



SSNAP Core Dataset 4.0.0

For queries, please contact ssnap@rcplondon.ac.uk
Webtool for data entry: www.strokeaudit.org

NB. There is a stand-alone intra-arterial proforma available in the support section of the dataset which lists only those additional questions related to this intervention. The changes in the SSNAP Core Dataset 3.1.1 are all related to these new dataset questions.

Version	Date	Changes
1.1.1	12 Dec 2012	– Official core dataset following pilot versions (most recent 3.6.16)
1.1.2	18 Feb 2013	– 1.12.2 – word ‘incident’ added to question and allowed values changed to 10 characters – 2.8 – sub questions renumbered – 6.10 – word ‘First’ added
2.1.1	02 Apr 2014	– 1.14 Which was the first ward the patient was admitted to at the first hospital? (wording change from ‘Which was the first ward the patient was admitted to?’) – 3.1 Has it been decided in the first 72 hours that the patient is for palliative care? (wording change from ‘If yes, does the patient have a plan for their end of life care?’) – 3.1.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 4.4.1 – New question: ‘If yes, at what date was the patient no longer considered to require this therapy?’ – 4.5.1 Question removed – 4.6.1 Question removed – 6.9.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 6.11 - New question: ‘Was intermittent pneumatic compression applied?’ – 6.11.1 - New question: ‘If yes, what date was intermittent pneumatic compression first applied?’ <i>Validations: Cannot be before clock start and cannot be after 7.3</i> – 6.11.2 - New question: ‘If yes, what date was intermittent pneumatic compression finally removed?’ <i>Cannot be before clock start or 6.11.1 and cannot be after 7.3</i> – 7.1 – Additional answer options: ‘Was transferred to another inpatient care team, not participating in SSNAP’; ‘Was transferred to an ESD/community team, not participating in SSNAP’. <i>Validations: Selecting either of these has same effect as selecting ‘discharged somewhere else’</i> – 7.3.1 – ‘Date patient considered by the multidisciplinary team to no longer require inpatient care?’ (wording change from ‘Date patient considered by the multidisciplinary team to no longer require inpatient rehabilitation?’) – 8.4 – Additional answer option: ‘Not Known’. (‘What is the patient’s modified Rankin Scale score?’) – 8.5 – Additional answer option: ‘Not Known’. (‘Is the patient in persistent, permanent or paroxysmal atrial fibrillation?’) – 8.6.1 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antiplatelet?’) – 8.6.2 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Anticoagulant?’) – 8.6.3 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Lipid Lowering?’) – 8.6.4 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antihypertensive?’) – 8.7.1 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Stroke’) – 8.7.2 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Myocardial infarction’) – 8.7.3 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Other illness requiring hospitalisation’)
3.1.1	01 Oct 2015	– 2.11 – New question – ‘Did the patient receive an intra-arterial intervention for acute stroke?’ – 2.11.1 – New question – ‘Was the patient enrolled into a clinical trial of intra-arterial

		<p>intervention?’</p> <ul style="list-style-type: none"> – 2.11.2 – New question – ‘What brain imaging technique was carried out prior to the intra-arterial intervention?’ – 2.11.3 – New question – ‘How was anaesthesia managed during the intra-arterial intervention?’ – 2.11.4 – New question – ‘What was the speciality of the lead operator?’ – 2.11.5 – New question – ‘Were any of the following used?’ – 2.11.6 – New question – ‘Date and time of:’ – 2.11.7 – New question – ‘Did any of the following complications occur?’ – 2.11.8 – New question – ‘Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):’ – 2.11.9 – New question – ‘Where was the patient transferred after the completion of the procedure?’
4.0.0	01 Dec 2017	<ul style="list-style-type: none"> – 2.1.7 - remove validation: Validation Change: “Yes” is available even if patient is not in AF prior to this admission ie if 2.1.3 “Atrial Fibrillation” = No then 2.1.7 answer options are not greyed out. – 2.1.7a - New question and validation – 2.1.7b - New question and validation – 2.1.8 - New question and validation – 2.8 - New question and validation – 2.9 - New question and validation – 2.9.1 - New question and validation – 2.9.2 - New question and validation – 2.9.3 - New question and validation – 2.9.4 - New question and validation – 2.9.5 - New question and validation – 2.9.6 - New question and validation – 2.9.7 - New question and validation – 2.9.8 - New question and validation – 2.9.9 - New question and validation – 2.9.10 - New question and validation – 2.9.11 - New question and validation – 2.9.12 - New question and validation – 2.9.13 - New question and validation – 2.9.14 - New question and validation – 2.9.15 - New question and validation – 2.12 - New question and validation – 2.13 - New question and validation – 2.14 - New question and validation – 2.14a - New question and validation – 2.15 - New question and validation – 2.15.1 - New question and validation – 3.3a - New question and validation – 3.3b - New question and validation – 3.3c - Change to previous question 3.3

Hospital / Team
Patient Audit Number

Demographics/ Onset/ Arrival (must be completed by the first hospital)

- 1.1. Hospital Number
- 1.2. NHS Number or No NHS Number
- 1.3. Surname
- 1.4. Forename
- 1.5. Date of birth
- 1.6. Gender Male Female
- 1.7. Postcode of usual address
- 1.8. Ethnicity or Not Known
- 1.9. What was the diagnosis? Stroke TIA Other (If TIA or Other please go to relevant section)
- 1.10. Was the patient already an inpatient at the time of stroke? Yes No
- 1.11. Date/time of onset/awareness of symptoms
- 1.11.1. The date given is: Precise Best estimate Stroke during sleep
- 1.11.2. The time given is: Precise Best estimate Not known
- 1.12. Did the patient arrive by ambulance? Yes No
- If yes:
- 1.12.1. Ambulance trust
- 1.12.2. Computer Aided Despatch (CAD) / Incident Number or Not known
- 1.13. Date/ time patient arrived at first hospital
- 1.14. Which was the first ward the patient was admitted to at the first hospital?
MAU/ AAU/ CDU Stroke Unit ITU/CCU/HDU Other
- 1.15. Date/time patient first arrived on a stroke unit or Did not stay on stroke unit

Casemix/ First 24 hours (if patient is transferred to another setting after 24 hours, this section must be complete)

- 2.1. Did the patient have any of the following co-morbidities prior to this admission?
- 2.1.1 Congestive Heart Failure: Yes No
- 2.1.2 Hypertension: Yes No
- 2.1.3 Atrial fibrillation: Yes No
- 2.1.4 Diabetes: Yes No
- 2.1.5 Stroke/TIA: Yes No

2.1.6 If 2.1.3 is yes, was the patient on antiplatelet medication prior to admission? Yes No No but

2.1.7 Was the patient on anticoagulant medication prior to admission? Yes No No but

2.1.7(a) What anticoagulant was the patient prescribed before their stroke?

Vitamin K antagonists (includes Warfarin)

DOAC

Heparin

2.1.7(b) What was the patient's International Normalised ratio (INR) on arrival at hospital (if inpatient, INR at the time of stroke onset)?

Allowable values (0.0 – 10.0) [0.0]

INR not checked

Greater than 10

2.1.8 Was a new diagnosis of AF made on admission?

Yes No

2.2. What was the patient's modified Rankin Scale score before this stroke?

2.3. What was the patient's NIHSS score on arrival?

		0	1	2	3	4	Not known
2.3.1	Level of Consciousness (LOC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2.3.2	LOC Questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.3	LOC Commands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.4	Best Gaze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.5	Visual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.6	Facial Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.7	Motor Arm (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.8	Motor Arm (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.9	Motor Leg (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.10	Motor Leg (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.11	Limb Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.12	Sensory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.13	Best Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.14	Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.15	Extinction and Inattention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>

2.4. Date and time of first brain imaging after stroke
or Not imaged

2.5. What was the type of stroke? Infarction Primary Intracerebral Haemorrhage

2.6. Was the patient given thrombolysis? Yes No No but (auto-selected if 2.5=PIH)

2.6.1 If no, what was the reason:

Thrombolysis not available at hospital at all Outside thrombolysis service hours

Unable to scan quickly enough None

2.6.2 If no but, please select the reasons:

Haemorrhagic stroke (auto-selected if 2.5=PIH)

Age

Arrived outside thrombolysis time window

Symptoms improving

Co-morbidity

Stroke too mild or too severe

Contraindicated medication

Symptom onset time unknown/wake-up stroke

Patient or relative refusal

Other medical reason

2.7. Date and time patient was thrombolysed

2.8. Was there evidence of cerebral haemorrhage on brain imaging after the patient received thrombolysis/thrombectomy?
Yes No

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis / intra-arterial intervention?

		0	1	2	3	4	Not known
2.9.1	Level of Consciousness (LOC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2.9.2	LOC Questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.3	LOC Commands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.4	Best Gaze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.5	Visual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.6	Facial Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.7	Motor Arm (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.8	Motor Arm (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.9	Motor Leg (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.10	Motor Leg (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.11	Limb Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.12	Sensory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.13	Best Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.14	Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.15	Extinction and Inattention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>

2.10. Date and time of first swallow screen
or Patient not screened in first 4 hours

2.10.1 If screening was not performed within 4 hours, what was the reason?

2.11 Did the patient receive an intra-arterial intervention for acute stroke? Yes No

2.11.1 Was the patient enrolled into a clinical trial of intra-arterial intervention? Yes No

2.11.2 What brain imaging technique(s) was carried out prior to the intra-arterial intervention?

a. CTA or MRA Yes No

b. Measurement of ASPECTS score Yes No

c. Assessment of ischaemic penumbra by perfusion imaging Yes No

2.11.3 How was anaesthesia managed during the intra-arterial intervention?

Local anaesthetic only (anaesthetist NOT present)

Local anaesthetic only (anaesthetist present)

Local anaesthetic and conscious sedation (anaesthetist NOT present)

Local anaesthetic and conscious sedation (anaesthetist present)

General anaesthetic

Other

2.11.4 What was the specialty of the lead operator?

Interventional neuroradiologist

Cardiologist

Interventional radiologist

Other

2.11.5 Were any of the following used?

a. Thrombo-aspiration system Yes No

b. Stent retriever Yes No

c. Proximal balloon/flow arrest guide catheter Yes No

d. Distal access catheter Yes No

2.11.6 Date and time of:

a. Arterial puncture:

b. First deployment of device for thrombectomy or aspiration

dd	mm	yyyy	hh	mm
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Not performed

c. End of procedure (time of last angiographic run on treated vessel):

dd	mm	yyyy	hh	mm
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2.11.7 Angiographic appearance of culprit vessel and result assessed by operator (modified TICl score)

a. Pre intervention 0 1 2a 2b 3

b. Post intervention 0 1 2a 2b 3

2.11.8 Where was the patient transferred after the completion of the procedure?

Intensive care unit or high dependency unit

Stroke unit

Other

2.12 What was the patient's systolic blood pressure on arrival at hospital (the first SBP taken in the hospital) (note: if onset in hospital, first systolic blood pressure after stroke onset) [0] mmHg (range = 30-300)

2.13. Date/time of acute blood pressure lowering treatment, if given to the patient within 24 hours of onset? ("if onset is unknown, only answer if given within 1 day of stroke onset")

Date: [Click here to enter a date.](#) Time: 00:00 Not given

2.14 Date/time SBP (Systolic Blood Pressure) of 140mmHg or lower was first achieved?

Date: [Click here to enter a date.](#) Time: 00:00

Not achieved within 24h

2.15. Was the patient given anticoagulant reversal therapy?

Yes No

If yes, 2.15.1. What reversal agent was given?

PCC

DOAC antidote

FFP

Protamine

Vitamin K

2.15.2. Date and time reversal agent was given

Date: [Click here to enter a date.](#) Time: 00:00

Assessments – First 72 hours (if patient is transferred after 72 hours, this section must be complete and locked)

3.1. Has it been decided in the first 72 hours that the patient is for palliative care? Yes No

If yes:

3.1.1. Date of palliative care decision

dd	mm	yyyy
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3.1.2. If yes, does the patient have a plan for their end of life care? Yes No

3.2. Date/time first assessed by nurse trained in stroke management

dd	mm	yyyy	hh	mm
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or No assessment in first 72 hours

3.3a Date/time first assessed by stroke specialist consultant physician
or No assessment in first 72 hours

3.3b How was contact first made with the stroke consultant?

In person

By telephone

Telemedicine

3.3c If first contact with consultant was not in person, date and time first assessed by stroke specialist consultant physician in person

3.4. Date/time of first swallow screen (If date/time already entered for screening within 4 hours (2.10), 3.4 does not need to be answered)
or Patient not screened in first 72 hours

3.4.1 If screening was not performed within 72 hours, what was the reason?

3.5. Date/time first assessed by an Occupational Therapist
or No assessment in first 72 hours

3.5.1 If assessment was not performed within 72 hours, what was the reason?

3.6. Date/time first assessed by a Physiotherapist
or No assessment in first 72 hours

3.6.1 If assessment was not performed within 72 hours, what was the reason?

3.7. Date/time communication first assessed by Speech and Language Therapist
or No assessment in first 72 hours

3.7.1 If assessment was not performed within 72 hours, what was the reason?

3.8. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment
or No assessment in first 72 hours

3.8.1 If assessment was not performed within 72 hours, what was the reason?

This admission (this section must be completed by every team/ hospital/ care setting)

4.1. Date/ time patient arrived at this hospital/team

4.2. Which was the first ward the patient was admitted to at this hospital?
 MAU/ AAU/ CDU Stroke Unit ITU/CCU/HDU Other

4.3. Date/time patient arrived on stroke unit at this hospital
 or Did not stay on stroke unit

	1. Physiotherapy	2. Occupational Therapy	3. Speech and language therapy	4. Psychology
4.4. Was the patient considered to require this therapy at any point in this admission?	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
4.4.1 If yes, at what date was the patient no longer considered to require this therapy?				
4.5. On how many days did the patient receive this therapy across their total stay in this hospital/team?				
4.6. How many minutes of this therapy in total did the patient receive during their stay in this hospital/team?				

4.7. Date rehabilitation goals agreed: or No goals

4.7.1. If no goals agreed, what was the reason?	
Not known <input type="radio"/>	Patient medically unwell for entire admission <input type="radio"/>
Patient refused <input type="radio"/>	Patient has no impairments <input type="radio"/>
Organisational reasons <input type="radio"/>	Patient considered to have no rehabilitation potential <input type="radio"/>

Patient Condition in first 7 days (if patient is transferred after 7 days, this section must be complete)

5.1. What was the patient's worst level of consciousness in the first 7 days following initial admission for stroke? (Based on patient's NIHSS Level of Consciousness (LOC) score): 0 1 2 3

5.2. Did the patient develop a urinary tract infection in the first 7 days following initial admission for stroke as defined by having a positive culture or clinically treated? Yes No Not known

5.3. Did the patient receive antibiotics for a newly acquired pneumonia in the first 7 days following initial admission for stroke? Yes No Not known

Assessments – By discharge (some questions are repeated from the “Assessments – First 72 hours” section but should only be answered if assessments not carried out in the first 72 hours)

- 6.1. Date/time first assessed by an Occupational Therapist
or No assessment by discharge
- 6.1.1 If no assessment, what was the reason?
- 6.2. Date/time first assessed by a Physiotherapist
or No assessment by discharge
- 6.2.1 If no assessment, what was the reason?
- 6.3. Date/time communication first assessed by Speech and Language Therapist

or No assessment by discharge
- 6.3.1 If no assessment, what was the reason?
- 6.4. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment

or No assessment by discharge
- 6.4.1 If no assessment, what was the reason?
- 6.5. Date urinary continence plan drawn up or No plan
- 6.5.1 If no plan, what was the reason?
- 6.6. Was the patient identified as being at high risk of malnutrition following nutritional screening?
Yes No Not screened
- 6.6.1 If yes, date patient saw a dietitian or Not seen by a dietitian
- 6.7. Date patient screened for mood using a validated tool or Not screened
- 6.7.1 If not screened, what was the reason?
- 6.8. Date patient screened for cognition using a simple standardised measure?
or Not screened
- 6.8.1 If not screened, what was the reason?
- 6.9. Has it been decided by discharge that the patient is for palliative care? Yes No
If yes:
- 6.9.1 Date of palliative care decision
- 6.9.2 If yes, does the patient have a plan for their end of life care? Yes No
- 6.10. First date rehabilitation goals agreed: or No goals
- This question is auto-completed. It will be based on the first date that is entered for 4.7. If no hospitals / care settings in the pathway enter a date (i.e. all select ‘no goals’), then ‘no goals’ will be selected here
- 6.11. Was intermittent pneumatic compression applied? Yes No Not Known
- 6.11.1 If yes, what date was intermittent pneumatic compression first applied?
- 6.11.2 If yes, what date was intermittent pneumatic compression finally removed?

Discharge / Transfer

- 7.1. The patient:
Died
Was discharged to a care home
Was discharged home
Was discharged to somewhere else
Was transferred to another inpatient care team
Was transferred to an ESD / community team
Was transferred to another inpatient care team, not participating in SSNAP
Was transferred to an ESD/community team, not participating in SSNAP
- 7.1.1 If patient died, what was the date of death?
- 7.1.2 Did the patient die in a stroke unit? Yes No
- 7.1.3 What hospital/team was the patient transferred to?
- 7.2. Date/time of discharge from stroke unit
- 7.3. Date/time of discharge/transfer from team
- 7.3.1 Date patient considered by the multidisciplinary team to no longer require inpatient care?
- 7.4. Modified Rankin Scale score at discharge/transfer (defaults to 6 if 7.1 is died in hospital)
- 7.5. If discharged to a care home, was the patient: Previously a resident Not previously a resident
- 7.5.1 If not previously a resident, is the new arrangement: Temporary Permanent
- 7.6. If discharged home, is the patient: Living alone Not living alone Not known
- 7.7. Was the patient discharged with an Early Supported Discharge multidisciplinary team?
Yes, stroke/neurology specific Yes, non-specialist No
- 7.8. Was the patient discharged with a multidisciplinary community rehabilitation team?
Yes, stroke/neurology specific Yes, non-specialist No
- 7.9. Did the patient require help with activities of daily living (ADL)? Yes No
If yes:
7.9.1 What support did they receive?
Paid carers Paid care services unavailable
Informal carers Patient refused
Paid and informal carers
- 7.9.2 At point of discharge, how many visits per week were social services going to provide?
or Not known
- 7.10. Is there documented evidence that the patient is in atrial fibrillation on discharge? Yes No
- 7.10.1 If yes, was the patient taking anticoagulation (not anti-platelet agent) on discharge or discharged with a plan to start anticoagulation within the next month? Yes No No but
- 7.11. Is there documented evidence of joint care planning between health and social care for post discharge management? Yes No Not applicable
- 7.12. Is there documentation of a named person for the patient and/or carer to contact after discharge? Yes No

Six month (post admission) follow-up assessment

8.1. Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?
Yes No No but No, patient died within 6 months of admission
N.B. 'No but' should only be answered for DNAs, patients who are not registered with a GP, or patients who have had another stroke and a new SSNAP record started

8.1.1 What was the date of follow-up?

8.1.2 How was the follow-up carried out: In person By telephone Online By post

8.1.3 Which of the following professionals carried out the follow-up assessment:

GP District/community nurse
Stroke coordinator Voluntary Services employee
Therapist Secondary care clinician
Other

8.1.4 If other, please specify

8.1.5 Did the patient give consent for their identifiable information to be included in SSNAP?*

Yes, patient gave consent No, patient refused consent Patient was not asked

8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?

Yes No No but

8.2.1 If yes, was the patient identified as needing support? Yes No

8.2.2 If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?

Yes No No but

8.3. Where is this patient living? Home Care home Other

8.3.1 If other, please specify

8.4. What is the patient's modified Rankin Scale score? Not known

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes No Not known

8.6. Is the patient taking:

8.6.1 Antiplatelet: Yes No Not known

8.6.2 Anticoagulant: Yes No Not known

8.6.3 Lipid Lowering: Yes No Not known

8.6.4 Antihypertensive: Yes No Not known

8.7. Since their initial stroke, has the patient had any of the following:

8.7.1 Stroke Yes No Not known

8.7.2 Myocardial infarction Yes No Not known

8.7.3 Other illness requiring hospitalisation Yes No Not known

*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.