RIKS-STROKE - TIA

Version 1.0 To be used for all acute TIA registrations from 1 January 2010 onwards.

Personal ID number I___I___I___I___I___I___I___I___I___I

Gender 1= male 2= female I___I

Name

Address

Telephone no.

Optional information (e.g. name and telephone number of next of kin or other)

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Reporting hospital I___I___I___I___I___I___I___I__ Ward/department I___I___I___I___I___I___I___I___I___I

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Date of onset I___I___I___I___I___I___I___I___I___I
(Debut of the last episode if there have been several previous episodes)

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Has the patient been admitted for treatment for this TIA episode? I___I
1= yes
2= no
3= already admitted at the time of onset

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PRIOR to the onset of TIA

Living arrangements I___I
1= in own accommodation without community home-help service
2= in own accommodation with community home-help service
3= in arranged accommodation (for instance service flat with full board, temporary accommodation, old people’s home, nursing home or equivalent)
5= other (please specify) Other .................................................................

Living alone I___I
1= patient lived on his/her own
2= patient lived with a spouse/partner or another person, for instance sibling, child or parents.

Mobility I___I
1= patient was able to move around without supervision both indoors and outdoors (use of walking-aid permitted)
2= patient was able to move around by himself/herself indoors but not outdoors
3= patient was assisted by another person when moving around, or he/she was bedridden

Toilet visits I___I
1= patient managed toilet visits unaided
2= patient was unable to get to the bathroom or go to the toilet without help, used a bedpan or incontinence pads, or required assistance when wiping himself/herself or to get dressed
Dressing
1 = patient was able to get dressed without assistance, including outdoor clothes, shoes and socks, or only needed help when tying shoelaces
2 = patient needed someone to fetch his/her clothes, or needed help with dressing/undressing, or remained undressed

RISK FACTORS

Please respond using 1 = yes  2 = no  9 = not known

Previous stroke

Previous TIA / Amaurosis fugax
(Does not apply to G45.4 transitory global amnesia)

Auricular fibrillation, previously diagnosed or recently identified
(including intermittent fibrillation or flutter)

Diabetes, previously diagnosed or recently identified

Treated for hypertension at the onset of TIA

Smoker (≥1 cigarette/day, or quit during the last three months)

Previous heart attack (or PTA = percutaneous transluminal angioplasty)

ABCD2 score

Only enter the number of the alternative if it corresponds, otherwise please leave empty!

Age
1 = ≥ 60 years

Blood pressure
1 = ≥ 140/90 at time of examination

Clinical picture
1 = speech difficulties without weakness
2 = weakness on one side (unilaterally), could be combined with other symptoms

Duration of symptom
1 = symptom lasted 10–59 minutes
2 = symptom lasted ≥ 60 minutes

Diabetes
1 = diabetes, previously diagnosed or recently discovered

Sum ABCD2 score (register the total score, max 7 points)

ACUTE CARE

CT brain scan acute 1 = yes  2 = no  9 = not known

MR brain scan acute 1 = yes  2 = no  9 = not known
Carotid ultrasound performed
1a = yes, within seven days after or within one month prior to onset
1b = yes, after 7 days 2 = no 9 = not known

CT or MR angiography performed
I___I = yes, of cervical vessels
I___I = yes, of intracranial vessels
I___I = yes, of both cervical and intracranial vessels
I___I = no
I___I = not known

Degree of stenosis in relevant vessel
1 = < 50%  2 = 50–69%  3 = 70–99%  4 = 100% (occlusion)  9 = not known

Long term ECG (Holter)
1a = yes, within 7 days 1b = yes, after 7 days 2 = no 9 = not known

------------------------------------------------------------------------------------------------------------ PHARMACEUTICAL TREATMENT ------------------------------------------------------------------------------------------------------------

See also FASS and list of pharmaceuticals in Riks-Stroke’s GUIDE 10.0

Please respond using 1 = yes 2 = no 9 = not known

<table>
<thead>
<tr>
<th>Medication</th>
<th>On admission</th>
<th>On discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diuretics</strong> (e.g. Esidrex, Moduretic, Normorix, Salures, Sparkal)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>ACE inhibitors</strong> (e.g. Accupro, Enalapril, Linisopril, Pramace, Ramipril, Renitec, Triatec)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>A2 inhibitors</strong> (e.g. Aprovel, Atacand, Cozaar, Diovan, Micardis)</td>
<td>I___I</td>
<td>I___I</td>
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<tr>
<td><strong>Beta blockers</strong> (e.g. Atenolol, Bisoprolol, Carvedilol, Emconcor, Metoprolol, Seloken, Tenormin)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Calcium inhibitors</strong> (e.g. Amlodipin, Cardizem, Felodipin, Norvasc, Plendil)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Other blood pressure medication</strong></td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Statins</strong> (e.g. Crestor, Lipitor, Pravastatin, Simvastatin, Zocord)</td>
<td>I___I</td>
<td>I___I</td>
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<tr>
<td><strong>ASA</strong> (e.g. Trombyl)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Clopidogrel</strong> (Plavix)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>ASA + dipyridamole</strong> (Asasantin)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Dipyridamole</strong> (Persantin)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
<tr>
<td><strong>Warfarin</strong> (Waran)</td>
<td>I___I</td>
<td>I___I</td>
</tr>
</tbody>
</table>

* Do NOT state medication at discharge if patient died during the acute phase.
INFORMATION

Smoker informed of need to quit smoking 1= yes 2= no 9= not known I___I

Information provided regarding driving
1= yes 2= no 3= not relevant/no driving licence 9= not known I___I

SEQUENCE OF CARE

A ACUTE MANAGEMENT

A Date of onset I___I___II___I___II___I___I Time of onset I___I___I.I___I___I

If the patient woke up with symptoms, please state the last time without symptoms.
Use code 9999 if the time is not known. Use code 99 for minutes if only the hour is known.
If the exact time of onset is not known, choose the closest possible time in the time interval below.

Number of hours from onset to arrival at hospital I___I
If patient woke up with symptoms, state last time without symptoms.
1= < 3 hrs
2= < 4.5 hrs
3= < 24 hrs
4= > 24 hrs
9= not known

Date of arrival I___I___II___I___II___I___I Time of arrival at hospital I___I___I.I___I___I (hr.min)

First admitted to
1= general ward 2= stroke unit 3= admissions/observation ward 4= intensive care unit
9= not known I___I

Continued care at
1= general ward 2= stroke unit 3= admissions/observation ward 4= intensive care unit
9= not known I___I

Date of discharge I___I___II___I___II___I___I

FOLLOW UP OF TIA PATIENTS

Is surgical vessel intervention planned (including endovascular treatment)?
1= yes 2= no 9= not known I___I

If no, please state primary reason
1= no need for surgery or endovascular treatment
2= medically related obstacle for surgery
3= patient does not want to be examined or operated upon
4= other reason

Co-ordination with Swedvasc is planned as regards information on time interval until surgical vessel intervention or endovascular treatment.

TIA-DIAGNOSIS

G 45 = TIA/cerebral ischemia/transient within 24 hrs
(G 45.4 transitory global amnesia is not registrerad)