## Third International Stroke Trial Hospital Treatment Follow-up form

**Hospital Number:**  
**Centre name:**

**Patients Trial ID:** (you will find this on randomisation form)  
**Patient Initials:**

Please complete at 7 days, or discharge, or transfer to another hospital, or death, whichever occurs first.

### Arrival Time at Hospital:

- **Arrival Time at Hospital:** ___:____ hrs mins

### How was consent obtained?

- **Patient signed form**
- **Assent by relatives**
- **Patient gave verbal consent**
- **Waiver of consent**
- **If waiver give reason:**

### Before admission for this stroke did the patient have any of the following treatments?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dipyridamole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clopidogrel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low dose heparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full dose heparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warfarin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other antithrombotic agents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please provide details: ___________________________

### Before admission for this stroke did this patient have:

- **Treatment for hypertension**
- **Treatment for Diabetes mellitus**
- A history of previous stroke or TIA

### Did the patient receive any of the following treatments in the 24 hours following randomisation?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other antiplatelet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low dose heparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full anti-coagulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any treatment aiming to lower blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any non trial thrombolysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Did the patient receive any of the following treatments between 24 hours & 7 days after randomisation?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
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</tr>
<tr>
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<td></td>
</tr>
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<td>Low dose heparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full anti-coagulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any treatment to lower blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any non trial thrombolysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding via nasogastric tube or percutaneous gastrostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IST-3 Open HFUP**  
**Effective date:** 01/02/2010  
**Version:** 5.4
### Final diagnosis of initial randomising event (using all clinical and/or imaging information available to you)

**Definite ischaemic stroke**
- Yes
- No

  - If **YES** state: side of brain
    - Right
    - Left
    - Midline

  - If **YES** state: location in brain
    - Cerebral hemisphere
    - Posterior circulation

**Definite or probable haemorrhagic stroke**
- Yes
- No

  - If **YES** was it due to:
    - Primary intracranial haemorrhage
    - Subdural haemorrhage
    - Subarachnoid haemorrhage

**Non-stroke cause**
- Yes
- No

  - If **YES** was it due to:
    - Cerebral tumour
    - Migraine
    - Epilepsy

**Brain Scans**

- Type of brain scan performed BEFORE randomisation
  - CT
  - MR

- Type of follow-up scan performed AFTER randomisation (at 24 – 48 hrs)
  - CT
  - MR

**Where was the patient treated in the 7 days since randomisation?** (Please tick all boxes that apply with the number of nights in each area)

<table>
<thead>
<tr>
<th>Ward Type</th>
<th>Number of nights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Unit</td>
<td>strk unitno</td>
</tr>
<tr>
<td>High Dependency Ward</td>
<td>criticareno</td>
</tr>
<tr>
<td>Intensive Care ward</td>
<td>critcareno</td>
</tr>
<tr>
<td>Neurology ward</td>
<td>critcareno</td>
</tr>
<tr>
<td>Geriatric Medicine Ward</td>
<td>genwardno</td>
</tr>
<tr>
<td>General (Internal) Medicine</td>
<td>med_adno</td>
</tr>
<tr>
<td>Medical Admissions Unit</td>
<td></td>
</tr>
<tr>
<td>Other, please specify</td>
<td></td>
</tr>
</tbody>
</table>
Hospital Number: [___] [___] [___]

Centre name: [__________________________]

Patients Trial ID: [you will find this on randomisation form] Patient Initials: [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___] [___]

CEREBRAL

Cerebral events in hospital after randomisation

sevendaycase, adjudicated, event_date

a) Further stroke with CT or MR scan or autopsy evidence of new intracranial bleeding

Yes

No

If YES, date occurred: [___] [___] [___] (dd/mm/yyyy)

If YES, give date of scan: [___] [___] [___] (dd/mm/yyyy)

b) Neurological deterioration of original stroke, with CT or MR scan evidence of significant new intracranial bleeding.

"significant" includes bleeding which obliterates the original infarct, or extends into the CSF (e.g. ventricles or basal cisterns), or creates major mass effect (e.g. displaces ventricle or midline).

If YES, was the bleed: (tick one box)

- Into infarct
- Remote from infarct
- Subarachnoid haemorrhage
- Subdural haemorrhage

If YES, date occurred: [___] [___] [___] (dd/mm/yyyy)

If YES, give date of scan: [___] [___] [___] (dd/mm/yyyy)

c) Neurological deterioration of original stroke, but CT or MR scan excluded significant intracranial bleeding (ignore modest petechial haemorrhage)

If YES, date occurred: [___] [___] [___] (dd/mm/yyyy)

If YES, give date of CT scan: [___] [___] [___] (dd/mm/yyyy)

d) Further stroke with CT or MR or autopsy evidence of new ischaemic stroke (or absence of any haemorrhage to account for the further stroke).

If YES, date of stroke: [___] [___] [___] (dd/mm/yyyy)

If YES, give date of CT scan or autopsy: [___] [___] [___] (dd/mm/yyyy)

e) Further stroke but no scan or autopsy.

If YES, date of stroke: [___] [___] [___] (dd/mm/yyyy)

OTHER EVENTS IN HOSPITAL

Myocardial Infarction

Yes

No

If YES, give date of MI: [___] [___] [___] (dd/mm/yyyy)

Major extracranial bleed requiring transfusion, or a drop in haemoglobin of > 5 g/dl, or decrease in haemocrit > 15% or bleeding associated with serious disability

If YES, give date: [___] [___] [___] (dd/mm/yyyy)

Major allergic reaction requiring treatment or cessation of trial infusion

If YES, give date: [___] [___] [___] (dd/mm/yyyy)

Any other possible side effect not recorded elsewhere

If YES, give date: [___] [___] [___] (dd/mm/yyyy)

Describe briefly: [______________________________]

Any other adverse reaction not recorded elsewhere.

If YES, give date: [___] [___] [___] (dd/mm/yyyy)

Describe briefly: [______________________________]

*If this adverse reaction is serious, related to the rt-PA and is unexpected (i.e. not recorded in the Summary of Product Characteristics), it is a Suspected Unexpected Serious Adverse Reaction (SUSAR) and subject to expedited reporting to the Sponsor. Please follow the instructions in Section 7 of your Trial manual.

IST-3 Open HFUP
Effective date: 01/02/2010
Version: 5.4
## Third International Stroke Trial

### Hospital Treatment Follow-up form

**Hospital Number:**  |  **Centre name:**  |  **Patient Initials:**
---|---|---

**Patients Trial ID:** (you will find this on randomisation form)

**Is this patient still alive?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If NO, give date of death: <strong><strong>/</strong></strong>/______ (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>deathdate</td>
</tr>
</tbody>
</table>

**If dead has cause of death been confirmed by autopsy?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Likely cause of death

(tick ONE box only)

- Neuro-damage from initial stroke with no evidence of intracranial haemorrhage
- Recurrent ischaemic stroke
- Recurrent stroke – type unknown
- Intracranial haemorrhage
- Extracranial haemorrhage
- Ischaemic heart disease
- Pulmonary embolism
- Pneumonia
- Other vascular cause of death (please specify)
- Other non vascular cause of death (please specify)

### If the patient is still alive:

**Current neurological status at 7 days, or at hospital discharge or transfer if earlier**

(please circle ONE number in each section)

- **Glasgow Coma Scale:**
  - *Eye opening*  
    - Never  
    - To pain  
    - To command  
    - Spontaneously
  
  
- **Glasgow Coma Scale:**
  - *Best motor*  
    - None  
    - Extend to pain (stereotypical)  
    - Abnormal flex to pain  
    - Normal flex to pain  
    - Localises movements to pain  
    - Normal
  
  
- **Glasgow Coma Scale:**
  - *Best verbal*  
    - None  
    - Noises only  
    - Inappropriate words  
    - Confused (time, place or person)  
    - Orientated in time, place and person

### Current functional ability

- Is the patient able to lift both arms off the bed?  
- Is the patient able to walk without help from another person?  
- Is the patient independent in activities of daily living (washing, dressing, feeding & toileting)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**If still in hospital, give Ward number or name:**

<table>
<thead>
<tr>
<th>Ward</th>
</tr>
</thead>
</table>

**If still in hospital, give the name of the doctor responsible for their care:**

<table>
<thead>
<tr>
<th>Dr</th>
</tr>
</thead>
</table>
Hospital Number: [__________]  Centre name: [__________________________]

Patients Trial ID: [□□ □□ □□ □□ □□ □□ □□ □□ □□ □□](you will find this on randomisation form)  Patient Initials: [□□ □□ □□ □□ □□ □□]

If the patient has been discharged from hospital
(tick ONE box only)

Were they discharged to their own home? [□]
Discharged to home of relative or friend? [□]  destination
Discharged to a nursing home? [□]
Discharged to a residential home? [□]
Discharged to another hospital? [□]
Discharged elsewhere? [□]  If elsewhere, please specify: _____________________________

If the patient is alive please complete the following:

Family name: [___________________________________]  Given name: [___________________________________]

Patient’s full postal address on discharge (please print clearly or attach an address label)
________________________________________________________________________
Postcode [____________________________]  Telephone: [____________________________]

Family doctor’s details
Name of family doctor [_________________________________________________________]
Address of family doctor [_________________________________________________________]
Postcode [____________________________]  Telephone: [____________________________]

Please give the name of a reliable contact below: (ideally next of kin not living at patients home address)
Contact name [_________________________________________________________]
Relationship to patient [_________________________________________________________]
Address [_________________________________________________________]
Postcode [____________________________]  Telephone: [____________________________]

Additional information
Please use this space for any additional information you any think relevant to the trial or the patient’s treatment.
________________________________________________________________________

Form completed by: [_________________________________________________________]

Today’s date: [____/____/____] (dd/mm/yyyy)

Now please photocopy this form for your own records and send the original, together with the IST-3 Patient treatment form and all CT scans to:

IST-3 Co-ordinating Centre, Bramwell Dott Building,
Western General Hospital, Crewe Road,
Edinburgh EH4 2XU, UK.
THANK YOU.