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

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

……
……
……
……

1. Pencegahan Sekunder				
Sejak serangan strok atau penilaian yang terakhir, adakah anda ada menerima sebarang nasihat berkaitan perubahan gaya hidup berkaitan kesihatan atau ubat-ubatan untuk mencegah serangan strok yang berikutnya?	☐ **Tidak**	→	☐ If **No**, refer to the Stroke Clinic for risk factor assessment and treatment if appropriate	
	☐ **Ya**	→	**Observe Progress**	
2. Aktiviti-aktiviti Kehidupan Harian (ADL)				
Sejak serangan strok atau penilaian yang terakhir, adakah anda dapati **lebih** sukar untuk menjaga diri anda sendiri?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	Adakah anda menghadapi kesukaran untuk memakai pakaian, mencuci diri dan/atau mandi? Adakah anda menghadapi kesukaran menyediakan minuman dan/atau makanan panas? Adakah anda menghadapi kesukaran untuk keluar rumah?	☐ If **Yes** to any, refer to the Stroke Clinic for further assessment
3. Kebolehgerakan				
Sejak serangan strok atau penilaian yang terakhir, adakah anda dapati **lebih** sukar untuk berjalan atau bergerak dengan selamat dari katil ke kerusi?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	Adakah anda masih terus menerima terapi rehabilitasi?	☐ If **No**, refer to the Stroke Clinic for further assessment.
4. Kespastikan				
Sejak serangan strok atau penilaian yang terakhir, adakah terdapat **peningkatan** kekakuan pada lengan, tangan dan/atau kaki anda?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	Adakah ia mengganggu aktiviti-aktiviti kehidupan harian?	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke spasticity for further assessment
5. Kesakitan				
Sejak serangan strok atau penilaian yang terakhir, adakah anda ada sebarang kesakitan yang **baharu**?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke pain for for further assessment and diagnosis	

6. Inkontinens				
Sejak serangan strok atau penilaian yang terakhir, adakah anda menghadapi **lebih** masalah untuk mengawal rasa ingin kencing atau membuang air besar?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes,** refer to the Stroke Clinic for further assessment	
7. Komunikasi				
Sejak serangan strok atau penilaian yang terakhir, adakah anda dapati **lebih** sukar untuk berkomunikasi dengan orang lain?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes,** refer to the Stroke Clinic for further assessment	
8. Ragam Perasaan (Mood)				
Sejak serangan strok atau penilaian yang terakhir, adakah anda berasa **lebih** resah atau murung?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes**, refer to the Stroke Clinic for further assessment or referral	
9. Kognisi				
Sejak serangan strok atau penilaian yang terakhir, adakah anda dapati **lebih** sukar untuk berfikir, menumpukan perhatian atau mengingat sesuatu?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	Adakah ia mengganggu aktiviti atau penyertaan?	☐ If **Yes**, refer to the Stroke Clinic with an interest in post-stroke cognition changes for further assessment
10. Kehidupan Selepas Strok				
Sejak serangan strok atau penilaian yang terakhir, adakah anda dapati perkara-perkara yang penting bagi anda **lebih** sukar untuk dilakukan (cth., aktiviti masa lapang, hobi, kerja, hubungan dengan orang tersayang)?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes,** refer patient to the Stroke Clinic for stroke support	
11. Hubungan dengan Keluarga				
Sejak serangan strok atau penilaian yang terakhir, adakah hubungan anda dengan keluarga menjadi **lebih** sukar atau tegang?	☐ **Tidak**	→	**Observe Progress**	
	☐ **Ya**	→	☐ If **Yes**, refer to the Stroke Clinic for stroke support	

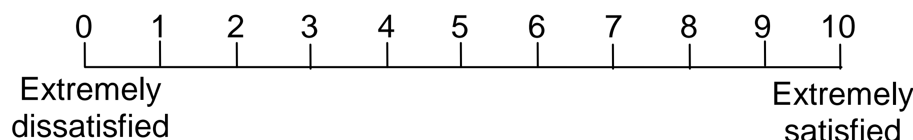
Post-assessment Patient Satisfaction Questionnaire

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.

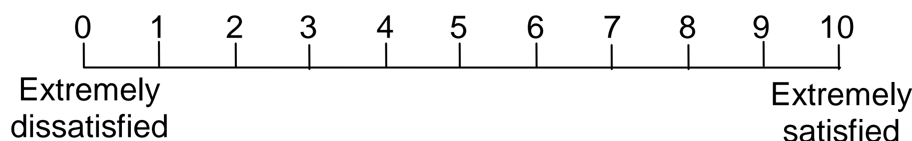
Today's date: /__/__/ (Day) /__/__/ (Month) /__/__/ (Year)

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?