

Patient Name: SURNAME FORENAME

Patient DOB: DD/MM/YYYY

NHS No.: \_\_\_\_\_

Hospital No.: \_\_\_\_\_

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1) Did the patient receive an intra-arterial intervention for acute stroke?  YES  NO

The following questions are only for patients in whom "YES" has been answered:

2) Was the patient enrolled into a clinical trial of intra-arterial intervention?  YES  NO

3) What brain imaging technique was carried out prior to the intra-arterial intervention? (Select all that apply)

CTA or MRA: <input type="checkbox"/> YES <input type="checkbox"/> NO	Measurement of ASPECTS score: <input type="checkbox"/> YES <input type="checkbox"/> NO	Assessment of ischaemic penumbra by perfusion imaging: <input type="checkbox"/> YES <input type="checkbox"/> NO
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4) How was anaesthesia managed during the intra-arterial intervention? (Select only the most appropriate response)

Local anaesthetic only (anaesthetist NOT present) <input type="checkbox"/>	Local anaesthetic only (anaesthetist present) <input type="checkbox"/>
Local anaesthetic and conscious sedation (anaesthetist NOT present) <input type="checkbox"/>	Local anaesthetic and conscious sedation (anaesthetist present) <input type="checkbox"/>
General anaesthetic <input type="checkbox"/>	Other <input type="checkbox"/>

5) What was the specialty of the lead operator? (Select only the most appropriate response)

Interventional neuroradiologist <input type="checkbox"/>	Cardiologist <input type="checkbox"/>
Interventional radiologist <input type="checkbox"/>	Other <input type="checkbox"/>

6) Were any of the following used?

Thrombo-aspiration system: <input type="checkbox"/> YES <input type="checkbox"/> NO	Stent retriever: <input type="checkbox"/> YES <input type="checkbox"/> NO
Proximal balloon/flow arrest guide catheter: <input type="checkbox"/> YES <input type="checkbox"/> NO	Distal access catheter: <input type="checkbox"/> YES <input type="checkbox"/> NO

7) Date and time of:

Arterial puncture:	DD/MM/YYYY	HH:MM
First deployment of device for thrombectomy or aspiration (if carried out):	DD/MM/YYYY	HH:MM
Was thrombectomy or aspiration carried out?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
End of procedure (time of last angiographic run on treated vessel):	DD/MM/YYYY	HH:MM

8) No longer required

9) Angiographic appearance of culprit vessel and result assessed by operator (modified TIC1 score):

Pre intervention:	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2a <input type="checkbox"/>	2b <input type="checkbox"/>	3 <input type="checkbox"/>
Post intervention:	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2a <input type="checkbox"/>	2b <input type="checkbox"/>	3 <input type="checkbox"/>

10) Where was the patient transferred after the completion of the procedure? (Select only the most appropriate response)

Intensive care unit or high dependency unit <input type="checkbox"/>	Stroke unit <input type="checkbox"/>	Other <input type="checkbox"/>
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