Event Checking Chart

Stroke

Name of Centre | **Gender** | **Year of Birth** (☐☐☐☐)

Patient ID (☐☐☐☐☐) **Date of event**

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1. Did the patient have any acute onset focal neurological symptoms related to the event?

If yes
- ☐ Acute onset motor impairment (uni-or bilateral paresis)
- ☐ Sensory impairment (uni-or bilateral)
- ☐ Aphasia
- ☐ Hemianopia/diplopia
- ☐ Ataxia
- ☐ Apraxia

☐ No ☐ Unknown

2. Did the patient have any acute onset global symptoms?

If yes:
- ☐ Seizure
- ☐ Confusion/coma
- ☐ Severe acute onset headache or vertigo

☐ No ☐ Unknown

3. Was an imaging (CT or MR) done?

If yes
- ☐ CT
- ☐ MR

☐ No ☐ Unknown

4. Did an imaging (CT or MR) confirm the stroke?

If yes, which
- ☐ Ischaemic infarction
- ☐ Haemorrhagic
- ☐ Unknown

If yes, which type
- ☐ Intracerebral
- ☐ Subarachnoid

☐ No ☐ Unknown

5. Was an invasive cardiovascular procedure performed in direct relation to the event (within 72h)?

If yes: Please remember to fill out a new respond event form and select ICP.

Yes ☐ ☐ No ☐ Unknown

6. Is there any other possible explanation for the symptoms and/or imaging results?
If brain cancer, please remember to fill out a new respond event form and select non-AIDS defining malignancy.

If yes ☐ CNS infection
☐ Space occupying lesion
☐ No ☐ Unknown

7. Was this a fatal stroke event?

Yes ☐ ☐ No ☐ Unknown

All available information regarding this event has been collected.

Reported by: **Date:** *Stamp/signature:*

Verified by (Senior physician): **Date:** *Stamp/signature:*