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. Secondary Prevention				
Since your stroke or last assessment, have you received any advice on health related life style changes or medications for preventing another stroke?	☐ No	→	☐ If No, refer to the Stroke Clinic for risk factor assessment and treatment if appropriate	
	☐ Yes	→	Observe Progress	
2. Activities of Daily Living (ADL)				
Since your stroke or last assessment, are you finding it more difficult to take care of yourself?	☐ No	→	Observe Progress	
	☐ Yes	→	Do you have difficulty dressing, washing and/or bathing? Do you have difficulty preparing hot drinks and/or meals? Do you have difficulty getting outside?	☐ If Yes to any, refer to the Stroke Clinic for further assessment
3. Mobility				
Since your stroke or last assessment, are you finding it more difficult to walk or move safely from bed to chair?	☐ No	→	Observe Progress	
	☐ Yes	→	Are you continuing to receive rehabilitation therapy?	☐ If No, refer to the Stroke Clinic for further assessment.
4. Spasticity				
Since your stroke or last assessment, do you have increasing stiffness in your arms, hands, and/or legs?	☐ No	→	Observe Progress	
	☐ Yes	→	Is this interfering with activities of daily living?	☐ If Yes, refer to the Stroke Clinic with an interest in post-stroke spasticity for further assessment
5. Pain				
Since your stroke or last assessment, do you have any new pain?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer to the Stroke Clinic with an interest in post-stroke pain for for further assessment and diagnosis	

6. Incontinence				
Since your stroke or last assessment, are you having more of a problem controlling your bladder or bowels?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer to the Stroke Clinic for further assessment	
7. Communication				
Since your stroke or last assessment, are you finding it more difficult to communicate with others?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer to the Stroke Clinic for further assessment	
8. Mood				
Since your stroke or last assessment, do you feel more anxious or depressed?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer to the Stroke Clinic for further assessment or referral	
9. Cognition				
Since your stroke or last assessment, are you finding it more difficult to think, concentrate, or remember things?	☐ No	→	Observe Progress	
	☐ Yes	→	Does this interfere with activity or participation?	☐ If Yes, refer to the Stroke Clinic with an interest in post-stroke cognition changes for further assessment
10. Life After Stroke				
Since your stroke or last assessment, are you finding things important to you more difficult to carry out (e.g. leisure activities, hobbies, work, relationships with loved ones)?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer patient to the Stroke Clinic for stroke support	
11. Relationship with Family				
Since your stroke or last assessment, has your relationship with your family become more difficult or stressed?	☐ No	→	Observe Progress	
	☐ Yes	→	☐ If Yes, refer to the Stroke Clinic for stroke support	

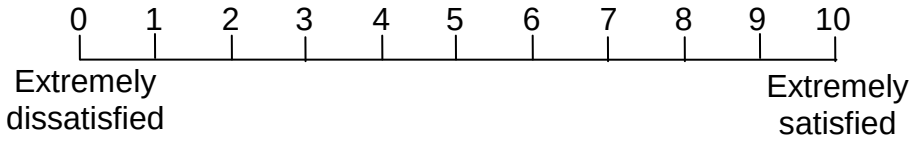
Post-assessment Patient Satisfaction Questionnaire

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.

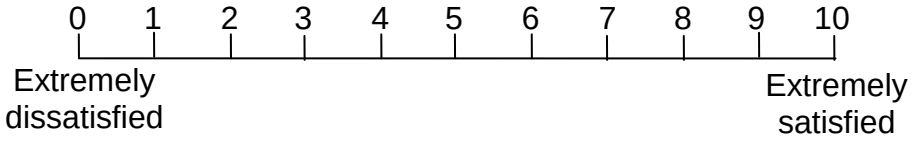
Today's date: /__/__/ /__/__/ /__/__/
Day Month Year

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?