Case Report File

Subject N° /_/_/

Validation of a Long-Term Post-Stroke Checklist

Patient Medical Form

ADULTS

(Please complete a form for each patient recruited)

Date of visit or contact: /__/__/ /__/__//__/__/
Day Month Year

INCLUSION CRITERIA

	Yes	No
Stroke survivors between 9 and 36 months following an intracerebral infarction.	☐1	☐0

↳ If the above answer is NO, the patient CANNOT be included in the study

EXCLUSION CRITERIA

	Yes	No
Stroke survivors under 9 and more than 36 months following an intracerebral infarction.	☐1	☐0

↳ If the above answers is YES, the patient CANNOT be included in the study

↳ Please include a patient only if all inclusion criteria are YES and all exclusion criteria are NO

GENERAL INFORMATION

1. Patient's gender**:** ☐$_1$ **Male** ☐$_2$ **Female**

2. Patient's age**:** **/__/__/ years**

3. **What types of healthcare professional does the patient visit for post-stroke monitoring or treatment? (tick all that apply)**

   ❑$_1$ General practitioner
   ❑$_2$ Community Stroke Team
   ❑$_3$ Does not know
   ❑$_4$ Specialised nurse
   ❑$_5$ Other _____

MEDICAL INFORMATION

4. **Date of most recent stroke event:** /__/__/ /__/__/ /__/__/
   Day Month Year

5. **Please give a brief description of the most recent stroke event:**

   _____
   _____

6. **What kind of treatment is the patient currently receiving for their post-stroke condition? (include all drug and non-drug therapies)**

Treatments	Name of the treatment
❑$_1$ Occupational therapy	
❑$_2$ Physical therapy	
❑$_3$ Speech and Language therapy	
❑$_4$ Pharmacological treatment	
❑$_5$ Psychological treatment	
❑$_6$ Other	

7. Does your patient currently have any chronic conditions?

❑$_1$ Yes ❑$_0$ No

↳If YES, please indicate which type of condition by ticking the corresponding box(es):

❑$_1$ Cardiovascular	❑$_7$ Stomatological / Dental
Specify _____	*Specify* _____
❑$_2$ Urological / Renal	❑$_8$ Ophthalmological
Specify _____	*Specify* _____
❑$_3$ Dermatological	❑$_9$ Haematological
Specify _____	*Specify* _____
❑$_4$ Endocrinological / Nutritional	❑$_{10}$ Respiratory
Specify _____	*Specify* _____
❑$_5$ Gastroenterological	❑$_{11}$ Rheumatological
Specify _____	*Specify* _____
❑$_6$ Gynaecological	❑$_{12}$ Neurological
Specify _____	*Specify* _____
	❑$_{13}$ Other: _____

8. If your patient is currently receiving treatment for any chronic diseases, please briefly describe which treatment:

……..……
……
……..……
……

1. 二级预防				
自中风或上次评估以来，您是否接受了任何有关改变生活方式的健康建议或药物，以预防再次发生中风？	☐ 否	→	☐ If **No**, refer to the Stroke Clinic for risk factor assessment and treatment if appropriate	
	☐ 是	→	**Observe Progress**	
2. 日常生活活动 (ADL)				
自中风或上次评估以来，您是否发现自理生活的难度<u>增加</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	是否有困难穿衣、洗漱和/或洗澡？ 是否有困难制备热饮和/或餐食？ 是否难以出门？	☐ If **Yes** to any, refer to the Stroke Clinic for further assessment
3. 活动能力				
自中风或上次评估以来，您是否发现行走或安全地从床上起来坐到椅子上的难度<u>增加</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	您是否在继续接受康复治疗？	☐ If **No**, refer to the Stroke Clinic for further assessment.
4. 痉挛状态				
自中风或上次评估以来，您在手臂、手部和/或腿部的僵直情况是否有<u>加重</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	这种情况是否干扰日常生活活动？	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke spasticity for further assessment
5. 疼痛				
自中风或上次评估以来，您是否有任何<u>新出现</u>的疼痛？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke pain for further assessment and diagnosis	

6. 失禁				
自中风或上次评估以来，您的尿失禁或大便失禁问题是否<u>加重</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes,** refer to the Stroke Clinic for further assessment	
7. 沟通				
自中风或上次评估以来，您是否发现与别人沟通的难度<u>增加</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes,** refer to the Stroke Clinic for further assessment	
8. 情绪				
自中风或上次评估以来，您是否感觉<u>更为</u>焦虑或抑郁？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes**, refer to the Stroke Clinic for further assessment or referral	
9. 认知能力				
自中风或上次评估以来，您是否发现思考、集中注意力或记住事情的难度<u>增加</u>？	☐ 否	→	**Observe Progress**	
	☐ 是	→	这种情况是否干扰其他活动或干扰您参加其他活动？	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke cognition changes for further assessment
10. 中风之后的生活				
自中风或上次评估以来，您是否发现<u>更加</u>难以做对您而言重要的事情（如休闲活动、业余爱好、工作、与关爱者的关系）？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes,** refer patient to the Stroke Clinic for stroke support	
11. 与家人的关系				
自中风或上次评估以来，您与家人是否<u>更为</u>难以相处或者关系紧张？	☐ 否	→	**Observe Progress**	
	☐ 是	→	☐ If **Yes**, refer to the Stroke Clinic for stroke support	

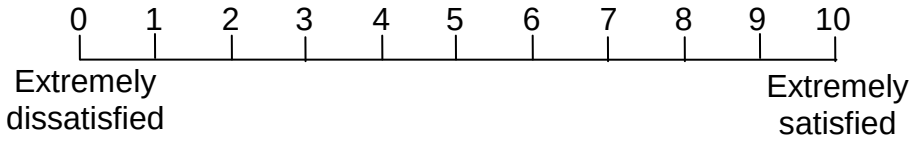
Post-assessment Patient Satisfaction Questionnaire

The following questions ask about your satisfaction with the assessment you have just received and the checklist used by the clinician. Please read the questions carefully and tick the answer that reflects your experience. Please ask the help of a relative, friend or carer if you have difficulties completing this questionnaire. Answer as honestly as you can without the help of anyone – there are no right or wrong answers. If you make a mistake then please cross out your answer and circle your correct answer.

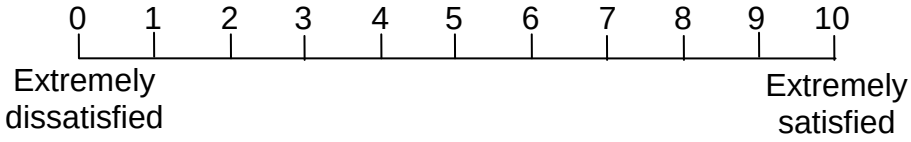
Today's date: /__/__/ Day /__/__/ Month /__/__/ Year

For the following questions, please indicate your level of satisfaction by circling the appropriate number. A higher number indicates a higher level of satisfaction

1. How satisfied are you with the overall assessment you have just received?



2. How satisfied are you that the checklist used by the clinician during the assessment identified your needs correctly?



3. How likely do you think you will receive the type of health and/or care services you think you need?