

Patient Name: SURNAME

FORENAME

Patient DOB: DD/MM/YYYY

NHS No.: _____

Hospital No.: _____

8.1 Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No but
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The following questions are only for patients in whom "YES" has been answered:

8.1.1 What was the date of follow-up?	DD/MM/YYYY
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8.1.2 How was the follow-up carried out:

<input type="checkbox"/> In person	<input type="checkbox"/> By telephone	<input type="checkbox"/> Online	<input type="checkbox"/> By post
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8.1.3 Which of the following professionals carried out the follow-up assessment:

<input type="checkbox"/> GP	<input type="checkbox"/> Voluntary Services employee
<input type="checkbox"/> Stroke coordinator	<input type="checkbox"/> Secondary care clinician
<input type="checkbox"/> Therapist	<input type="checkbox"/> Other
<input type="checkbox"/> District/community nurse	

8.1.4 If other, please specify	Free text (30-character limit)
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8.1.5 Did the patient give consent for their identifiable information to be included in SSNAP?*

<input type="checkbox"/> Yes, patient gave consent	<input type="checkbox"/> No, patient refused consent	<input type="checkbox"/> Patient was not asked
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8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No but
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8.2.1 If yes, Was the patient identified as needing support?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8.2.2 If yes, Has this patient received psychological support for mood, behaviour or cognition since discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No but
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8.3 Where is this patient living?

<input type="checkbox"/> Home	<input type="checkbox"/> Care home	<input type="checkbox"/> Other
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8.3.1 If other, please specify	Free text (30-character limit)
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8.4 What is the patient's modified Rankin Scale score?	0 - 6
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8.5 Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8.6 Is the patient taking:

8.6.1. Antiplatelet:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8.6.2. Anticoagulant:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8.6.3. Lipid Lowering:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8.6.4. Antihypertensive:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8.7 Since their initial stroke, has the patient had any of the following:

8.7.1 Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8.7.2 Myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8.7.3 Other illness requiring hospitalisation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*8.1.5. This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board.

For further assistance, please contact the SSNAP Helpdesk (09:00-17:00 Mon-Fri):
02030751318 / 02030751383 www.strokeaudit.org ssnap@kcl.ac.uk

SSNAP Six Month Assessment Form

