

Section	Field	Response	Required	Valid	Invalid	Required	Invalid	
Demographics	Patient ID	George LONGID				OK		
Demographics	Stroke Band ID					Required		
Demographics	Patient First Name		PIA					
Demographics	Patient Last Name		PIA					
Demographics	Gender	<input type="checkbox"/> Male Gender <input type="checkbox"/> Female Gender <input type="checkbox"/> Gender Unknown				Canada	None	
Demographics	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female				Mexico	None	
Demographics	Patient Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM) Transgender Male/Trans Man <input type="checkbox"/> Male-to-Female (MTF) Transgender Female/Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Additional gender category or other _____ <input type="checkbox"/> Do not disclose	Stroke Stroke-Limited	CON, STN, TSC		Canada, USA, Mexico, PSE, LA, DM, LAM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None	
Demographics	Patient Identified Sexual Orientation	<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer, pansexual, another questioning <input type="checkbox"/> Something else, please specify _____ <input type="checkbox"/> Do not know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Other Patient-Identified Sexual Orientation: _____	Stroke Stroke-Limited	CON, STN, TSC		Canada, USA, Mexico, PSE, LA, DM, LAM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None	
Demographics	Date of Birth	____/____/____	Stroke Stroke-Limited	AGE, CON, STN, TSC		LA, DM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	Required	
Demographics	Age	____	Stroke Stroke-Limited	AGE, CON, STN, TSC		Canada, USA, Mexico, PSE, LA, DM, LAM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	Required	
Demographics	Homeless	<input type="checkbox"/>	Stroke			ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None	
Demographics	State	____				Mexico	None	
Demographics	Zip Code	____	Stroke			ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None (Optional)	
Demographics	Patient Postal Code	____				Canada	None	
Demographics	Patient Postal Code	____				Mexico	None	
Demographics	Province or Territory	____				Canada	None	
Demographics	Street Address	____	PIA				None	
Demographics	Payment Source	<input type="checkbox"/> Medicare Title 18 <input type="checkbox"/> Medicare Title 19 <input type="checkbox"/> Medicare - Private/MOP/PO/Other <input type="checkbox"/> Private/MOP/PO/Other <input type="checkbox"/> WAC/MOP/PT/Trans <input type="checkbox"/> Self-Pay/No Insurance <input type="checkbox"/> Other/Not Documented/UTD	Stroke				Canada, USA, Mexico, MEX	Required
Demographics	Payment Source	<input type="checkbox"/> Government Insurance <input type="checkbox"/> Private Insurance <input type="checkbox"/> Combination Government/Private <input type="checkbox"/> No Insurance					Mexico	None
Demographics	Government Insurance Type	<input type="checkbox"/> ASES <input type="checkbox"/> BESI <input type="checkbox"/> EGAS <input type="checkbox"/> EUBIC/DT <input type="checkbox"/> IMSS/IA <input type="checkbox"/> PEMEX					Mexico	None
Demographics	What is the patient's source of payment for this episode of care?	<input type="checkbox"/> Medicare <input type="checkbox"/> Non-Medicare		AGE, CON, STN, TSC			Required	
Demographics	MRN	____	PIA				None	
Demographics	Medical Record Number	____	MRN				None	
Demographics	Race and Ethnicity	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> UTD	Stroke Stroke-Limited				Canada, USA, Mexico, PSE, LA, DM, LAM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	Required
Demographics	American Indian/Alaska Native - MCH	<input type="checkbox"/> Anishinaabe/Ojibwa <input type="checkbox"/> Central/Alaska <input type="checkbox"/> Other American Indian or Alaska Native Tribal Nation					MCH	None
Demographics	Black or African American - MCH	<input type="checkbox"/> African American <input type="checkbox"/> Caribbean <input type="checkbox"/> Nigerian <input type="checkbox"/> Somali <input type="checkbox"/> Sudanese <input type="checkbox"/> Other Black Ethnicity					MCH	None
Demographics	White - MCH	<input type="checkbox"/> Russian <input type="checkbox"/> Other White Ethnicity					MCH	None
Demographics	Race	<input type="checkbox"/> Black <input type="checkbox"/> East/Southeast Asian <input type="checkbox"/> Indigenous <input type="checkbox"/> First Nations <input type="checkbox"/> Mestizo <input type="checkbox"/> Mestizo <input type="checkbox"/> Prefer not to answer (Indigenous) <input type="checkbox"/> Latino <input type="checkbox"/> Middle Eastern <input type="checkbox"/> South Asian <input type="checkbox"/> White <input type="checkbox"/> Another Race Category <input type="checkbox"/> Do not know <input type="checkbox"/> Prefer not to answer					Canada	None
Demographics	Race	<input type="checkbox"/> Black (White) <input type="checkbox"/> Mexican (Indigenous) <input type="checkbox"/> Other (Other)					Mexico	None
Demographics	Ethnicity	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> UTD <input type="checkbox"/> Non-Middle Eastern <input type="checkbox"/> Other					Middle East	None
Demographics	Asian Ethnicity	<input type="checkbox"/> Asian Indian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Pakistani <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian					Middle East	None
Demographics	Asian	<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	Stroke Stroke-Limited				Canada, LA, DM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None
Demographics	Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Chamorro or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	Stroke Stroke-Limited				Canada, LA, DM, ME, CA, CO, CR, CU, EC, SV, GT, HN, NI, PA, PE, PR, PY, US, VE, ZJ	None
Demographics	Additional Asian - MCH	<input type="checkbox"/> Burmese <input type="checkbox"/> Cambodian <input type="checkbox"/> Hmong <input type="checkbox"/> Laotian <input type="checkbox"/> Lao <input type="checkbox"/> Other Asian Ethnicity not listed in GWTC element list above or in Additional Asian - MCH list					MCH	None
Demographics	Arab/Middle Eastern	<input type="checkbox"/> Bahraini <input type="checkbox"/> Egyptian <input type="checkbox"/> Emirati <input type="checkbox"/> Iraqi <input type="checkbox"/> Lebanese <input type="checkbox"/> Jordanian <input type="checkbox"/> Saudi <input type="checkbox"/> Syrian <input type="checkbox"/> Turkish <input type="checkbox"/> Other Middle Eastern <input type="checkbox"/> Palestinian <input type="checkbox"/> Kuwaiti <input type="checkbox"/> Yemeni <input type="checkbox"/> Other					Middle East	None
Demographics	Current Place of Residence	<input type="checkbox"/> USA <input type="checkbox"/> UAE <input type="checkbox"/> Other <input type="checkbox"/> Bahrain <input type="checkbox"/> Jordan <input type="checkbox"/> Kuwait <input type="checkbox"/> Other					Middle East	None
Demographics	Subsidiary Government	<input type="checkbox"/> Capital Government <input type="checkbox"/> Military Government <input type="checkbox"/> Northern Government <input type="checkbox"/> Southern Government					Middle East	None

Clinical Codes	ICD-10-CM Admitting Diagnosis Code			CSTA	Canada, Middle-East, Mexico	Required
Clinical Codes	ICD-10-CM Discharge Diagnosis Related to Stroke		Stroke, Stroke-Limited		Canada, Chi, Michigan, Middle-East, Mexico	None
Clinical Codes	No Stroke or TIA Related ICD-10-CM Code Present		Stroke, Stroke-Limited		Canada, Chi, Michigan, Middle-East, Mexico	None
Clinical Codes	OP-STX, ICD-10-CM Principal Diagnosis Code				OMS-OP-23	Required
Clinical Codes	OP-STX, ICD-10-CM Diagnosis Codes				OMS-OP-23	None
Clinical Codes	CSTA Initial Patient Population:	<input type="checkbox"/> Ischemic Stroke Without Procedure <input type="checkbox"/> Ischemic Stroke With IV alteplase, At alteplase, or MEXR <input type="checkbox"/> Hemorrhagic Stroke		CSTA, STX, TSC		None
Admission	During the hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (ie, STX, VTE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	CSTA, STX, TSC	Canada, Chi, Michigan, PSS, Middle-East, Mexico, Canada, Mexico	Required
Admission	If Yes, Type of Clinical Trial(s) (check all that apply):	<input type="checkbox"/> Antithrombotics <input type="checkbox"/> YFE Therapeutics <input type="checkbox"/> Anticoagulation for AFib/Aflutter <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Restless Legs Therapy <input type="checkbox"/> Therapeutic administration <input type="checkbox"/> Endovascular Therapy <input type="checkbox"/> Other	Stroke, Stroke-Limited, Endovascular Therapy (Stroke), Endovascular Therapy (Stroke), Endovascular Therapy (Stroke), Endovascular Therapy (Stroke)	CSTA, STX, TSC	Canada, Chi, Michigan, PSS, Middle-East, Mexico, Canada, Mexico	None
Admission	Was this patient admitted for the sole purpose of performance of elective cardiac intervention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited, Endovascular Therapy (Stroke), Endovascular Therapy (Stroke), Endovascular Therapy (Stroke)	CSTA, STX, TSC	Canada, Chi, Michigan, PSS, Middle-East, Mexico, Canada, Mexico	Required
Admission	Point of Origin for Admission or Visit:	<input type="checkbox"/> Clinic <input type="checkbox"/> Outpatient Enhancement <input type="checkbox"/> Emergency Room <input type="checkbox"/> Non-acute care facility (point of origin) <input type="checkbox"/> Transfer from a hospital (different facility) <input type="checkbox"/> Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) <input type="checkbox"/> Transfer from ambulatory surgery center <input type="checkbox"/> Transfer from another health care facility <input type="checkbox"/> Transfer from hospice and to enter a Hospital Plan of Care or enrolled in Hospice program <input type="checkbox"/> Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the system <input type="checkbox"/> Information not available <input type="checkbox"/> N/A/ND <input type="checkbox"/> Transfer from a Critical Access Hospital	Stroke	LA-DM	None (Stroke) Required (LA-DM)	
Admission	Patient location when stroke symptoms discovered:	<input type="checkbox"/> Not in a healthcare setting <input type="checkbox"/> Another acute care facility <input type="checkbox"/> Chronic health care facility <input type="checkbox"/> Outpatient ambulatory setting <input type="checkbox"/> Stroke occurred after hospital arrival (in ED/Obs/patient) <input type="checkbox"/> ND or Cannot be determined	Stroke, Stroke-Limited, SPO		Canada, Chi, Michigan, PSS, Middle-East, Mexico, Canada, Mexico	Required
Admission	How patient arrived at your hospital:	<input type="checkbox"/> EMS from home/private <input type="checkbox"/> Mobile Stroke Unit <input type="checkbox"/> Private transport/other from home/private <input type="checkbox"/> Transfer from other hospital <input type="checkbox"/> ND or Unknown	Stroke, Stroke-Limited	CSTA, TSC	Canada, Chi, Michigan, PSS, Middle-East, Mexico, Canada, Mexico	Required
Admission	Referring Hospital Discharge Date/Time	MM/DD/YYYY only <input type="checkbox"/> Unknown	Stroke		Canada, Middle-East, Mexico	None
Admission	If transfer from another hospital, specify hospital name:	<input type="checkbox"/> Transfer from Hospital Not on the List <input type="checkbox"/> Transfer from Hospital Not Documented	Stroke		Canada, Mexico	None
Admission	Referring Hospital Arrival Date/Time	MM/DD/YYYY only <input type="checkbox"/> Unknown	Stroke		Canada, Mexico, Middle-East	None
Admission	If patient transferred to your hospital, select transfer reason(s):	<input type="checkbox"/> Evaluation for IV alteplase up to 4.5 hours <input type="checkbox"/> Post Management of IV alteplase (e.g. Drip and Stop) <input type="checkbox"/> Evaluation for Endovascular Intervention <input type="checkbox"/> Advanced stroke care (e.g., Neurocritical care, surgical or other time critical therapy) <input type="checkbox"/> Patient/family request <input type="checkbox"/> Other advanced care (not stroke related) <input type="checkbox"/> Not documented	Stroke		Canada, Mexico, Middle-East	None
Admission	EMS Agency Transporting Patient to Referring Hospital	<input type="checkbox"/> Not Documented			Almanac	Required
Admission	Was the patient an ED patient at the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No		ASA, CSTX, STX, TSC		Required
Admission	Was the patient a direct admission to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSTA, STX		Required
Admission	Where patient first received care at your hospital:	<input type="checkbox"/> Emergency Department/urgent care <input type="checkbox"/> Chief clinic, and through ICU <input type="checkbox"/> Imaging suite <input type="checkbox"/> ND or Cannot be determined	Stroke		Canada, Chi, Michigan, PSS, Middle-East, Mexico	None
Admission	Did a stroke-capable Provider consult in decision-making during the acute phase of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited			Required
Admission	Stroke-capable Provider(s) (specify):	<input type="checkbox"/> Emergency Provider <input type="checkbox"/> EndEmergency Provider <input type="checkbox"/> Nonstroke-capable <input type="checkbox"/> Telestroke Provider <input type="checkbox"/> Medical Hospitalist <input type="checkbox"/> Advanced Practice Provider	Stroke, Stroke-Limited			Required
Admission	Advanced notification by EMS or MSU?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited		PSS, LA-DM, Middle-East, West/HongKong/China, Mexico	Required
Admission	Initial admitting service:	<input type="checkbox"/> Medicine <input type="checkbox"/> Neurocritical care <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Surgery <input type="checkbox"/> Other	Stroke, CH		Middle-East, Canada, Mexico	None
Admission	In which settings were care delivered - Other:	<input type="checkbox"/> Neuro/Neurosurgery ICU <input type="checkbox"/> General care floor <input type="checkbox"/> Other ICU <input type="checkbox"/> Outpatient <input type="checkbox"/> Stroke unit (non-ICU) <input type="checkbox"/> Other	Stroke, CH		Middle-East, Canada, Mexico	Required (CH)
Admission	Specialist unit admission date/time:	MM/DD/YYYY only <input type="checkbox"/> Unknown		CH		Required
Admission	If the patient was not cared for in a dedicated stroke unit, was a formal hospital consultation from a stroke expert obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ND	Stroke, CH		Middle-East, Canada, Mexico	None
Admission	ED Physician		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Stroke NIV PA		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Admitting Physician		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Attending Physician		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Neurologist		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Neurosurgeon		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Interventionalist		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Discharging Provider		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Other Provider		Stroke, Stroke-Limited		Chi, Michigan, PSS, Canada, Mexico	None
Admission	Was telestroke consultation performed?	<input type="checkbox"/> Yes, the patient received telestroke consultation from my hospital staff when the patient was located at another hospital <input type="checkbox"/> Yes, the patient received telestroke consultation from someone other than my hospital staff when the patient was at another hospital <input type="checkbox"/> Yes, the patient received telestroke consultation from a remotely located expert when the patient was located at my hospital <input type="checkbox"/> No telestroke consult performed <input type="checkbox"/> Not Documented	Stroke, Stroke-Limited, Telestroke	DMV	Middle-East, Canada, Mexico, Canada, Stroke-Rural	Required
Admission	Previously known medical history of:	<input type="checkbox"/> No Previous Medical History <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> CAD/ Prior MI <input type="checkbox"/> Cancer <input type="checkbox"/> Coronary Stenosis <input type="checkbox"/> Chronic Kidney Disease (CKD) <input type="checkbox"/> Current Pregnancy (up to 8 weeks postpartum) <input type="checkbox"/> DVT/PE <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Diabetes Type <input type="checkbox"/> Drug/Alcohol Abuse <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> E-Cigarette Use (Vaping) <input type="checkbox"/> Family/Hypertension/Anemia <input type="checkbox"/> Family History of Stroke	Stroke, Stroke-Limited		Canada, Chi, Michigan, Middle-East, Canada, Mexico, OMS	Required
Admission	Previously known medical history of (cont):	<input type="checkbox"/> HIV <input type="checkbox"/> HST <input type="checkbox"/> History of Emerging Infectious Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Migraine <input type="checkbox"/> Obesity/Overweight <input type="checkbox"/> Pregnancy (8 weeks to 12 months postpartum) <input type="checkbox"/> Previous Stroke <input type="checkbox"/> Previous TIA <input type="checkbox"/> Prosthetic Heart Valve <input type="checkbox"/> PVD <input type="checkbox"/> Rheumatoid Arthritis - Chronic <input type="checkbox"/> Stroke <input type="checkbox"/> Stroke <input type="checkbox"/> Stroke	Stroke, Stroke-Limited		Canada, Chi, Michigan, Middle-East, Canada, Mexico, OMS	Required
Admission	Most Recent CKD Stage Prior to This Encounter	<input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Stage 5: Dialysis <input type="checkbox"/> Unable to Determine		OMS		Required
Admission	Currently pregnant?	<input type="checkbox"/> Yes, currently pregnant <input type="checkbox"/> No, postpartum up to 8 weeks	Stroke, Stroke-Limited			None
Admission	Diabetes Type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> NED	Stroke, Stroke-Limited, Diabetes		Middle-East, Canada, Mexico, OMS	Required
Admission	Diabetes Duration	<input type="checkbox"/> < 5 years <input type="checkbox"/> 5 - 10 years <input type="checkbox"/> 10 - 20 years <input type="checkbox"/> > 20 years <input type="checkbox"/> Unknown	Stroke, Stroke-Limited, Diabetes		Middle-East, Canada, Mexico, OMS	None
Admission	Emerging Infectious Disease	<input type="checkbox"/> MERS <input type="checkbox"/> MERS-CoV1 <input type="checkbox"/> MERS-CoV2 (COVID-19) <input type="checkbox"/> Other infectious respiratory pathogen	Stroke, Stroke-Limited, Diabetes		Middle-East, Canada, Mexico, OMS	Required

Pre-hospital Care	How was destination decision made?	<input type="checkbox"/> Directed to designated stroke center by protocol <input type="checkbox"/> Directed to nearest facility by protocol <input type="checkbox"/> Patient/Family choice <input type="checkbox"/> Online Medical Direction <input type="checkbox"/> Closed facility <input type="checkbox"/> Other <input type="checkbox"/> Unknown/ND	EMS-Pre-hospital Care	Mid-East, West-Region-Stroke	None	
Pre-hospital Care	If other destination decision, specify		EMS-Pre-hospital Care	Mid-East, West-Region-Stroke	None	
Pre-hospital Care	What was destination hospital's level of service?	<input type="checkbox"/> Non-stroke designated hospital <input type="checkbox"/> A&E <input type="checkbox"/> PSC <input type="checkbox"/> CSC <input type="checkbox"/> TSC <input type="checkbox"/> ND		West-Region-Stroke	None	
Pre-hospital Care	Was closed facility bypassed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ND		West-Region-Stroke	None	
Pre-hospital Care	Was a Thrombolytic Checklist used?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	EMS-Pre-hospital Care	Mid-East, West-Region-Stroke	None	
Pre-hospital Care	If severity scale used, did result alter hospital destination (e.g. CSC vs PSC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	EMS-Pre-hospital Care	Mid-East, West-Region-Stroke	Required (West-Region)	
Pre-hospital Care	EMS Additional Comments		EMS-Pre-hospital Care	Mid-East, West-Region-Stroke	None	
HOSPITALIZATION						
Hospitalization	When was the patient last known to be well?	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Linked	Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required	
Hospitalization	Date/Time of discovery of stroke symptoms?	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown <input type="checkbox"/> Same as time last known well	Stroke, Stroke-Linked	Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required	
Pre-hospital						
Hospitalization	How soon was vascular imaging performed prior to transfer to your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Endovascular-Therapy		None	
Hospitalization	Imaging type at prior facility not documented	<input type="checkbox"/>	Endovascular-Therapy		None	
Hospitalization	If yes, which imaging tests were performed prior to transfer to your facility? (select all that apply)	<input type="checkbox"/> CT <input type="checkbox"/> CTA <input type="checkbox"/> CT Perfusion <input type="checkbox"/> MRI <input type="checkbox"/> MRA <input type="checkbox"/> MRI Perfusion	Endovascular-Therapy		None	
Hospitalization	Date/Time for vessel or perfusion imaging initiated at your hospital	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Endovascular-Therapy		None	
Hospitalization	Brain imaging completed at your hospital for this episode of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND <input type="checkbox"/> NC	Stroke, Stroke-Linked	DW	Cleveland, Ohio, Michigan, PSC, Mid-East, West-Region-Stroke, Canada, Mexico	Required
Hospitalization	Type of brain imaging completed at your hospital for this episode of care	<input type="checkbox"/> CT <input type="checkbox"/> MRI	Stroke, Stroke-Linked	DW	Cleveland, Canada, Mexico	Required (Cleveland & DW)
Hospitalization	Date/Time Brain Imaging First Initiated at your hospital	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Documented reason for delay in initial brain imaging at your hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Linked		None	
Hospitalization	Specify reason for delay in initial brain imaging at this hospital (select all that apply)	<input type="checkbox"/> Management of concomitant emergent/urgent conditions such as cardiopulmonary arrest, respiratory failure, imaging infeasibility <input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> Hospital time delay <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> Other (specify)	Stroke, Stroke-Linked		None	
Hospitalization	Date/Time Brain Imaging Repeated	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Linked	ETX, DW	LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required (Other Region, Rural, DW)
Hospitalization	Interpretation of first brain image after symptoms onset, time at any facility	<input type="checkbox"/> Acute Hemorrhage <input type="checkbox"/> No Acute Hemorrhage <input type="checkbox"/> Not Available	Stroke		Cleveland, Ohio, Michigan, Mid-East, Canada, Mexico	Warning
Hospitalization	Vascular imaging (e.g. CTA, MRA, DSA) performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Linked, Endovascular-Therapy		Mid-East, Canada, Mexico	Required
Hospitalization	Date/Time for vessel or perfusion imaging initiated at your hospital	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Linked		Mid-East, Canada, Mexico	None
Hospitalization	Vascular or perfusion imaging performed at your hospital (select all that apply)	<input type="checkbox"/> CTA <input type="checkbox"/> CT Perfusion <input type="checkbox"/> MRA <input type="checkbox"/> MRI Perfusion <input type="checkbox"/> DSA (inhalator angiography) <input type="checkbox"/> ND	Stroke, Stroke-Linked		Mid-East, Canada, Mexico	None
Hospitalization	Vascular imaging result	<input type="checkbox"/> Normal <input type="checkbox"/> Mismatch Present <input type="checkbox"/> Absent Mismatch			Mid-E	Required
Hospitalization	Target lesion location?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Linked, Endovascular-Therapy	DW/ADV	Mid-East, Canada, Mexico	Required
Hospitalization	Site of occlusion	<input type="checkbox"/> ICA <input type="checkbox"/> MCA <input type="checkbox"/> Basilar Artery <input type="checkbox"/> Other/Cerebral Artery Branch <input type="checkbox"/> Vertebral Artery	Stroke, Stroke-Linked, Endovascular-Therapy	DW/ADV	Mid-East, Canada, Mexico	Required
Hospitalization	ICA segment	<input type="checkbox"/> Intracranial ICA <input type="checkbox"/> Cervical ICA <input type="checkbox"/> Other/NTD	Stroke, Stroke-Linked, Endovascular-Therapy	DW/ADV	Mid-East, Canada, Mexico	Required
Hospitalization	MCA segment	<input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> Other/NTD	Stroke, Stroke-Linked, Endovascular-Therapy	DW/ADV	Mid-East, Canada, Mexico	Required
Hospitalization	Vascular imaging at an outside hospital for a hemorrhage patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI	DW, DW/ADV		Required
Hospitalization	Vascular imaging at your hospital for a hemorrhage patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI	DW, DW/ADV		Required
Hospitalization	Type of vascular imaging	<input type="checkbox"/> CTA <input type="checkbox"/> MRA <input type="checkbox"/> DSA	SAI			Warning
Hospitalization	Structural cause of hemorrhage	<input type="checkbox"/> None <input type="checkbox"/> Aneurysm <input type="checkbox"/> Arteriovenous malformation (AVM) <input type="checkbox"/> Brain neoplasm <input type="checkbox"/> Other	SAI	DW, DW/ADV		Required
Hospitalization	ASPECT 1 core Score	<input type="checkbox"/> ND	Endovascular-Therapy		Mid-E	Warning (DW/ADV) Required (DW)
Thrombolytic Therapy						
Hospitalization	Thrombolytic initiated at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Thrombolytic Initiation Date/Time	<input type="checkbox"/> M/M/CC/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Linked	CST, TSC	Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Thrombolytic used	<input type="checkbox"/> Alteplase (Class 1 evidence) <input type="checkbox"/> Tenecteplase (Class 2b evidence)	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Alteplase total dose (mg)	<input type="checkbox"/> ND	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Tenecteplase total dose (mg)	<input type="checkbox"/> ND	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Reason for selecting tenecteplase instead of alteplase	<input type="checkbox"/> Large Vessel Occlusion (LVO) with potential thrombolysis <input type="checkbox"/> Mild Stroke <input type="checkbox"/> Other	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	If IV thrombolytic administered beyond 4.5-hour, was imaging used to justify eligibility?	<input type="checkbox"/> Yes, Diffusion-FLAIR mismatch <input type="checkbox"/> Yes, Core-Perfusion mismatch <input type="checkbox"/> None <input type="checkbox"/> Other	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	BP before alteplase	<input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> ND			Mid-E	Required
Hospitalization	Documented exclusions or relative exclusions (contraindications or warnings) for not initiating IV thrombolytic in the 0-3 hr treatment window?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Documented exclusions or relative exclusions (contraindications or warnings) for not initiating IV thrombolytic in the 3-4.5 hr treatment window?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Exclusion Criteria (contraindications) 0-3 hr treatment window. Select all that apply.	<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Active bleeding diathesis (low platelet count, increased PTT, INR > 1.7 or use of MNO) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrated midline shift (approximately > 1/3 unilateral hemispheres) <input type="checkbox"/> C8: Atrial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration < 50 mg/dL (2.7 mmol/L)	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Relative Exclusion Criteria (Warnings) 0-3 hr treatment window. Select all that apply.	<input type="checkbox"/> W1: Case-team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombolysis at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe co-morbid illness or DMO on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Priorly transfused <input type="checkbox"/> W6: Stroke severity too mild (per disabling) <input type="checkbox"/> W7: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W8: Stroke of onset with practical residual neurological impairments <input type="checkbox"/> W9: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W10: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days) <input type="checkbox"/> W12: Current taking tPA-inhibitor / Disease thrombolysis	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required
Hospitalization	Exclusion Criteria (contraindications) 3-4.5 hr treatment window. Select all that apply.	<input type="checkbox"/> C1: Elevated blood pressure (systolic > 185 mm Hg or diastolic > 110 mm Hg) despite treatment <input type="checkbox"/> C2: Recent intracranial or spinal surgery or significant head trauma, or prior stroke in previous 3 months <input type="checkbox"/> C3: History of previous intracranial hemorrhage, intracranial neoplasm, arteriovenous malformation, or aneurysm <input type="checkbox"/> C4: Active internal bleeding <input type="checkbox"/> C5: Active bleeding diathesis (low platelet count, increased PTT, INR > 1.7 or use of MNO) <input type="checkbox"/> C6: Symptoms suggest subarachnoid hemorrhage <input type="checkbox"/> C7: CT demonstrated midline shift (approximately > 1/3 unilateral hemispheres) <input type="checkbox"/> C8: Atrial puncture at non-compressible site in previous 7 days <input type="checkbox"/> C9: Blood glucose concentration < 50 mg/dL (2.7 mmol/L)	Stroke, Stroke-Linked		Cleveland, Ohio, Michigan, PSC, LA&S, Mid-East, West-Region-Rural, Canada, Mexico	Required

Hospitalization	Relative Exclusion Criteria (Warnings) 3.4.5 for treatment venous. Select all that apply:	<input type="checkbox"/> WT: Case team unable to determine eligibility <input type="checkbox"/> W2: IV or IA thrombolysis/thrombolysis at an outside hospital prior to arrival <input type="checkbox"/> W3: Life expectancy < 1 year or severe or medical illness or CNS on admission <input type="checkbox"/> W4: Pregnancy <input type="checkbox"/> W5: Previously treated <input type="checkbox"/> W6: Stroke severity too mild (non-disabling) <input type="checkbox"/> W7: Recent acute myocardial infarction (within previous 3 months) <input type="checkbox"/> W8: Recent acute myocardial infarction (within previous 14 days) <input type="checkbox"/> W9: Stroke at onset with practical residual neurological impairments <input type="checkbox"/> W10: Major surgery or serious trauma within previous 14 days <input type="checkbox"/> W11: Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days) <input type="checkbox"/> W12: Current bleeding/bleeding or Disease thrombolysis	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, West, Region-Rock, Canada, Mexico	Required	
Hospitalization	Additional Relative Exclusion Criteria 3.4.5 for treatment venous. Select all that apply:	<input type="checkbox"/> A01: Age > 80 <input type="checkbox"/> A02: History of both diabetes and prior ischemic stroke <input type="checkbox"/> A03: Taking oral anticoagulant regardless of INR <input type="checkbox"/> A04: Active Stroke (NINDS) > 2	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, West, Region-Rock, Canada, Mexico	None	
Hospitalization	Other Reasons (Hospital-related or other factors) 3.4.5 for treatment venous. Select all that apply:	<input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> Hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Need of Early Intervention <input type="checkbox"/> Advanced Age <input type="checkbox"/> Stroke too severe <input type="checkbox"/> Other: _____	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	Other Reasons (Hospital-related or other factors) 3.4.5 for treatment venous. Select all that apply:	<input type="checkbox"/> Delay in Patient Arrival <input type="checkbox"/> Hospital Time Delay <input type="checkbox"/> Delay in Stroke diagnosis <input type="checkbox"/> No IV access <input type="checkbox"/> Need of Early Intervention <input type="checkbox"/> Advanced Age <input type="checkbox"/> Stroke too severe <input type="checkbox"/> Other: _____	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	If IV thrombolysis was initiated greater than 60 minutes after hospital arrival, was Eligibility or Medical reason(s) documented on the cases for delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited, SPO	LA&M, Mid-Est, West, Region-Rock, Canada, Mexico	Required	
Hospitalization	If IV thrombolysis was initiated greater than 60 minutes after hospital arrival, was Eligibility or Medical reason(s) documented on the cases for delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited, SPO	LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	If IV thrombolysis was initiated greater than 30 minutes after hospital arrival, was Eligibility or Medical reason(s) documented on the cases for delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited, SPO	LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	Causes for IV thrombolysis delay, Eligibility Reason(s):	<input type="checkbox"/> Social/Pediatric <input type="checkbox"/> Initial refusal <input type="checkbox"/> Case team unable to determine eligibility <input type="checkbox"/> Specify eligibility reason for delay in IV thrombolysis: _____	Stroke, Stroke-Limited, SPO	LA&M, Mid-Est, West, Region-Rock, Canada, Mexico	Required	
Hospitalization	Causes for IV thrombolysis delay, Medical Reason(s):	<input type="checkbox"/> Reperfusion requiring aggressive control with IV medications <input type="checkbox"/> Further diagnostic evaluation to confirm stroke for patients with hypoglycemia (blood glucose < 2.0), or arrhythmia, or major medical conditions <input type="checkbox"/> Management of concomitant arrhythmogenic conditions such as supraventricular arrhythmia (beta-blocker required) <input type="checkbox"/> Investigational or experimental protocol for thrombolysis <input type="checkbox"/> Need for additional PFC in suspected/confirmed infectious disease <input type="checkbox"/> Specify medical reason for delay in IV thrombolysis: _____	Stroke, Stroke-Limited, SPO	LA&M, Mid-Est, West, Region-Rock, Canada, Mexico, Consent	Required	
Hospitalization	Causes for IV thrombolysis delay, Hospital Related or Other Reason(s):	<input type="checkbox"/> Need for additional imaging <input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> Hospital time delay <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> Other: _____	Stroke, Stroke-Limited	LA&M, Mid-Est, Canada, Mexico	None	
Hospitalization	IV thrombolysis at an outside hospital or EMS/ Mobile Stroke Unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited, SPO	Consent: Ont., Michigan, PIS, Mid-Est, West, Region-Rock, Canada, Mexico	Required	
Hospitalization	Thrombolysis administered at outside hospital or Mobile Stroke Unit	<input type="checkbox"/> Adjective <input type="checkbox"/> Transcription	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, Mid-Est, Canada, Mexico	Required	
Hospitalization	Investigational or experimental protocol for thrombolysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Specify investigational or experimental protocol for thrombolysis: _____	Stroke	Mid-Est, Canada, Mexico	Required	
Conclusion of Thrombolysis						
Hospitalization	Is there documentation of a suspected LVO in the medical record?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	AGL, STX, TSC	Required	
Hospitalization	Is there documentation in the medical record that the patient is eligible for MER therapy or mechanical thrombolysis procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	AGL, STX, TSC	Required	
Hospitalization	Catheter-based stroke treatment at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	IA alteplase or MER initiation Date/Time	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Limited	CFX, TSC	Required	
Hospitalization	Catheter-based stroke treatment of outside hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	PIS, Mid-Est, Canada, Mexico	Required	
Conclusion of Reperfusion Therapy						
Hospitalization	Complications of IV Thrombolysis Therapy	<input type="checkbox"/> Symptomatic intracranial hemorrhage <36 hours <input type="checkbox"/> Other serious complication <input type="checkbox"/> Life threatening serious systemic hemorrhage >36 hours <input type="checkbox"/> No serious complications <input type="checkbox"/> UTD	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	Complications of IA Thrombolysis Therapy or MER	<input type="checkbox"/> Symptomatic intracranial hemorrhage with >= 4 point increase in INR/PTT > 36 hours since the onset of treatment <input type="checkbox"/> Serious complication <input type="checkbox"/> Other serious complication <input type="checkbox"/> No serious complications <input type="checkbox"/> UTD	Stroke, Stroke-Limited	Consent: Ont., Michigan, PIS, LA&M, Mid-Est, Canada, Mexico	Required	
Hospitalization	If bleeding complications occur in patient transferred after IV thrombolysis:	<input type="checkbox"/> Symptomatic hemorrhage detected prior to patient transfer <input type="checkbox"/> Symptomatic hemorrhage detected only after patient transfer <input type="checkbox"/> Unable to determine <input type="checkbox"/> N/A	Stroke	Consent: Ont., Michigan, PIS, Mid-Est, Canada, Mexico	Required	
Conclusion of Mechanical Thrombolysis						
Hospitalization	Was an initial dysphagia screen performed?	<input type="checkbox"/> Yes, within 24 hours of arrival <input type="checkbox"/> Yes, greater than 24 hours after arrival <input type="checkbox"/> No <input type="checkbox"/> N/A	Stroke, Stroke-Limited	CA	Required	
Hospitalization	Was patient screened for dysphagia prior to any oral intake (including water or medications)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A/ND <input type="checkbox"/> N/A	Stroke, Stroke-Limited	Consent: Ont., Michigan, Mid-Est, Canada, Mexico	Required	
Hospitalization	If yes, Dysphagia screening results:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	Stroke	Consent: Ont., Michigan, Mid-Est, Canada, Mexico	None	
Hospitalization	Treatment for Hospital-Acquired Pneumonia:	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND <input type="checkbox"/> N/A	Stroke	Consent: Ont., Michigan, Mid-Est, Canada, Mexico	None	
Hospitalization	Which assessment(s) were completed or attempted within 24 hours of admission?	<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech+Language Pathology <input type="checkbox"/> None of the above	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was there a medical reason for Occupational Therapy assessment not being completed or attempted within 24 hours of admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was there a medical reason for Physical Therapy assessment not being completed or attempted within 24 hours of admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was there a medical reason for Speech-Language Pathology assessment not being completed or attempted within 24 hours of admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was an Occupational Therapy assessment completed or attempted within 24 hours once medically feasible?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was a Physical Therapy assessment completed or attempted within 24 hours once medically feasible?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Hospitalization	Was a Speech-Language Pathology assessment completed or attempted within 24 hours once medically feasible?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke, Stroke-Limited	DMV	Required	
Conclusion of Anticoagulation						
Hospitalization	VTE Interventions	<input type="checkbox"/> 1. Low dose unfractionated heparin (LDUH) <input type="checkbox"/> 2. Low molecular weight heparin (LMWH) <input type="checkbox"/> 3. Inferior vena cava mechanical compression device (IPC) <input type="checkbox"/> 4. GCS <input type="checkbox"/> 5. Factor Xa inhibitor <input type="checkbox"/> 6. Warfarin <input type="checkbox"/> 7. Venous foot pumps <input type="checkbox"/> 8. Oral Factor Xa inhibitor <input type="checkbox"/> 9. Aspirin <input type="checkbox"/> A. None of the above or not documented or unable to determine from medical record documentation	Stroke, Stroke-Limited	STX, TSC	Consent: Ont., Michigan, Mid-Est, Canada, Mexico	Required
Hospitalization	What date was the VTE prophylaxis administered after hospital admission?	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Limited	STX, TSC	Consent: Mid-Est, Canada, Mexico	Required
Hospitalization	What was the Date and Time the IPC device was placed?	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	Stroke, Stroke-Limited	CA	Required	
Hospitalization	Is there physician/PTN/PA documentation why IPC was not used for VTE prophylaxis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	CA	Required	
Hospitalization	Is there physician/PTN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	STX, TSC	Consent: Mid-Est, Canada, Mexico	Required
Hospitalization	Is there physician/PTN/PA documentation why Oral Factor Xa inhibitor was administered for VTE prophylaxis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	STX, TSC	Consent: Mid-Est, Canada, Mexico	Required
Hospitalization	Other Therapeutic Anticoagulation	<input type="checkbox"/> apixiban (Equis) <input type="checkbox"/> argatroban <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> drotrecogin (Spikestat) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> idarucizumab (Praxbind) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> unfractionated heparin IV <input type="checkbox"/> Other Anticoagulant	Stroke, Stroke-Limited	STX, TSC	Consent: Mid-Est, Canada, Mexico	None
Hospitalization	Was DVT or PE documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	Consent: Ont., Michigan, Mid-Est, Canada, Mexico	None (Stroke-Required/Consent)	
Conclusion of Anticoagulation						
Hospitalization	Was antithrombotic therapy administered by the end of hospital day 27?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND <input type="checkbox"/> N/A	Stroke, Stroke-Limited	Ont., Michigan, Mid-Est, Canada, Mexico	Required	
Hospitalization	Subtype(s) of antithrombotic therapy administered by the end of hospital day 27	<input type="checkbox"/> Anticoagulant <input type="checkbox"/> Antiplatelet	Stroke	Ont., Michigan, Mid-Est, Canada, Mexico	None	
Hospitalization	Is there documentation by a physician/advanced practice nurse/physician assistant (physician/PTN/PA) or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 27?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, Stroke-Limited	AGL, STX, TSC	Consent	Required
Hospitalization	Was patient treated for a urinary tract infection (UTI) during the admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke	Consent	None	
Hospitalization	If patient was treated for a UTI, did the patient have a Foley catheter during the admission?	<input type="checkbox"/> Yes, patient had catheter in place on arrival <input type="checkbox"/> No <input type="checkbox"/> Yes, but only after admission <input type="checkbox"/> Unable to determine	Stroke	Consent	None	

Hospitalization	Active bacterial or viral infection at admission or during hospitalization	<input type="checkbox"/> None/ND <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> Malaria <input type="checkbox"/> Severe Cyst <input type="checkbox"/> Other Viral Infection	Stroke, Stroke-Limited		Canada, Middle-East, Canada, Mexico	Required	
Hospitalization	Is there a new diagnosis of Chronic Kidney Disease (CKD) during the hospital stay?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND			OSM	Required	
Hospitalization	What components were used to make the diagnosis?	<input type="checkbox"/> Prior abnormal labs <input type="checkbox"/> Labi during admission <input type="checkbox"/> Physician documentation			OSM	Required	
Hospitalization	CKD Stage assigned during this hospital stay	<input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Stage 5 <input type="checkbox"/> Unable to Determine			OSM	Required	
Preoperative							
Hospitalization	Tyrol Cholesterol		Stroke, Stroke-Limited		Canada, Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	None (OSMA) Required (OSMA)	
Hospitalization	Triglycerides		Stroke, Stroke-Limited		Middle-East, Canada, Mexico, OSMA	None (OSMA) Required (OSMA)	
Hospitalization	FEL		Stroke, Stroke-Limited		Middle-East, Canada, Mexico, OSMA	None (OSMA) Required (OSMA)	
Hospitalization	LDL		Stroke, Stroke-Limited, ASC/UG		Canada, Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	Required	
Hospitalization	Lipids ND		Stroke, Stroke-Limited		Canada, Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	None	
Hospitalization	Lipids NC		Stroke, Stroke-Limited		Canada, Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	None	
Hospitalization	LP(a) measurement obtained	<input type="checkbox"/> This hospitalization <input type="checkbox"/> Prior to this hospitalization <input type="checkbox"/> Planned after discharge <input type="checkbox"/> No measurement documented	Stroke, Stroke-Limited, ASC/UG		OSM	Required (ASC/UG & OSMA)	
Hospitalization	LP(a) Value		Stroke, Stroke-Limited		OSM	Required	
Hospitalization	LP(a) Unit		Stroke, Stroke-Limited		OSM	Required	
Hospitalization	LP(a) ND		Stroke, Stroke-Limited		OSM	Required	
Hospitalization	A1C		Stroke		Middle-East, Canada, Mexico, OSMA	Missing (OSMA) Required (OSMA)	
Hospitalization	What is the first blood glucose value obtained prior to or after hospital arrival? (mg/dL)		Stroke	CSX, TSC	Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	Required (OSMA)	
Hospitalization	Seven Cholesterol		Stroke		Ohio, Michigan, Middle-East, Canada, Mexico	Missing	
Hospitalization	What is the first platelet count obtained prior to or after hospital arrival?		ICH	CSX, TSC		Required	
Hospitalization	Is there documentation of any platelet count after arrival of >100,000 cells?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ICH			None	
Hospitalization	aPTT (sec)		ICH			Required	
Hospitalization	On Activity				MS	None	
Hospitalization	BNR	<input type="checkbox"/> ND <input type="checkbox"/> NC	Stroke, ICH		Ohio, Michigan, Middle-East, Canada, Mexico	Missing (OSMA) Required (OSMA)	
Hospitalization	BNR Value >= 1.4	<input type="checkbox"/> Yes <input type="checkbox"/> No	ICH	CSX		Required	
Hospitalization	Ash Factor 2a level		ICH			None	
Hospitalization	Heart Rate (beats per minute)		Stroke		Ohio, Michigan, Middle-East, Canada, Mexico	Missing	
Hospitalization	What is the first blood pressure obtained prior to or after hospital arrival?	Blood Pressure (Systolic) - Initial: _____ Blood Pressure (Diastolic) - Initial: _____	Stroke, ICH	CSX	Ohio, Michigan, Middle-East, Canada, Mexico	Required	
Hospitalization	Vital Signs: UTD		Stroke, ICH	CSX	Ohio, Michigan, Middle-East, Canada, Mexico	None	
Hospitalization	Height	_____ <input type="checkbox"/> lb <input type="checkbox"/> kg <input type="checkbox"/> ND	Stroke, Stroke-Limited		Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	Required (OSMA) & (OSMA)	
Hospitalization	Weight	_____ <input type="checkbox"/> lb <input type="checkbox"/> kg <input type="checkbox"/> ND	Stroke, Stroke-Limited		Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	Required	
Hospitalization	Waist Circumference	_____ <input type="checkbox"/> lb <input type="checkbox"/> kg <input type="checkbox"/> ND	Stroke		Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	None	
Hospitalization	BMI	_____ <input type="checkbox"/> ND	Stroke, Stroke-Limited		Ohio, Michigan, Middle-East, Canada, Mexico, OSMA	Required (OSMA) & (OSMA)	
ACCORDING TO THE PROTOCOL							
Time Tracker	Date/Time Stroke Team Activated	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time Stroke Team Arrived	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX, DW	Canada, Mexico, Middle-East	Required (DW)	
Time Tracker	Date/Time ED Provider Assessment	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX, DW	Canada, Mexico, Middle-East	Required (DW & MS)	
Time Tracker	Date/Time Neurological Services Consulted	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time Brain Imaging Ordered	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East, LA, EMS	None	
Time Tracker	Date/Time T1 Thrombolytic Ordered	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited		Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time Lab Tests Ordered	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX, DW	Canada, Mexico, Middle-East	Required (DW)	
Time Tracker	Date/Time Lab Tests Completed	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX, DW	Canada, Mexico, Middle-East	Required (DW)	
Time Tracker	Date/Time ECG Ordered	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time ECG Completed	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time Chest X-ray Ordered	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Time Tracker	Date/Time Chest X-ray Completed	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Canada, Mexico, Middle-East	None	
Endovascular Core Team							
Time Tracker	Date/Time Neurointerventional Team Activation	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Middle-East, Canada, Mexico	None	
Time Tracker	Date/Time Patient Arrival in Neurointerventional Suite	____/____/____ C MMDDYYYY only <input type="checkbox"/> NA	Stroke, Stroke-Limited	STX	Middle-East, Canada, Mexico	None	
Endovascular Activation / P201							
Advanced	To there documentation that the route of alteplase administration was intravenous (IV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX, TSC		Required	
Advanced	To there documentation that tPA thrombolytic therapy was initiated at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX		Required	
Advanced	What is the date and time that tPA thrombolytic therapy was initiated for this patient at the hospital?	<input type="checkbox"/> MMDDYYYY only <input type="checkbox"/> Unknown		CSX		Required	
Advanced	To there documentation in the medical record that the first endovascular treatment procedure was initiated greater than 6 hours after arrival at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX, TSC		Required	
Advanced	To there documentation of skin puncture at the hospital to access the arterial site selected for endovascular treatment of a cerebral artery occlusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX, TSC, DW, ADV		Required	
Advanced	What is the date and time of skin puncture at the hospital to access the arterial site selected for endovascular treatment of a cerebral artery occlusion?	<input type="checkbox"/> MMDDYYYY only <input type="checkbox"/> Unknown		Endovascular-Therapy, CSX, TSC, DW, ADV	Middle-East	Required	
Advanced	Did the patient receive intravenous (IV) alteplase at this hospital or transferring hospital prior to receiving intravenous (IV) alteplase or mechanical reperfusion therapy at the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX, TSC		Required	
Advanced	Was a mechanical endovascular reperfusion procedure attempted during the episode of care at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Endovascular-Therapy, CSX, DW, DW, ADV	Middle-East, PSL	Required	
Advanced	Was a mechanical thrombectomy procedure attempted but unsuccessful or aborted before removal of the EVT?	<input type="checkbox"/> Yes <input type="checkbox"/> No		CSX, TSC		Required	
Advanced	Was there a reason for not performing mechanical endovascular reperfusion therapy documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Endovascular-Therapy	DW	Required	
Advanced	Reasons for not performing mechanical endovascular reperfusion therapy (select all that apply):	<input type="checkbox"/> Significant pre-stroke disability (pre-stroke mRS > 1) <input type="checkbox"/> No evidence of proximal occlusion <input type="checkbox"/> mRS < 4 <input type="checkbox"/> Brain imaging not favorable/hemorrhage transformation (ASPECTS score < 6) <input type="checkbox"/> Occlusion puncture could not be initiated within 6 hours of symptom onset <input type="checkbox"/> Anatomical reason: unfavorable vascular anatomy that limits access to the occluded artery <input type="checkbox"/> Patient/family refusal <input type="checkbox"/> MERT performed at outside hospital <input type="checkbox"/> Attempts to contact contact <input type="checkbox"/> Does not include from measure population <input type="checkbox"/> Equipment-related delay <input type="checkbox"/> No endovascular specialist available <input type="checkbox"/> Delay in stroke diagnosis <input type="checkbox"/> Vascular imaging not performed <input type="checkbox"/> Advanced Age <input type="checkbox"/> Other		Endovascular-Therapy	DW	Middle-East	Required
Advanced	Was MERT treatment at this hospital, type of treatment:	<input type="checkbox"/> Retrieval device <input type="checkbox"/> Other mechanical clot retrieval device besides stent retrieval <input type="checkbox"/> Clot suction device <input type="checkbox"/> Intracranial angioplasty, with or without permanent stent <input type="checkbox"/> Catheter directed angioplasty, with or without permanent stent <input type="checkbox"/> Other		Endovascular-Therapy, CSX		Middle-East	Required
Advanced	To there documentation in the medical record of the first case of a mechanical reperfusion device to remove a clot occluding a cerebral artery at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Endovascular-Therapy, CSX, DW, ADV	PSL	Required	
Advanced	What is the date and time of the first case of a clot retrieval device at the hospital?	<input type="checkbox"/> MMDDYYYY only <input type="checkbox"/> Unknown		Endovascular-Therapy, CSX, DW, ADV	PSL, Middle-East	Required	
Advanced	Was a reason(s) for delay in performing mechanical endovascular reperfusion therapy documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Endovascular-Therapy, DW, ADV	Middle-East	Required	

Advanced	Reason for delay in performing mechanical endovascular reperfusion therapy (select all that apply)	<ul style="list-style-type: none"> Sociodemographic Other reason Core team unable to determine eligibility Management of concomitant emergent/pediatric conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) Management or experimental protocol for thrombolysis Additional proximal vascular procedure required prior to final pass (stenosis) Need for additional PPE for suspected confirmed infectious disease 	Endovascular Therapy	DNADV	Multi-Care	Required
Advanced	Does not include time from measure population	<ul style="list-style-type: none"> Delay in stroke diagnosis Thrombolysis time delay Equipment-related delay Need for additional imaging Collateral (not not available) Other 				
Advanced	What is the location of the clot in the cerebral circulation?	<ul style="list-style-type: none"> Proximal cerebral circulation Distal cerebral circulation Neither proximal or distal, OR unable to determine (LTD) from the medical record documentation 	CSX			None
Advanced	What cerebral artery is occluded?	<ul style="list-style-type: none"> Anterior cerebral artery (ACA) AT ACA Anterior communicating artery Internal carotid artery (ICA) CA terminal 1 (basilar, 1 midbasilar) Middle cerebral artery (MCA) Distal MCA M2 MCA Distal MCA Superior cerebellar artery (SCA) Basilar artery (BA) Posterior cerebral artery (PCA) Other cerebral artery branch/segment The distal location of the primary occluded vessel was not documented, OR unable to determine (LTD) from the medical record documentation 	CSX, TSC			Required
Advanced	Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade	<ul style="list-style-type: none"> Grade 1 Grade 2a Grade 2b Grade 3 IND 	Endovascular Therapy	CSX, DNADV	Multi-Care	Required (DNV)
Advanced	Is there a documented TICI reperfusion grade post-treatment?	<ul style="list-style-type: none"> 1 - A TICI reperfusion grade greater than or equal to (+) 2B was documented post-treatment 2 - A TICI reperfusion grade was less than 2B was documented post-treatment 3 - A TICI reperfusion grade was not done post-treatment, OR unable to determine (LTD) from the medical record documentation 	CSX, TSC			Required
Advanced	What was the date and time that TICI 2c was first documented during the mechanical thrombectomy procedure?	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 	Endovascular Therapy	ASL, CSX, DNADV	Multi-Care	Required
Advanced	Date/Time End of Endovascular Procedure	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 	Endovascular Therapy	CSX	Multiple, Multi-Care	None
Advanced	Complications					
Advanced	Was there a possible finding on brain imaging of parenchymal hemorrhage, subarachnoid hemorrhage, and/or intraventricular hemorrhage following IV or IA alteplase therapy, or mechanical endovascular reperfusion therapy administered?	<ul style="list-style-type: none"> Yes No 	Endovascular Therapy	CSX, TSC		Required
Advanced	Date/Time of positive brain image	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 	Endovascular Therapy	CSX, TSC		Required
Advanced	Results of abnormal brain image	<ul style="list-style-type: none"> PHI (parenchymal hemorrhage Type 2) PH (parenchymal hemorrhage) SDH (subdural hemorrhage) SD (subarachnoid hemorrhage) RIH (Rancho site of intraparenchymal hemorrhage outside the area of infarction) Other possible finding not listed above Not documented 	Endovascular Therapy	CSX, TSC		Required
Advanced	This score obtained from (documented prior to initiation of IV alteplase at this hospital)	<ul style="list-style-type: none"> Baseline NHISS Subsequent NHISS 		CSX	Multi-Care	None
Advanced	What is the last NHISS score documented prior to initiation of IV alteplase at this hospital?	LTD	Endovascular Therapy	CSX, TSC		Required
Advanced	What is the highest NHISS score documented within 36 hours following initiation of IV alteplase?	LTD	Endovascular Therapy	CSX, TSC		Required
Advanced	This score obtained from (documented prior to initiation of IA alteplase or MER at this hospital)	<ul style="list-style-type: none"> Baseline NHISS Subsequent NHISS 	Endovascular Therapy	CSX, TSC	Multi-Care	Required
Advanced	What is the last NHISS score documented prior to initiation of IA alteplase or MER at this hospital?	<ul style="list-style-type: none"> Baseline NHISS Subsequent NHISS 	Endovascular Therapy	CSX, TSC	Multi-Care	Required
Advanced	What is the highest NHISS score documented within 36 hours following IA alteplase or MER initiation?	LTD	Endovascular Therapy	CSX, TSC		Required
Advanced	BP lowering agent administered at your hospital	<ul style="list-style-type: none"> Yes No/ND INC 		CA		Required
Advanced	Date/Time of first administration of a BP lowering agent at your hospital	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 		CA		Required
Advanced	Systolic BP never escalated at <= 149 for >= 3 minutes	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 		CA		Required
Advanced	Systolic BP never escalated at <= 149 for >= 5 minutes			CA		None
Advanced	Is there documentation that a procoagulant reversal agent was initiated at this hospital?	<ul style="list-style-type: none"> Yes No 		CA, CSX		Required
Advanced	If yes, select reversal agent administered (at this hospital)	<ul style="list-style-type: none"> Prothrombin complex concentrate (PCC) <ul style="list-style-type: none"> 3-factor prothrombin complex concentrate (3-factor PCC) 4-factor prothrombin complex concentrate (4-factor PCC) Activated prothrombin complex concentrate (APCC) Fresh frozen plasma (FFP) Factor Xa reversal - Andexa (andexanet alfa) Protease (dabigatran) reversal - Praxidar (dabicitran) Protamine Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) Other 		CA		Required
Advanced	Date/Time procoagulant initiated	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 		CA, CSX		Required
Advanced	If reversal therapy was initiated greater than 90 minutes after arrival, were reasons (documented as cause for delay)?	<ul style="list-style-type: none"> Yes No 		CA		Required
Advanced	Causes for delay in reversal therapy (greater than 90 minutes after arrival)	<ul style="list-style-type: none"> Unable to determine last dose of anticoagulant Information on anticoagulant status not readily available Unable to determine time of symptom onset Lab delay in INR or PT/PTT/PTT results Delay in stroke diagnosis Delay in lab testing Delay in imaging results reported Equipment-related delay Initial refusal Management of concomitant emergent/pediatric conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) Sociodemographic Other 		CA		Required
Advanced	If reversal therapy was initiated greater than 90 minutes after arrival, were reasons (documented as cause for delay)?	<ul style="list-style-type: none"> Yes No 		CA		Required
Advanced	Causes for delay in reversal therapy (greater than 90 minutes after arrival)	<ul style="list-style-type: none"> Unable to determine last dose of anticoagulant Information on anticoagulant status not readily available Unable to determine time of symptom onset Lab delay in INR or PT/PTT/PTT results Delay in stroke diagnosis Delay in lab testing Delay in imaging results reported Equipment-related delay Initial refusal Management of concomitant emergent/pediatric conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) Sociodemographic Other 		CA		Required
Advanced	Was a repeat dose of procoagulant reversal agent required for this patient?	<ul style="list-style-type: none"> Yes No 		CA		None
Advanced	If yes, select reversal agent used for rebleeding administration	<ul style="list-style-type: none"> Prothrombin complex concentrate (PCC) <ul style="list-style-type: none"> 3-factor prothrombin complex concentrate (3-factor PCC) 4-factor prothrombin complex concentrate (4-factor PCC) Activated prothrombin complex concentrate (APCC) Fresh frozen plasma (FFP) Factor Xa reversal - Andexa (andexanet alfa) Protease (dabigatran) reversal - Praxidar (dabicitran) Protamine Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) Other 		CA		Required
Advanced	Date/Time of Procoagulant rebleeding	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 		CA		Required
Advanced	Was a procoagulant reversal agent administered to the patient prior to arrival at your hospital (in MSU or first hospital)?	<ul style="list-style-type: none"> Yes No 		CA		Required
Advanced	If yes, select reversal agent administered (prior to arrival)	<ul style="list-style-type: none"> Prothrombin complex concentrate (PCC) <ul style="list-style-type: none"> 3-factor prothrombin complex concentrate (3-factor PCC) 4-factor prothrombin complex concentrate (4-factor PCC) Activated prothrombin complex concentrate (APCC) Fresh frozen plasma (FFP) Factor Xa reversal - Andexa (andexanet alfa) Protease (dabigatran) reversal - Praxidar (dabicitran) Protamine Other factor complexes (including anti-inhibitor coagulant complex, factor IX complex) Other 		CA		Required
Advanced	Was Vitamin K administered to this patient?	<ul style="list-style-type: none"> Yes, prior to arrival (in MSU or first hospital) Yes, at your hospital No 		CA		Required
Advanced	Other reversal therapy administered at this hospital	<ul style="list-style-type: none"> Activated charcoal Renal replacement therapy (RRT) Other non-pharmacological therapy Specify other non-pharmacological therapy at this hospital _____ None 		CA		Required
Advanced	Other reversal therapies prior to arrival	<ul style="list-style-type: none"> Activated charcoal Renal replacement therapy (RRT) Other non-pharmacological therapy Specify other non-pharmacological therapy at this hospital _____ None 		CA		Required
Advanced	Is there documentation by a physician/NP/PA or pharmacist in the medical record of a reason for not administering a procoagulant reversal agent?	<ul style="list-style-type: none"> Yes No 		CA, CSX		Required
Advanced	If patient is currently taking DOACs, is there documentation in the medical record of a reason for not administering an anticoagulant reversal agent?	<ul style="list-style-type: none"> Yes, medical reason Yes, patient reason Yes, system reason No 		CA		Required
Advanced	INR (INR - 1) and treated with procoagulant, Date/Time last INR >= 1.4 after treatment	<ul style="list-style-type: none"> MM/DD/YYYY only Unknown 		CSX		None

Advanced	No documented PRT = 1.4 after treatment	<input type="checkbox"/>		CSX			None
External Ventricular Drain							
Advanced	Was an External Ventricular Drain (EVD) placed during the hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI, Anesth-Report	DM, DM-ADV			Required
Advanced	Date/Time EVD placed	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	SAI	DM			Required
Advanced	Was the patient diagnosed with ventriculitis during the hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI, Anesth-Report	DM, DM-ADV			Required
Drugs (Medications)							
Advanced	Is there documentation that remdesivir was administered at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI	CSX, DM			Required
Advanced	What is the date and time that remdesivir was first administered to this patient at this hospital?	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	SAI	CSX, DM			Required
Advanced	Is there documentation of a prescription/PPR (as per protocol in the medical record) of a reason for not administering remdesivir treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI	CSX, DM			Required
Advanced	Specify reason(s) for not administering remdesivir treatment	<input type="checkbox"/> Remdesivir Allergy <input type="checkbox"/> Integritation or no prescriber <input type="checkbox"/> Route of administration unavailable <input type="checkbox"/> Other	SAI				Required
Advanced	Was remdesivir continued until discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No		DM			Required
Advanced	Date and time that remdesivir was discontinued	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown		DM			Required
Advanced	Documented reason(s) for not continuing remdesivir treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		DM			Required
Advanced	**Surgical treatment for CHT at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ICH	CSX, DM			Required
Advanced	**Surgical treatment for CHT at this hospital, type	<input type="checkbox"/> Conventional craniotomy and evacuation of clot under direct vision <input type="checkbox"/> External Ventricular Drain (EVD) <input type="checkbox"/> Endoscopic infusion via catheter <input type="checkbox"/> Neuroendoscopy <input type="checkbox"/> Without clot evacuation <input type="checkbox"/> With clot evacuation <input type="checkbox"/> Minimally Invasive <input type="checkbox"/> Catheter aspiration followed by Thrombolysis <input type="checkbox"/> Tubular tractor <input type="checkbox"/> Endoscopic assisted <input type="checkbox"/> Suboccipital decompression <input type="checkbox"/> Other intracranial monitoring <input type="checkbox"/> Other neurosurgical treatment	ICH	CSX			Required
Advanced	Surgical treatment for CHT at this hospital is, what was the procedure (date first)?	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	ICH	DM			Required
Advanced	**ECH was evacuated, time from idea to evacuation procedure and date		ICH	CSX			None
Advanced	Was an AVM repair attempted during the episode of care at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		DM-ADV			None
Advanced	Did the patient experience any serious complications within 24 hours of the AVM repair procedure?	<input type="checkbox"/> No serious complications <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> Symptomatic Intracranial Hemorrhage <input type="checkbox"/> Death <input type="checkbox"/> Other Serious		DM-ADV			Required
Advanced	Was the patient treated with an IV or oral corticosteroid?	<input type="checkbox"/> Yes, prior to arrival (in MICU or Intensive) <input type="checkbox"/> Yes, at your hospital <input type="checkbox"/> No	ICH				Required
Advanced	Documentation of a neurological or other medical reason for prescribing corticosteroids	<input type="checkbox"/> Yes <input type="checkbox"/> No	ICH				Required
Advanced	Was the patient administered a platelet transfusion at your hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ICH				Required
Advanced	Initial Platelet Transfusion Date/Time	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	ICH				Required
Procedures							
Advanced	Was a cerebral aneurysm repair attempted during this episode of care at this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI, Anesth-Report	DM, DM-ADV			Required
Advanced	Documented reason for not attempting aneurysm repair	<input type="checkbox"/> Yes <input type="checkbox"/> No	SAI				Required
Advanced	Repair Approach(es)	<input type="checkbox"/> Surgical clipping <input type="checkbox"/> Endovascular coiling (embolization) <input type="checkbox"/> Conventional <input type="checkbox"/> Stent-assisted (stent permanently deployed) <input type="checkbox"/> Temporary balloon or stent-assisted <input type="checkbox"/> Flow diverter <input type="checkbox"/> Other endovascular device <input type="checkbox"/> Other (specify) _____	SAI, Anesth-Report	DM, DM-ADV			Required
Advanced	What is the location of the cerebral aneurysm?	<input type="checkbox"/> Anterior circulation <input type="checkbox"/> Posterior circulation	SAI, Anesth-Report				None
Advanced	What is the size of the aneurysm (mm)	_____	SAI, Anesth-Report				None
Advanced	Was the aneurysm ruptured prior to repair procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Documented	SAI, Anesth-Report	DM, DM-ADV			Required
Advanced	Fisher Scale grade prior to repair:	<input type="checkbox"/> Grade 1: No subarachnoid hemorrhage or intraventricular hemorrhage detected <input type="checkbox"/> Grade 2: Diffuse 0-1 mm subarachnoid hemorrhage <input type="checkbox"/> Grade 3: Localized clot and/or layer of blood >1 mm in thickness <input type="checkbox"/> Grade 4: Diffuse or no subarachnoid hemorrhage, intraventricular hemorrhage or intraventricular hemorrhage present <input type="checkbox"/> ND or Unable to Determine from medical record	SAI, Anesth-Report				None
Advanced	Date/time repair procedure initiated	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	SAI, Anesth-Report	DM			Required
Advanced	Date/time repair procedure completed	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	SAI				Required
Advanced	Documented reason for delay in aneurysm repair	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	SAI				Required
Advanced	Specify reason(s) for delay in aneurysm repair	<input type="checkbox"/> Social/hygienic <input type="checkbox"/> Initial refusal <input type="checkbox"/> Care team unable to determine eligibility <input type="checkbox"/> Patient not medically stable <input type="checkbox"/> Medical futility <input type="checkbox"/> Resource limitations*	SAI				Required
Advanced	Post-procedure Hunt and Hess scale done	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	SAI				Required
Advanced	Post-procedure Hunt and Hess score	_____	SAI				None
Advanced	What is the date and time that the Hunt and Hess scale was first performed post-procedure?	____/____/____ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown	SAI				Required
Advanced	Did the patient experience any serious complications during the aneurysm repair procedure, or within 24 hours of the procedure?	<input type="checkbox"/> No serious complications <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> Symptomatic Intracranial Hemorrhage <input type="checkbox"/> Death <input type="checkbox"/> Other serious (please specify) _____	SAI, Anesth-Report				Required
Discharge							
Discharge	Discharge (SAI) - Inpatient Stroke Only	Discharge	Stroke, Stroke-Unit				None
Discharge	Discharge (SAI) - Outpatient Stroke	Discharge	Stroke, Stroke-Unit				None
Discharge	Was a Modified Rankin Scale (mRS) performed at discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	Stroke	DM	LA, ME, PT, DM, DM-ADV		Required
Discharge	Method used to obtain Modified Rankin Scale at discharge	<input type="checkbox"/> Actual <input type="checkbox"/> Estimated from the record <input type="checkbox"/> ND	Stroke		LA, ME, PT, DM, DM-ADV		None
Discharge	Modified Rankin at Discharge, Total Score	_____	Stroke	DM	Consul, LA, ME, DM, DM-ADV		Required
Discharge	Modified Rankin Scale at Discharge	<input type="checkbox"/> 0 - No symptoms at all <input type="checkbox"/> 1 - No significant disability despite symptoms. Able to carry out all usual activities <input type="checkbox"/> 2 - Slight disability <input type="checkbox"/> 3 - Moderate disability. Requiring some help but able to walk without assistance <input type="checkbox"/> 4 - Moderate to severe disability. Unable to walk without assistance and unable to attend to own bodily needs without assistance <input type="checkbox"/> 5 - Severe disability. Bedridden, incontinent and requiring constant nursing care and attention <input type="checkbox"/> 6 - Death	Stroke		LA, ME, PT, DM, DM-ADV		None
Discharge	Arbitrary status at discharge?	<input type="checkbox"/> Able to ambulate independently (no help from another person) w/ or w/o device <input type="checkbox"/> With assistance (from person) <input type="checkbox"/> Unable to ambulate <input type="checkbox"/> ND	Stroke		Consul, CH, MI, ME, DM, DM-ADV		Required
Discharge (Blood Pressure) (SAI) - Discharge							
Discharge	Blood Pressure (Systolic) - Discharge	_____	Stroke, CH		CH, MI, ME, DM, DM-ADV		Required
Discharge	Blood Pressure (Diastolic) - Discharge	_____	Stroke, CH		CH, MI, ME, DM, DM-ADV		Required
Discharge	Discharge Blood Pressure Not Documented	<input type="checkbox"/>	Stroke, CH				None
Discharge	Did the patient receive any antihypertensive medication on the day of or the day prior to discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	CH				Required
Discharge	Were there two or more systolic blood pressure readings > 130 within 24 hours prior to the time of discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	CH				Required
Discharge (BUN/Creatinine) (SAI)							
Discharge	Urinary Albumin (mg/dL)	<input type="checkbox"/> Unavailable					OBMI
Discharge	Urinary Serum Creatinine (mg/dL)	<input type="checkbox"/> Unavailable					OBMI
Discharge	Urinary Albumin-to-Creatinine Ratio (mg/g)	<input type="checkbox"/> Unavailable					OBMI
Discharge	uGFR (4.73x10 ⁻¹ 73x2)	<input type="checkbox"/> Unavailable					OBMI
Discharge	CKD Risk Calculated During this Hospital Stay	<input type="checkbox"/> Unavailable					OBMI
Discharge (Medications) (SAI) - Discharge							
Discharge	Anticoagulant Medication(s) Prescribed at Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No/ND <input type="checkbox"/> NC	Stroke, Stroke-Unit		Consul, CH, MI, ME, DM, DM-ADV		Required

Certification	Was antimicrobial therapy administered by the end of hospital day 07 (STK)?	<input type="radio"/> Yes <input type="radio"/> No	ASL STL TSC			Required
Demographics						
Certification	Discharge Date/Time (ACT)	<input type="radio"/> MMDDYYYY only <input type="radio"/> UTD	ASL STL CEN TSC			Required
Certification	Was antimicrobial therapy prescribed at hospital discharge?	<input type="radio"/> Yes <input type="radio"/> No	ASL STL TSC			Required
Certification	Is there documentation by a physician/advanced practice nurse/physician assistant (physician/NP/PA) or pharmacist in the medical record of a reason for not prescribing antimicrobial therapy at hospital discharge?	<input type="radio"/> Yes <input type="radio"/> No	ASL STL TSC			Required
Certification	Was anticoagulation therapy prescribed at hospital discharge?	<input type="radio"/> Yes <input type="radio"/> No	STL TSC			Required
Certification	Is there documentation by a physician/advanced practice nurse/physician assistant (physician/NP/PA) or pharmacist in the medical record of a reason for not prescribing anticoagulation therapy at hospital discharge?	<input type="radio"/> Yes <input type="radio"/> No	STL TSC			Required
Certification	Was a statin medication prescribed at discharge?	<input type="radio"/> Yes <input type="radio"/> No	STL TSC			Required
Outpatient						
Outpatient	Hospital MRN				OMG-OP-03	None
Outpatient	Other MRN				OMG-OP-03	None
Outpatient	External Tracking ID				OMG-OP-03	None
Outpatient	Encounter Date	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown	ASL STL TSC		OMG-OP-03	Required
Outpatient	EM Code		ASL STL TSC		OMG-OP-03	Required
Outpatient	Arrival Date/Time (OP STK)	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			OMG-OP-03	None
Demographics						
Outpatient	Birth Date (OP STK)	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			OMG-OP-03	Required
Outpatient	Sex (OP STK)	<input type="radio"/> Female <input type="radio"/> Male			OMG-OP-03	None
Outpatient	Race (OP STK)	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian (2020) / Asian or Pacific Islander (2021) <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Pacific Islander (discharge prior to 2021) <input type="radio"/> White <input type="radio"/> UTD			OMG-OP-03	Required
Outpatient	Hispanic Ethnicity (OP STK)	<input type="radio"/> Yes <input type="radio"/> No			OMG-OP-03	Required
Outpatient	Patent Zip Code (OP STK)				OMG-OP-03	Required
Outpatient	Zip Code Extension (OP STK)				OMG-OP-03	None
Outpatient	Homeless (OP STK)	<input type="checkbox"/>			OMG-OP-03	None
Insurance						
Outpatient	What is the patient's source of payment for this outpatient encounter?	<input type="radio"/> Medicare <input type="radio"/> Non-Medicare			OMG-OP-03	Required
Discharge						
Outpatient	What is the date/time the patient departed from the emergency department?	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown	ASL STL TSC		OMG-OP-03	Required
Outpatient	For discharges on or after 07/01/2012, What was the patient's discharge code from the outpatient setting?	<input type="checkbox"/> Home - Home <input type="checkbox"/> Hospice - Home <input type="checkbox"/> Hospice - Health Care Facility <input type="checkbox"/> An Acute Care Facility - General Inpatient Care <input type="checkbox"/> An Acute Care Facility - Critical Access Hospital <input type="checkbox"/> An Acute Care Facility - Cancer Hospital or Children's Hospital <input type="checkbox"/> An Acute Care Facility - Department of Defense or Veterans Administration <input type="checkbox"/> Other Health Care Facility <input type="checkbox"/> Deceased <input type="checkbox"/> Left Against Medical Advice/WAA <input type="checkbox"/> Not Documented or Unable to Determine (UTD)	ASL STL TSC		OMG-OP-03	Required
Head CT or MRI Done and Read Known (H)						
Outpatient	Was a Head CT or MRI scan ordered by the physician during the emergency department visit?	<input type="radio"/> Yes <input type="radio"/> No			OMG-OP-03	Required
Outpatient	Is there documentation that the date and time of last known well was witnessed or reported (Discharge)?	<input type="radio"/> Yes <input type="radio"/> No			OMG-OP-03	Required
Outpatient	What was the date and time at which the patient was last known to be well or at her/his baseline state of health? (Outpatient)	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			OMG-OP-03	Required
Outpatient	What is the date and time the earliest Head CT or MRI Scan Interpretation was completed or reported?	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			OMG-OP-03	Required
SPECIAL NOTES						
Special	If yes, Reasons transported to this facility:	<input type="checkbox"/> Met EMS stroke protocol criteria <input type="checkbox"/> Presumed diagnosis in the field is Ischemic Stroke, Transient Ischemic Attack, Intracerebral Hemorrhage, Intraventricular Hemorrhage, or Subarachnoid Hemorrhage <input type="checkbox"/> Neurological <input type="checkbox"/> Transferred from another hospital for higher level of care <input type="checkbox"/> None of the above			A2E6	None
Special	Receiving Facility:				A2E6	Required
Special	Provider Agency:				A2E6	Required
Special	Run Number:				A2E6	Required
Special	Unit Number:				A2E6	None
Special	Dispatched as a Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NED			A2E6	None
Special	Date/Time patient last known well per EMS:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Date/Time of discovery of stroke symptoms per EMS:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Date/Time Dispatched:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Date/Time EMS arrival at patient:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Date/Time EMS departed scene:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Date/Time EMS arrived at hospital:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	Required
Special	Transfer from a Hospital (Different Facility):	<input type="checkbox"/> Yes <input type="checkbox"/> No			A2E6	Required
Special	If A catheter-based reperfusion initiated at the hospital, type:	<input type="checkbox"/> IA Thrombolysis <input type="checkbox"/> Endovascular Aspiration Device <input type="checkbox"/> Endovascular Retrievable Device <input type="checkbox"/> Angioplasty and/or Stenting <input type="checkbox"/> Other			A2E6	None
Special	Date/Time groin puncture (infiltrary time):	<input type="radio"/> MMDDYYYY only <input type="radio"/> Not Documented			A2E6	None
PHYSICIAN						
Special	Pre-hospital stroke screen findings	<input type="checkbox"/> Yes <input type="checkbox"/> No			MS004	None
Special	Last Known Well	<input type="checkbox"/> Yes <input type="checkbox"/> No			MS004	None
Special	If advanced notification by EMS, was the stroke team activated prior to patient arrival?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Documented <input type="checkbox"/> Not Applicable			MS004	None
Special	Was patient transferred from an inpatient floor to another acute care hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No			MS004	None
Special	If patient was transferred from acute ED or from an inpatient floor to another acute care hospital, select reason for transfer (check all that apply):	<input type="checkbox"/> Ischemic Stroke (for IV alteplase within the 3 hr treatment window) <input type="checkbox"/> Ischemic Stroke (for IV alteplase within the 3-4.5 hr treatment window) <input type="checkbox"/> Ischemic Stroke (for reperfusion interventions only, not IV alteplase) <input type="checkbox"/> Ischemic Stroke - neurocritical or neurosurgical care <input type="checkbox"/> CTA interventional procedure, neurocritical, or neurosurgical care <input type="checkbox"/> DVT interventional procedure, neurocritical, or neurosurgical care <input type="checkbox"/> Patient/Family requests transfer <input type="checkbox"/> Transferred to a procedure or treatment not related to stroke <input type="checkbox"/> Reason for transfer not documented <input type="checkbox"/> Other, please specify _____			MS004	Required
Special	Date/Time MD/DO/PNP Assessment:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			MS004	None
Special	Date/Time Stroke Team Arrival (treatment decision made):	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			MS004	None
Special	Date/Time Brain Image Reported/Read:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			MS004	None
Special	NIH Stroke Scale at discharge:				MS004	None
PHYSICIAN						
Special	Did EMS pre-notification contain the following (check all that apply):	<input type="checkbox"/> Adult Pk <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Previous Stroke/TIA <input type="checkbox"/> CAD/Prior MI <input type="checkbox"/> Hypertension <input type="checkbox"/> Smoker <input type="checkbox"/> Diabetes Mellitus			MS004	None
PHYSICIAN						
Special	Date/Time Transport Requested:	<input type="radio"/> MMDDYYYY only <input type="radio"/> Unknown			MS004 MD, Med-Request Stroke, Health-Service	None

Special	Date/Time Transport Arrived	MMDDYYYY only Unknown			MSDGM, MDL, West Region Stroke, Metabolic Transfer	None	
Special	Date/Time Transfer Requested by Referring Hospital	MMDDYYYY only Unknown			MSDGM, MDL, West Region Stroke, Metabolic Transfer	None	
Special	Date/Time Transfer Accepted by Receiving Hospital	MMDDYYYY only Unknown			MSDGM, MDL, West Region Stroke, Metabolic Transfer	None	
Special	Mode of Transport	Air Ground Ambulance			West Region Stroke, Metabolic Transfer	None	
Special	Inter-Facility EMS Agency				West Region Stroke, Metabolic Transfer	None	
Special	Date/Time of Acute Stroke Team Consultation	MMDDYYYY only Unknown			Michigan	None	
Special	No Acute Stroke Team Consultation				Michigan	None	
Special	N/A - No Acute Stroke Team				Michigan	None	
Other							
Special	Admit From	Home Nursing Home Skilled Nursing Facility or Inpatient Rehabilitation Facility Another Acute Care Hospital (Inpatient) Other N/A			Ohio	None	
Special	Follow-up not applicable due to discharge status	Yes No			Ohio	None	
Special	Was a follow-up appointment made prior to discharge for the patient to see their pre-admission Primary Care Provider (PCP)?	Yes - Evidence that appointment was made No - Patient has a PCP but no evidence that appointment was made NA - Patient did not have a PCP prior to hospitalization			Ohio	None	
Special	If the patient was not being followed by a PCP prior to admission, was a PCP assigned prior to discharge?	Yes - Patient was assigned a PCP No - Patient was not assigned a new PCP Yes - Evidence that appointment was made No - No evidence that appointment was made			Ohio	None	
Special	If a new PCP was assigned to the patient, was a follow-up appointment with the new PCP made prior to discharge?	Yes - Evidence that appointment was made No - No evidence that appointment was made			Ohio	None	
Special	Was a referral ordered or recommended for a follow-up appointment after discharge with a Neurologist, Neurosurgeon or Neurology Provider?	Yes - Referral was ordered or recommended No - No evidence of a referral ordered or recommended NA - Referral to Neurology Provider was not appropriate			Ohio	None	
Special	Was a follow-up appointment made prior to discharge for the patient to see a Neurologist, Neurosurgeon or Neurology Provider?	Yes - Evidence that appointment was made No - No evidence that appointment was made			Ohio	None	
Special	Date/Time First Seen by ED MD	MMDDYYYY only Unknown			Ohio	None	
Other							
Special	FFR: What is your preferred language?	English Spanish French/Creole Other Not Documented/LTD			Florida Stroke Registry	Required	
Special	FFR: What is your highest grade or year of school you have completed?	Less than high school Completed high school Some college or more Not Documented/LTD			Florida Stroke Registry	Required	
Provision							
Special	Was a mobile communications app used to message the patient?	Yes No N/A			Alabama	Required	
Special	Mobile communications app that was used	Pulsen Other			Alabama	Required	
Special	What was the indication for use of a mobile communications app?	To pre-notify Stroke team In-hospital transfer Transfer CT scans/ images Neurology consult To control waiting or "step and skip" facility Other			Alabama	Required	
Special	Who created the patient channel using the mobile communications app?	EMS (prior to arrival) ED Other			Alabama	Required	
Special	What time was the patient channel opened?	Unknown			Alabama	Required	
Special	What time was the communication sent through the mobile communications app?	Unknown			Alabama	Required	
Telestroke							
Telestroke	If Yes, telestroke consult performed, select all applicable delivery methods.	Interactive Video Teleneurology Telephone Call N/A	Telestroke		Multi-Care	None	
Telestroke	What was the type of Telestroke provider?	Hospital Based (In-State) Hospital Based (Out-of-State) Private Provider (Independent)	Telestroke		Multi-Care	Required	
Telestroke	Who provided Telestroke Service?		Telestroke		Multi-Care	None	
Telestroke	Did the Telestroke consultant recommend transfer?	Yes No N/A	Telestroke		Multi-Care	None	
Telestroke	Patient transfer status after Telestroke consult (T, AC or equivalent)	Not Transferred Transferred to Transferred to TISC Transferred to CSC Transferred to Unknown	Telestroke		Multi-Care	Required	
Telestroke	Which option best describes the destination facility for transferred patient?	Hospital where the telestroke consultant primarily practices Hospital unrelated to the telestroke consultant and outside of my health system Hospital unrelated to the telestroke consultant but within my health system Unable to determine from medical record	Telestroke		Multi-Care	Required	
Telestroke	Did Telestroke consultation result in thrombolytic administration at the referring site?	Yes No N/A	Telestroke		Multi-Care	Required	
Telestroke Stroke Status							
Telestroke	Date/Time of End of Neurological Maximal Recovery	MMDDYYYY only Unknown	Telestroke		MD	Required	
Telestroke	Date/Time of first Telestroke consultation request	MMDDYYYY only Unknown	Telestroke	DW	Multi-Care	Required	
Telestroke	Date/Time Telestroke Response	MMDDYYYY only Unknown	Telestroke	DW	Multi-Care	Required	
Telestroke	Date/Time start of Telestroke video session	MMDDYYYY only Unknown	Telestroke		Multi-Care	Required	
Telestroke	Date/Time Decision to Administer Thrombolytic (By Telestroke)	MMDDYYYY only Unknown	Telestroke		Multi-Care	None	
Telestroke	Additional Comments:		Telestroke		Multi-Care	None	
Telestroke Equipment System							
Telestroke	How was telestroke used?	Camera on Phone only No Console Not a telestroke case N/A			PTSD	None	
Telestroke	Session Time (the time the robot was turned on)	MMDDYY N/A			PTSD	None	
Telestroke	Consulting Neurologist or Neurosurgeon?				PTSD	None	
Telestroke	Stroke Symptom Great Zip Code	None			PTSD	None	
Telestroke	Date and Time first ED physician saw the patient	MMDDYY N/A			PTSD	None	
Telestroke	When was last NISS done?	ED On admission to hospital unit Within 12 hours from ED arrival Between 12 and 24 hours from ED arrival More than 24 hours from ED arrival N/A			PTSD	None	
Telestroke	24 hour post treatment NISS (1-6 hours from the 24 hour mark)	N/A N/A			PTSD	None	
Telestroke	Discharge NISS (All Patients)	N/A N/A			PTSD	None	
Telestroke	Treatment related mortality? (if your patient died, did they die due to documented complications from treatment with alteplase?)	Yes No/N/A			PTSD	None	
Telestroke	What state was the hospital in?	Oregon Washington Maine Not Documented			PTSD	None	
Telestroke	Please select the Hospital:				PTSD	None	
Telestroke	Type of Transfer (if your patient transferred FROM your hospital to another acute care facility, by what mode did they travel?)	Air Ambulance Combination of Air and Ambulance			PTSD	None	
Telestroke	Pre-symptom onset Barthel Score	0-5: No independence at all 1-1: No significant disability despite symptoms, able to carry out all usual duties and activities 2-2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3-3: Moderate disability; requiring some help, but able to walk without assistance 4-4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5-5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6-6: Dead Unknown: Check this category only if you definitely cannot classify the patient status			PTSD	None	

Telestroke	Discharge Rankin Scale	<input type="checkbox"/> 0 - No symptoms at all <input type="checkbox"/> 1 - No significant disability despite symptoms, able to carry out all usual duties and activities <input type="checkbox"/> 2 - Slight disability, unable to carry out all previous activities, but able to look after own affairs without assistance <input type="checkbox"/> 3 - Moderate disability, requiring some help, but able to walk without assistance <input type="checkbox"/> 4 - Moderately severe disability, unable to walk without assistance and unable to attend to own bodily needs without assistance <input type="checkbox"/> 5 - Severe disability, bedridden, incontinent and requiring constant nursing care and attention <input type="checkbox"/> 6 - Dead <input type="checkbox"/> Unknown: Check this category only if you definitely cannot classify the patient status				PTSA	None
Telestroke	What state was the hospital in?	<input type="checkbox"/> Oregon <input type="checkbox"/> Washington <input type="checkbox"/> Idaho <input type="checkbox"/> Not Documented				PTSA	None
Telestroke	Patient Transferred From Location	_____				PTSA	None
Telestroke	Type of Transfer: If your patient transferred TO your hospital from another acute care facility, by what mode did they travel?	<input type="checkbox"/> Air <input type="checkbox"/> Ambulance <input type="checkbox"/> Combination of Air and Ambulance				PTSA	None
Telestroke	Optional Field 1	_____				PTSA	None
Telestroke	Optional Field 2	_____				PTSA	None
LAEMS							
LAEMS	WOLSON CRITERIA: Patients Transported by 0-1-1 to their Facility OR Arrive to their Facility via 0-1-1	<input type="checkbox"/> Yes <input type="checkbox"/> No				LAEMS	Required
LAEMS	If yes, select all that apply:	<input type="checkbox"/> Did the Patient Meet the Prehospital Care Stroke Policy? <input type="checkbox"/> Was the First Hospital or ED Diagnosis Ischemic Stroke, Transient Ischemic Attack, Intracranial Hemorrhage, Intracranial Hemorrhage, or Subarachnoid Hemorrhage? <input type="checkbox"/> Was the Patient Transported to Your Facility because Facility is Stroke Center? <input type="checkbox"/> Was Patient Transferred from Another Facility for Stroke Care?				LAEMS	Required
LAEMS	Transfer from a Hospital (Different Facility)	_____				LAEMS	None
LAEMS	Receiving Facility	_____				LAEMS	Required
LAEMS	Provider Agency/Code	_____				LAEMS	Required
LAEMS	Sequence Number	_____				LAEMS	Required
LAEMS	ALS Unit Number	<input type="checkbox"/> Unknown				LAEMS	None
LAEMS	Dispatch Date/Time	<input type="checkbox"/> M/M/DD/YYYY only <input type="checkbox"/> Unknown				LAEMS	Required
LAEMS	Mode of arrival	<input type="checkbox"/> RTT air <input type="checkbox"/> RTT ground <input type="checkbox"/> Air private <input type="checkbox"/> Ground private <input type="checkbox"/> Mobile Stroke Unit <input type="checkbox"/> N/D				LAEMS	Required
LAEMS	Patient Initial Complaint Codes	Y: _____				LAEMS	Required
LAEMS	Provider Primary Impression	Y: _____				LAEMS	Required
LAEMS	Advanced Notification by EMS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/D				LAEMS	Required
LAEMS	Field Triage Decision:	<input type="checkbox"/> M - Most Accessible Receiving Facility (MARF) <input type="checkbox"/> A - Primary Stroke Center (PSC) <input type="checkbox"/> SC - Comprehensive Stroke Center (CSC) <input type="checkbox"/> U - Unknown <input type="checkbox"/> N/D - Not Documented				LAEMS	None
LAEMS	Last Known Well Date/Time Documented by EMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				LAEMS	None
LAEMS	Date/Time patient last known well per EMS	<input type="checkbox"/> M/M/DD/YYYY only <input type="checkbox"/> Not Documented				LAEMS	Required
LAEMS	Date/Time of EMS arrival at patient?	<input type="checkbox"/> M/M/DD/YYYY only <input type="checkbox"/> Not Documented				LAEMS	Required
LAEMS	HLAPSS Documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/D				LAEMS	Required
LAEMS	HLAPSS criteria met:	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/D <input type="checkbox"/> N/A				LAEMS	Required
LAEMS	LAMS performed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/D				LAEMS	Required
LAEMS	LAMS Score	_____				LAEMS	Required
LAEMS	Pre-hospital Research Study Enrollment	<input type="checkbox"/> Yes <input type="checkbox"/> No				LAEMS	None
LAEMS	Blood Glucose (mg/dL) documented by EMS	<input type="checkbox"/> Unknown				LAEMS	Required
LAEMS	Complications of Thrombolytic Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/D				LAEMS	None
LAEMS	Complications:	<input type="checkbox"/> ICH: Intracranial hemorrhage >30 hours from initiation of therapy - a CT within 30 hours shows intracranial hemorrhage AND physician's notes indicate clinical deterioration due to hemorrhage <input type="checkbox"/> HEM: Systemic hemorrhage >30 hours from initiation of therapy - bleeding within 30 hours of therapy and > 3 transfused units of blood within 7 days, or before discharge (whichever is earlier) AND physician note attributing bleeding problem as reason for transfusion <input type="checkbox"/> OTH - Other _____				LAEMS	Required
LAEMS	ED Disposition:	<input type="checkbox"/> Admitted to OR <input type="checkbox"/> Admitted to ICU <input type="checkbox"/> Admitted to Floor/Step-down <input type="checkbox"/> Admitted to Ward <input type="checkbox"/> Admitted to < 24 hour observation unit <input type="checkbox"/> Neuro Interventional Radiology <input type="checkbox"/> Final Hospital (complete hospital disposition)				LAEMS	Required
LAEMS	Hospital Disposition:	<input type="checkbox"/> Home/Private place of residence <input type="checkbox"/> Acute Care Facility <input type="checkbox"/> SNF <input type="checkbox"/> Rehab center <input type="checkbox"/> Hospice <input type="checkbox"/> AMMI/Spect/WBS <input type="checkbox"/> Merge/Mortuary				LAEMS	Required
LAEMS	Referrals for Disposition to an Acute Care Facility:	<input type="checkbox"/> P - Financial Health Plan <input type="checkbox"/> H - Higher level or specialized care <input type="checkbox"/> N/D - Not documented <input type="checkbox"/> OTH - Other _____				LAEMS	None
LAEMS	Transfer to:	_____				LAEMS	None
LAEMS	Date of Birth:	_____				LAEMS	None
LAEMS	If IA catheter-based reperfusion initiated at the hospital, type:	<input type="checkbox"/> IA Thrombolysis <input type="checkbox"/> Endovascular Retrievable Device <input type="checkbox"/> Endovascular Aspiration Device <input type="checkbox"/> Angioplasty and/or Stenting <input type="checkbox"/> Other _____				LAEMS	Required

