Notification Form

*Instruction: Where check boxes ☐ are provided, check (√) one or more boxes. Where radio buttons ○ are provided, check (√) one box only. * indicates compulsory field.*		Office use (ID)	/
1.	Name of Hospital		
2.	Date of Notification	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*	

A. PATIENT DEMOGRAPHICS

1.	*Patient Name				
2.	*Patient Identification No	MyKad/MyKid			
		Other ID Document Type (Passport, Armed Force)		Other ID Document Number	
3.	*Date of Birth	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*			
4.	*Age at onset	__ __ __ years old *(Auto-calculated)*			
5.	*Sex	○ Male ○ Female			
6.	*Ethnicity	○ Malay ○ Chinese ○ Indian	○ Bumiputera Sarawak: _____ ○ Bumiputera Sabah: _____ ○ Other Malaysian: _____ ○ Foreigner, specify country: _____		

B. CLINICAL DETAILS

1	*Hospital arrival	a. Date & time of hospital arrival (Door time)	__ __ / __ __ / __ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*		
2	*Stroke onset	a. In patient stroke	○ No ○ Yes		
		b. Stroke onset	○ Known onset →	i. Date & time of symptom onset	__ __ / __ __ / __ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*
				ii. Time of onset to door	__ __ __ minutes *(Auto-calculated if in patient stroke = No)*
			○ Unknown onset / wake up stroke →	iii. Date & time when patient went to bed / last seen well	__ __ / __ __ / __ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*
				iv. Time of onset to door	__ __ __ minutes *(Auto-calculated if in patient stroke = No)*
		c. Date & time of medical/ neurology team review	__ __ / __ __ / __ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*		
3	*Hospital admission	a. Admitted?	○ No ○ Yes → answer b & c		
		b. Date of admission	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*		
		c. Location of admission (day 1)	○ ICU ○ Stroke unit ○ Other monitored bed with telemetry ○ Standard bed		
4	*Risk factors	Previous known history (select all that apply)	☐ None ☐ Diabetes mellitus ☐ Hyperlipidemia ☐ Previous TIA / ischemic stroke ☐ Atrial fibrillation / flutter (proxysmal / persistent / permanent) ☐ Valvular heart disease ☐ Chronic kidney disease ☐ Malignancy ☐ Gout ☐ Obesity ☐ Unknown	☐ Hypertension ☐ Smoker ↓ ○ Current ○ Former (>30 days) ☐ Previous hemorrhagic stroke ☐ Coronary artery disease / previous MI ☐ Congestive heart failure ☐ Hormonal contraception ☐ Covid positive in last 6 months ☐ HIV ☐ Family history of stroke ☐ Obstructive sleep apnoea (OSA) ☐ Other: _____	

B. CLINICAL DETAILS

5	*Vital signs, neurological assessment & blood investigation at presentation	a. NIHSS	__ __ ○ Not done
		b. Baseline mRS (prior to stroke)	○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ Not done
6	*Imaging	a.* Brain imaging type (select all that apply)	

#	Brain imaging type	Date & Time of imaging *(dd/mm/yyyy hh:mm) (24 hr clock)*	Door to CT/MRI *(Auto-calculated)*
i.	☐ Imaging done in another hospital		
ii.	☐ Non-contrast CT	__ __/__ __/__ __ __ __ __ __ : __ __	__ __ __ minutes
iii.	☐ CT Angiography	__ __/__ __/__ __ __ __ __ __ : __ __	__ __ __ minutes
		1. Large vessel occlusion (LVO):	○ No ○ Yes
iv.	☐ CT Perfusion	__ __/__ __/__ __ __ __ __ __ : __ __	__ __ __ minutes
v	☐ MR DWI / Flair	__ __/__ __/__ __ __ __ __ __ : __ __	__ __ __ minutes
vi	☐ Not done		

7	*Stroke classifications	a. WHO classification	○ Ischemic stroke ○ Intracerebral haemorrhage ○ Transient ischemic attack (TIA) ○ Subarachnoid haemorrhage ○ Undetermined (the imaging finding is not available) ○ Determined	
			i. If ischemic stroke	a. OCSP classification: ○ TACI ○ PACI ○ LACI ○ POCI
				b. TOAST classification: ○ Large artery atherosclerosis ○ Small vessel occlusion ○ Cardioembolism ○ Other determined aetiologies ○ Undetermined aetiology
8	*IV thrombolysis treatment	a. Treated with IV thrombolysis in current admission	○ No ○ Yes	
		i. If Yes	a. IVT agent (select one)	○ Alteplase ○ Streptokinase ○ Tenecteplase ○ Staphylokinase
			b. Treatment dose	__ __ __ . __mg
			d. Bolus date & time (time at which first IV shot given)	__ __/__ __/__ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*
			e. CT/MRI to needle time (in minutes)	__ __ __ __ *(Auto-calculated)*
			f. Stroke onset to thrombolysis time (minutes)	__ __ __ __ *(Auto-calculated)*
9	*Mechanical thrombectomy treatment	a. Treated with mechanical thrombectomy in your hospital	○ No ○ Yes ○ Service not available	
		i. If Yes	a. Groin puncture date & time	__ __/__ __/__ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*
			b. Reperfusion date & time	__ __/__ __/__ __ __ __ __ __ : __ __ *(dd/mm/yyyy hh:mm) (24 hr clock)*
			c. Door to groin puncture time (in minutes)	__ __ __ __ *(Auto-calculated)*
			d. Groin puncture to reperfusion time (in minutes)	__ __ __ __ *(Auto-calculated)*
			e. Thrombectomy outcome	○ Success ○ Fail

B. CLINICAL DETAILS					
10	*Post acute care	a. Screening for atrial fibrillation/flutter	○ Not screened ○ Known AF	○ No AF detected	○ Detected during hospitalization
		b. Swallowing assessment done	○ No	○ Yes	
		c. Patient received speech therapy	○ No	○ Yes	○ Not required
		d. DVT prophylaxis	○ No	○ Yes	○ Not required
11	*Post stroke complications	a. Post stroke complications (select all that apply)	☐ None ☐ Recurrence / extension of stroke ☐ Pulmonary embolism (PE) ☐ Delirium	☐ Pneumonia ☐ Deep vein thrombosis (DVT) ☐ Drip site sepsis ☐ Others, specify: _____	☐ Pressure sores ☐ Urinary tract infection ☐ Seizure
		b. Hemorrhagic transformation	○ No	○ Yes	
		c. Neurosurgical intervention (decompressive craniectomy etc)	○ No	○ Yes	
12	Secondary prevention work-up	a. Secondary prevention work-up (select all that apply)	☐ Echocardiography ☐ Carotid ultrasonography ☐ Fasting lipid profile	☐ Holter ☐ TCD ☐ Young stroke workup	☐ CTA/MRA ☐ Diabetes screening ☐ Cancer screening

C. DISCHARGE			
1	*NIHSS on discharge	__ __	○ Not done
2	*mRS on discharge	○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6	○ Not done
3	*Date of discharge / death	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*	
4	*Length of hospital stay	__ __ __ days *(Auto-calculated)*	