	○ Yes		○ No/ND
If yes:	○ Actual	○ Estimated from record	○ ND
Modified Rankin at Discharge Total Score	______		
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		
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		
Discharge Blood Pressure (Measurement closest to discharge)	________/________ mmHg (Systolic/Diastolic) ○ ND		

Discharge Treatments					
Antithrombotic Medication(s) Prescribed at Discharge	Prescribed?	○ Yes	○ No/ND	○ NC	
	If yes,	Class:	Medication:	Dosage:	Frequency:
		Class:	Medication:	Dosage:	Frequency:
		Class:	Medication:	Dosage:	Frequency:
		Class:	Medication:	Dosage:	Frequency:
	Documented reason for not prescribing an antithrombotic	○ Yes		○ No/ND	

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

	approved in stroke	
	If NC, documented contraindications	☐ 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

Persistent or Paroxysmal Atrial Fibrillation/Flutter	O Yes O No
If atrial fib/flutter or history of PAF documented, was patient discharged on anticoagulation?	O Yes O No/ND O NC
If NC, documented reasons for no anticoagulation	☐ Allergy to or complication r/t warfarin or heparins ☐ 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
Anti-hypertensive Tx (Select all that apply)	☐ None prescribed/ND ☐ Ace Inhibitors ☐ Beta Blockers ☐ Diuretics ☐ None - Contraindicated ☐ ARB ☐ CA++ Channel Blockers ☐ Other antihypertensive med
Cholesterol-Reducing Tx (Select all that apply)	☐ None prescribed/ND ☐ Absorption Inhibitor ☐ Niacin ☐ Statin ☐ None - Contraindicated ☐ Fibrate ☐ PCSK 9 inhibitor ☐ Other med

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)	Statin Total Daily Dose:	________

Documented Reason for Not Prescribing Guideline Recommended 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
Documented reason for not prescribing a statin medication at discharge?	O Yes O No
New Diagnosis of Diabetes?	O Yes O No O ND
Basis for Diagnosis (Select all that apply)	☐ HbA1c ☐ Oral Glucose Tolerance ☐ Fasting Blood Sugar ☐ Test Other

Anti-hyperglycemic medications:	Prescribed?	O Yes O No O 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?	O Yes O No/ND	

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.

Follow-up appointment scheduled for diabetes management?	O Yes O No/ND O NC
Date of scheduled diabetes follow-up appointment:	____/_____/_______ O Unknown

Anti-Smoking Tx	O Yes O No/ND O NC
Smoking Cessation Therapies Prescribed (select all that apply	☐ Counseling ☐ Over the Counter Nicotine Replacement Therapy ☐ Prescription Medications ☐ Other ☐ Treatment not specified
Other Lifestyle Interventions	
Was the patient prescribed any antidepressant class of medication at discharge	O Yes, SSRI O Yes, any other antidepressant class O No/ND
Reducing weight and/or increasing activity recommendations	O Yes O No/ND O NC
TLC Diet or Equivalent	O Yes O No/ND O NC
Antihypertensive Diet	O Yes O No/ND O NC
Was Diabetic Teaching Provided?	O Yes O No/ND O NC

Stroke Education			
Patient and/or caregiver received education and/or resource materials regarding all the following:			
Risk Factors for Stroke	O Yes O No	Stroke Warning Signs and Symptoms	O Yes O No
How to Activate EMS for Stroke	O Yes O No	Need for Follow-Up After Discharge	O Yes O No
Their Prescribed medications	O Yes O No		

Stroke Rehabilitation	
Patient assessed for and/or received rehabilitation services during this hospitalization?	O Yes O No
Check all rehab 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

Health Related Social Needs Assessment	
During this admission, was a standardized health related social needs form or assessment completed?	O Yes O No/ND
If Yes, identify the areas of unmet social need. Select all that apply.	☐ Living Situation/ Housing ☐ Food ☐ Utilities ☐ Personal Safety ☐ Financial Strain ☐ Employment ☐ Education ☐ Mental Health ☐ Substance Use ☐ Transportation Barriers ☐ None

Stroke Diagnostic Tests and Interventions		
Cardiac ultrasound/echocardiography O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	Extended implantable cardiac rhythm monitoring O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	Carotid imaging O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned

Hypercoagulability testing	Carotid revascularization	Intracranial vascular imaging
O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned
Extended surface cardiac rhythm monitoring > 7 days O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	Short-term cardiac rhythm monitoring <= 7 days O Performed during this admission or in the 3 months prior O Planned post discharge O Not performed or planned	

OPTIONAL			
PMT used concurrently or retrospectively or combination?	O Concurrently	O Retrospectively	O Combination
Was a stroke admission order set used in this patient?	O Yes	O No	
Was a stroke discharge checklist used in this patient?	O Yes	O No	
Patient adherence contract/compact used?	O Yes	O No	
END OF FORM			

NOT FOR USE WITHOUT PERMISSION. ©2023 American Heart Association. All Rights Reserved.