

Comments

Patient ID: (MN 1.1) _____

Patient

Elective carotid intervention sole purpose for admission? (MN 1.14) <input type="checkbox"/>	Was this patient participating in a stroke-related clinical trial? (MN 1.13) <input type="checkbox"/>
Arrival Date (MN 1.4) _____ / _____ / _____	
Time (MN 1.5) _____ : _____	
Age (MN 1.10) _____	Gender (MN 1.11) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown

Demographics

Health Insurance (MN 2.1)			
<input type="checkbox"/> Medicare/Medicare Advantage	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private/VA/Champus/Other	<input type="checkbox"/> Self Pay/No Insurance <input type="checkbox"/> ND
Race (MN 2.2)		Ethnicity (MN 2.3)	
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Not Hispanic or Latino or Unknown	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other		
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown		
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			

Pre-Hospital/ EMS

Patient Location When Symptoms Discovered (MN 3.1)			
<input type="checkbox"/> Not in a healthcare setting	<input type="checkbox"/> Chronic health care facility	<input type="checkbox"/> Outpatient healthcare setting	
<input type="checkbox"/> Another acute care facility	<input type="checkbox"/> Stroke occurred while patient was an inpatient in your hospital	<input type="checkbox"/> Cannot be determined	
Arrival Mode (MN 3.3) <input type="checkbox"/> EMS <input type="checkbox"/> Private transportation/taxi/other <input type="checkbox"/> Transfer from another hospital <input type="checkbox"/> ND or Unknown			
Name of Hospital: _____			
Where patient was first evaluated (MN 3.4)			
<input type="checkbox"/> Emergency Department/Urgent Care	<input type="checkbox"/> Direct Admit or direct to floor (not through ED)	<input type="checkbox"/> Imaging suite (prior to ED arrival or direct admit)	<input type="checkbox"/> Cannot be determined
EMS Notification (MN 3.7) <input type="checkbox"/> Yes <input type="checkbox"/> No/UTD		Glasgow Coma Scale Score (MN 3.8) GCS (3-15): _____ <input type="checkbox"/> ND	

Hospital¹

Was patient placed on observation status or in an observation unit at this hospital? (MN 4.9)		Was patient admitted to this hospital? (MN 4.10)	
<input type="checkbox"/> Yes <input type="checkbox"/> No/ND		<input type="checkbox"/> Yes <input type="checkbox"/> No/ND	
If not admitted to this hospital, where was patient transferred/ released? (MN 4.8) <input type="checkbox"/> Acute Care Facility <input type="checkbox"/> Home <input type="checkbox"/> Expired <input type="checkbox"/> Other <input type="checkbox"/> ND/UTD			
Name of Acute Care Facility: _____			
<input type="checkbox"/> Stroke Code declared?			
Admission date (MN 4.2) _____ / _____ / _____		Discharge date (MN 4.3) _____ / _____ / _____	
Admission Diagnosis (MN 4.4)			
<input type="checkbox"/> Intracerebral Hemorrhage	<input type="checkbox"/> Transient Ischemic Attack		
<input type="checkbox"/> Subarachnoid Hemorrhage	<input type="checkbox"/> Stroke Not Otherwise Specified		
<input type="checkbox"/> Ischemic Stroke	<input type="checkbox"/> No Stroke Related Diagnosis		
Ambulation Status Prior to the Current Event (MN 4.5)		When is the earliest time that the physician, advanced practice nurse, or physician assistant documented that the patient was on comfort measures only? (MN 4.6)	
<input type="checkbox"/> Able to Ambulate Independently with or without a device	<input type="checkbox"/> Unable to Ambulate	<input type="checkbox"/> Day of arrival or first day after arrival	<input type="checkbox"/> Timing unclear
<input type="checkbox"/> With Assistance (from person)	<input type="checkbox"/> ND	<input type="checkbox"/> 2 nd day after arrival or later	<input type="checkbox"/> ND/UTD or Not Applicable

Imaging

Was brain imaging performed at your hospital after arrival? (MN 5.1)		Imaging Date and Time (MN 5.2, 5.3)	
<input type="checkbox"/> Yes <input type="checkbox"/> No/ND <input type="checkbox"/> NC		Date: _____ / _____ / _____	<input type="checkbox"/> ND
Initial Brain Imaging Findings (MN 5.4)		Time: _____ : _____	<input type="checkbox"/> ND
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> No hemorrhage <input type="checkbox"/> Not available		

¹ If any option is selected for data element 4.8, then skip data elements 4.2 and 4.4.

Onset

Last Known Well Date and Time (MN 6.1, 6.2)			
Date: _____ / _____ / _____	<input type="checkbox"/> Unknown/ND/UTD	Time: _____ : _____	<input type="checkbox"/> Unknown/ND/UTD
Discovery Date and Time (MN 6.3, 6.4)			
Date: _____ / _____ / _____	<input type="checkbox"/> Discovery date/time = Last Known Well date/time	Time: _____ : _____	<input type="checkbox"/> Unknown/ND/UTD
Did symptoms resolve completely prior to presentation? (MN 6.7)		Was the NIH Stroke Scale performed? (MN 6.5)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ND		<input type="checkbox"/> Yes <input type="checkbox"/> Yes, but NIHSS score is ND <input type="checkbox"/> No/ND	
Initial Exam Findings (MN 6.8a, 6.8b, 6.8c)			
<input type="checkbox"/> Weakness or paresis		<input type="checkbox"/> Altered level of consciousness	<input type="checkbox"/> Aphasia
			Total NIHSS score (MN 6.6) _____

Thrombolytics²

Was IV-tPA Initiated at this hospital? (MN 7.1)		If "Yes", what was the date and time of initiating IV-tPA? (MN 7.2, 7.3)	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Date: _____ / _____ / _____	<input type="checkbox"/> ND
		Time: _____ : _____	<input type="checkbox"/> ND
Was IV-tPA initiated at an outside hospital? (MN 7.4) <input type="checkbox"/> Yes <input type="checkbox"/> No			
IA catheter-based reperfusion initiated at this hospital? (MN 7.5)		If "Yes", what was the date and time of administration? (MN 7.6, 7.7)	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Date: _____ / _____ / _____	<input type="checkbox"/> ND
		Time: _____ : _____	<input type="checkbox"/> ND
Symptomatic intracranial hemorrhage (MN 7.11)		Life-threatening, serious systemic hemorrhage (MN 7.12)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/UTD		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/UTD	

Thrombolytics Non-Treatment

Were one or more of the following reasons for not administering IV thrombolytic therapy at this hospital explicitly documented or clearly implied by a physician, nurse practitioner, advanced practice nurse or physician assistant's notes in the chart?			
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Contraindications (MN 8.1)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	CT findings (ICH, SAH, or major infarct signs) (MN 8.2)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Warnings (MN 8.3)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Advanced Age (MN 8.4)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Stroke severity too mild (MN 8.5a)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Rapid Improvement (MN 8.5b)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Life expectancy < 1 year or severe co-morbid illness or CMO on admission (MN 8.6)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Patient or Family refused (MN 8.7)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Care team unable to determine eligibility (MN 8.8)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	IV or IA tPA given at outside hospital (MN 8.9)	
	<input type="checkbox"/> 3-4.5 hr	Age greater than 80 (MN 8.16)	
	<input type="checkbox"/> 3-4.5 hr	Prior stroke and presence or history of diabetes (MN 8.17)	
	<input type="checkbox"/> 3-4.5 hr	Any anticoagulant use prior to admission (MN 8.18)	
	<input type="checkbox"/> 3-4.5 hr	NIHSS score > 25 (MN 8.19)	
	<input type="checkbox"/> 3-4.5 hr	CT findings of stroke involving more than 1/3 of middle carotid artery (MN 8.20)	
Hospital-related or other factors:			
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Unable to diagnose or did not diagnose in 3 hour time frame (MN 8.10)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	In-hospital time delay (MN 8.11)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Delay in patient arrival (MN 8.12)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	No IV access (MN 8.13)	
<input type="checkbox"/> 0-3 hr	<input type="checkbox"/> 3-4.5 hr	Other (MN 8.14, 8.15) Specify _____	

² If options "Home", "Other", or "ND/UTD" are selected for data element 4.8, then skip data elements 7.1 – 7.12.

History³

Medical History: <input type="checkbox"/> Diabetes mellitus (DM) (MN 9.1) <input type="checkbox"/> Stroke (MN 9.2) <input type="checkbox"/> TIA/VBI (MN 9.25) <input type="checkbox"/> Carotid stenosis (MN 9.3) <input type="checkbox"/> Peripheral arterial disease (PAD) (MN 9.4) <input type="checkbox"/> Hypertension (MN 9.5) <input type="checkbox"/> Currently pregnant or within 6 weeks postpartum (MN 9.7)	<input type="checkbox"/> Valve prosthesis (MN 9.8) <input type="checkbox"/> MI or CAD (MN 9.9) <input type="checkbox"/> Heart Failure (MN 9.10) <input type="checkbox"/> Sickle cell disease/anemia (MN 9.11) <input type="checkbox"/> Atrial fibrillation/flutter (MN 9.12) <input type="checkbox"/> Dyslipidemia (MN 9.6)
Cholesterol reducing/controlling medication (MN 9.13) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND Antihypertensive medications (MN 9.14) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND Antithrombotic medications (MN 9.15) <input type="checkbox"/> Yes <input type="checkbox"/> No or UTD	
Lipid Profile, HgbA1C, INR (MN 9.16, 9.18, 9.17, 9.19) Total Cholesterol _____ mg/dl LDL _____ mg/dl HgbA1C _____ % INR _____	

Procedures^{4 5}

Unit Type (MN 10.3) <input type="checkbox"/> In Stroke Unit <input type="checkbox"/> Not in Stroke Unit or UTD If "Not in Stroke Unit or UTD" selected, please specify unit type: _____		
Stroke Order Set (MN10.10) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		
Was antithrombotic therapy received by the end of hospital day 2? (MN 10.4a) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		If "No/ND" was there a documented reason for not administering antithrombotic therapy by the end of hospital day 2? (MN 10.4b) <input type="checkbox"/> Yes <input type="checkbox"/> No
Was patient ambulating the day of admission or the day after admission? (MN 10.5) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		
Please select all of the following types of VTE prophylaxis provided: (MN 10.6a) <input type="checkbox"/> Low dose unfractionated heparin (LDUH) <input type="checkbox"/> Warfarin <input type="checkbox"/> Low molecular weight heparin (LMWH) <input type="checkbox"/> Venous foot pumps <input type="checkbox"/> Intermittent pneumatic compression devices <input type="checkbox"/> Not documented or none of the above <input type="checkbox"/> Factor Xa inhibitor		If "ND or None of the above", was there a documented reason for not administering VTE prophylaxis? (MN 10.6b) <input type="checkbox"/> Yes <input type="checkbox"/> No
What date was the initial VTE prophylaxis administered? (MN 10.6c) Date ____/____/____ <input type="checkbox"/> ND/ UTD		
Were graduated compression stockings provided to the patient? (MN 10.6d) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		
No oral intake of medications, fluids, or food throughout the entire hospital stay (MN 10.7) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND		
Was patient screened for dysphagia prior to any oral intake, including food, fluids or medications? (MN 10.8) <input type="checkbox"/> Yes <input type="checkbox"/> No/Not documented <input type="checkbox"/> NC		
Dysphagia Screen date and time: Date ____/____/____ Time ____:____:____ <input type="checkbox"/> ND	First PO medication date and time: Date ____/____/____ Time ____:____:____ <input type="checkbox"/> ND	Earliest liquid/food intake date and time: Date ____/____/____ Time ____:____:____ <input type="checkbox"/> ND
Results of dysphagia screen (MN 10.9) <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> ND		

Complications⁶

Did patient experience a DVT or pulmonary embolus (PE) during the admission? (MN 11.1) <input type="checkbox"/> Yes <input type="checkbox"/> No/ND	
Was there documentation that the patient was treated for hospital acquired pneumonia during this admission? (MN 11.2) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the patient treated for a urinary tract infection (UTI) during this admission? (MN 11.3) <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", did the patient have a Foley catheter during this admission? (MN 11.4) <input type="checkbox"/> Yes, patient had catheter in place on arrival <input type="checkbox"/> No <input type="checkbox"/> Yes, but only after arrival <input type="checkbox"/> UTD
Atrial or paroxysmal fibrillation/flutter during this admission? (MN 11.5) <input type="checkbox"/> Yes <input type="checkbox"/> No or UTD	

Discharge

Principal ICD-9 discharge diagnosis: (MN 12.2) _____ <input type="checkbox"/> Principal diagnosis is Stroke/TIA	ICD-9 discharge diagnosis related to stroke: (MN 12.1) _____ <input type="checkbox"/> Not present
Final hospital diagnosis related to stroke that was ultimately responsible for this admission: (MN 12.3) <input type="checkbox"/> Intracerebral hemorrhage <input type="checkbox"/> Transient ischemic attack <input type="checkbox"/> Subarachnoid hemorrhage <input type="checkbox"/> Stroke not otherwise specified <input type="checkbox"/> Ischemic stroke <input type="checkbox"/> No stroke related diagnosis	Was the NIH Stroke Scale performed at Discharge? (MN 12.11) <input type="checkbox"/> Yes <input type="checkbox"/> Yes, but NIHSS score is ND <input type="checkbox"/> No/ND Total NIHSS score (MN 12.12) _____

³ If any option for data element 4.8 is selected, then skip data elements 9.16 and 9.18.

⁴ If any option for data element 4.8 is selected, then skip data elements 10.3-10.6d.

⁵ If option "Day of arrival or first day after arrival" is selected for data element 4.6, then skip 10.4a, 10.4b, 10.6a, 10.6b, 10.6c, and 10.6d.

⁶ If any option for data element 4.8 is selected, then skip data elements 11.1-11.5.

Discharge^{7 8 9 10}

Discharge Destination (MN 12.4)

- | | |
|---|---|
| <input type="checkbox"/> 01 Home care or self care | <input type="checkbox"/> 50 Hospice-home |
| <input type="checkbox"/> 02 Another short term general hospital for inpatient care | <input type="checkbox"/> 51 Hospice-medical facility (certified) |
| <input type="checkbox"/> 03 A skilled nursing facility (SNF) with Medicare certification | <input type="checkbox"/> 61 Within this institution to hospital-based Medicare approved swing bed |
| <input type="checkbox"/> 04 An intermediate care facility | <input type="checkbox"/> 62 An inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital |
| <input type="checkbox"/> 05 A designated cancer center or Children's hospital | <input type="checkbox"/> 63 A Medicare certified long term care hospital (LTCH) |
| <input type="checkbox"/> 06 Home under care of organized home health service organization | <input type="checkbox"/> 64 A nursing facility certified under Medicaid but not certified under Medicare |
| <input type="checkbox"/> 07 Left against medical advice or discontinued care | <input type="checkbox"/> 65 Psychiatric hospital or psychiatric distinct part unit of a hospital |
| <input type="checkbox"/> 20 Expired (or did not recover-Religious) | <input type="checkbox"/> 66 Critical Access Hospital (CAH) |
| <input type="checkbox"/> 21 Jail, prison or other detention facilities | <input type="checkbox"/> 70 Another healthcare unit not defined elsewhere in this code list |
| <input type="checkbox"/> 43 Discharged/transferred to a federal health care facility | <input type="checkbox"/> Not Documented or Unable to Determine |

Ambulation Status at discharge (MN 12.5)

- Able to ambulate independently with or without a device With assistance (from person) Unable to ambulate ND

Cholesterol reducing/controlling treatment (MN 12.7a)

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Statin | <input type="checkbox"/> Niacin | <input type="checkbox"/> Other medication |
| <input type="checkbox"/> Fibrate | <input type="checkbox"/> Absorption Inhibitor | <input type="checkbox"/> None prescribed/ND |

If a statin was not prescribed, was there a documented reason for not prescribing statins? (MN 12.7b) Yes No/ND

If a non-statin cholesterol medication was not prescribed, was there documented reason for not prescribing this medication? (MN 12.7c) Yes No/ND

Antihypertensive medication prescribed (MN 12.8) Yes No/ND

Antithrombotic medication prescribed (MN 12.9a) Yes No or UTD

If "No/ND", was there a documented reason for not prescribing antithrombotic therapy (MN 12.9b) Yes No

Anticoagulation medication prescribed (MN 12.10a) Yes No/ND

If "No/ND", was there a documented reason for not prescribing anticoagulation therapy (MN 12.10b) Yes No

Discharge Services^{11 12}

Documented past medical history of smoking (patient smoked at least one cigarette during the prior year)? (MN 13.1) Yes No/ND

If "Yes", was the patient/caregiver given smoking cessation advice or counseling during admission (MN 13.2) Yes No/ND NC

Education (MN 13.3-13.7)

- | | | |
|-------------------------------------|------------------------------|--------------------------------|
| Risk factors for stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| Stroke Warning Signs & Symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| How to activate EMS for stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| Need for follow-up after discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| Medications prescribed at discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |

Rehabilitation (MN 13.8, 13.11, 13.12)

- | | | |
|---|------------------------------|--------------------------------|
| Was assessed for or received rehabilitation services | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| Referred to rehabilitation services following discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |
| Ineligible to receive rehabilitation services | <input type="checkbox"/> Yes | <input type="checkbox"/> No/ND |

Staff

Position _____	Name _____
Position _____	Name _____
Position _____	Name _____
Position _____	Name _____
Position _____	Name _____
Position _____	Name _____
Position _____	Name _____
Position _____	Name _____

DISCLAIMER: The contents of this document are not official patient medical record data. This document is intended only to be used as a data collection tool for the Minnesota Stroke Registry. Please do not submit this document to the Minnesota Department of Health.



⁷ If options "Home", "Expired", "Other", or "ND/UTD" are selected for data element 4.8, then skip data element 12.4.
⁸ If options "Acute care hospital" or "Expired" are selected for data element 4.8, then skip data elements 12.5-12.10b.
⁹ If option "Expired" is selected for data element 12.4, then skip data elements 12.7a-12.10b, 13.2, and 13.8-13.12.
¹⁰ If options "Day of arrival or first day after arrival" or "2nd day after arrival or later" are selected for data element 4.6, then skip 12.7a-12.10b.
¹¹ If options "Acute care hospital" or "Expired" are selected for data element 4.8, then skip data elements 13.2-13.12.
¹² If options "Day of arrival or first day after arrival" or "2nd day after arrival or later" are selected for data element 4.6, then skip 13.2-13.8, 13.11, and 13.12.