Subject ID: _____

Date: _____

Screening Visit

Inclusion/Exclusion Criteria

Inclusion Criteria:		
Patient/legally authorized representative has signed the informed consent form.	☐ Yes	☐ No
Age ≥18 years	☐ Yes	☐ No
AIS symptom onset within 4.5 to 24 hours • Stroke onset is defined as the time the patient was last known to be at their neurologic baseline (wake-up strokes are eligible if they present within the 4.5 to 24-hour time limits) • Note: All study-related treatment needs to be initiated within 24 hours	☐ Yes	☐ No
Signs and symptoms consistent with the diagnosis of an acute anterior circulation ischemic stroke involving occlusion of the ICA, M1, or M2 vessels	☐ Yes	☐ No
Functionally independent (mRS 0-2) prior to stroke onset	☐ Yes	☐ No
Baseline NIHSS ≥ 5 and that remains ≥ 5 immediately prior to randomization	☐ Yes	☐ No
Neuroimaging: ICA or M1, M2 occlusion (carotid occlusions can be cervical or intracranial, with or without tandem MCA lesions) by MRA or CTA **AND** target mismatch profile on CT perfusion or MRI (ischemic core volume <70 mL, mismatch ratio is ≥ 1.8 and mismatch volume is ≥to 15 mL) ---The mismatch volume is determined by RAPID software based on the difference between the ischemic core lesion volume and the Tmax>6s lesion volume. If both a CTP and multimodal MRI are performed prior to enrollment, the latter of the 2 scans is assessed to determine eligibility. For patients screened with MRA, only an intracranial MRA is required (cervical MRA is not required). Cervical and intracranial CTA are typically obtained simultaneously in patients screened with CTA, but only the intracranial CTA is required for enrollment. **ALTERNATIVE NEUROIMAGING** --If CTA (or MRA) is technically inadequate: Tmax >6s perfusion deficit consistent with an ICA or M1, M2 occlusion AND target mismatch profile (ischemic core volume <70 mL, mismatch ratio ≥1.8 and mismatch volume ≥15 mL as determined by RAPID software) -- If MR perfusion (MRP) is technically inadequate: ICA or M1, M2 occlusion by MRA ***AND*** diffusion-weighted imaging (DWI) lesion volume < or equal to 25 mL for an M1 or ICA occlusion and < or equal to 15 mL for an M2 occlusion. If MRA is technically inadequate, a CTA can be used if performed within 60 minutes prior to the MRI. Carotid occlusions can be cervical or intracranial; with or without tandem MCA lesions. -- If CTP is technically inadequate: patient can be screened with MRI and randomized if neuroimaging criteria are met.	☐ Yes	☐ No

Ability to comply with the study protocol, in the investigator's judgment	☐ Yes	☐ No

Exclusion Criteria		
Current participation in another investigational drug or device study	☐ Yes	☐ No
Active internal bleeding	☐ Yes	☐ No
Known hypersensitivity or allergy to any ingredients of tenecteplase	☐ Yes	☐ No
Known hereditary or acquired hemorrhagic diathesis, coagulation factor deficiency; recent oral anticoagulant therapy with INR ☐.7	☐ Yes	☐ No
Use of one of the new oral anticoagulants within the last 48 hours (dabigatran, rivaroxaban, apixaban, edoxaban)	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No
Intracranial neoplasm (except small meningioma), arteriovenous malformation, or aneurysm	☐ Yes	☐ No
Seizures at stroke onset if it precludes obtaining an accurate baseline NIHSS	☐ Yes	☐ No
Severe, uncontrolled hypertension (systolic blood pressure >180 mmHg or diastolic blood pressure >110 mmHg)	☐ Yes	☐ No
Baseline platelet count <100,000/☐ (results must be available prior to treatment)	☐ Yes	☐ No
Baseline blood glucose >400 mg/dL (22.20 mmol/L)	☐ Yes	☐ No
Baseline blood glucose <50 mg/dL needs to be normalized prior to randomization	☐ Yes	☐ No
Clot retrieval attempted using a neurothrombectomy device prior to randomization	☐ Yes	☐ No
Intracranial or intraspinal surgery or trauma within 2 months	☐ Yes	☐ No
Treatment with a thrombolytic within the last 3 months prior to randomization	☐ Yes	☐ No
Other serious, advanced, or terminal illness (investigator judgment) or life expectancy is less than 6 months	☐ Yes	☐ No
History of acute ischemic stroke in the last 90 days	☐ Yes	☐ No
History of hemorrhagic stroke	☐ Yes	☐ No
Presumed septic embolus; suspicion of bacterial endocarditis	☐ Yes	☐ No
Any other condition that, in the opinion of the investigator, precludes an endovascular procedure or poses a significant hazard to the patient if an endovascular procedure was to be performed	☐ Yes	☐ No
Imaging specific exclusions		
Unable to undergo a contrast brain perfusion scan with either MRI or CT	☐ Yes	☐ No
Extensive early ischemic change (hypodensity) on non-contrast CT estimated to be >1/3 MCA territory, or significant hypodensity outside the Tmax☐s	☐ Yes	☐ No

Subject ID: _____

Date: _____

perfusion lesion that invalidates mismatch criteria (if patient is enrolled based on CT perfusion criteria)		
Significant mass effect	☐ Yes	☐ No
Acute symptomatic arterial occlusions in more than one vascular territory confirmed on CTA/MRA (e.g., bilateral MCA occlusions, or an MCA and a basilar artery occlusion)	☐ Yes	☐ No
Evidence of intracranial tumor (except small meningioma) acute intracranial hemorrhage, neoplasm, or arteriovenous malformation	☐ Yes	☐ No

Did the subject meet the eligibility criteria for the study?	**☐ Yes**	**☐ No**

Signature of Investigator Confirming Eligibility

Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Informed Consent

Visit Date (dd-mon-yyyy):		
Protocol Version # Subject was Consented:		
Date Informed Consent Signed (dd-mon-yyyy):		
ICF Signed by:	☐ Subject	☐ LAR
Method of Consent:	☐ In Person	
	☐ FAX	
	☐ Email	
	☐ Combination remote/in person	

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Demographics

Sex:	☐ Male	☐ Female
Date of birth:		
Age at Informed Consent:		
Ethnicity:	☐ Hispanic or Latino	
	☐ Not Hispanic or Latino	
	☐ Not reported	
	☐ Unknown	
Race:	☐ American Indian or Alaska Native	
	☐ Asian	
	☐ Black or African American	
	☐ Native Hawaiian or Other Pacific Islander	
	☐ White	
	☐ Other	
Race Other, Specify:		
Veteran Status	☐ Yes	
	☐ No	

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Baseline CT

Date of imaging: _____

Start time of imaging: _____

Side of lesion:

- ☐ Left
- ☐ Right

Type of occlusion:

- ☐ ICA
- ☐ MCA-M1
- ☐ MCA-M2
- ☐ Other, specify:

_____

From the RAPID software, please provide ischemic core volume, mismatch ratio, absolute mismatch volume, and Tmax >6s Lesion volume.

Ischemic Core Volume: _____ mL

Mismatch Ratio: _____

Absolute Mismatch Volume: _____ mL

Tmax >6s Lesion Volume: _____ mL

Is scan sufficient quality to determine an ASPECTS score:

- ☐ Yes
- ☐ No

If yes, complete below:

a. Caudate head
   - ☐ Abnormal
   - ☐ Normal

b. Lentiform nucleus
   - ☐ Abnormal
   - ☐ Normal

c. Insular ribbon
   - ☐ Abnormal
   - ☐ Normal

d. Internal capsule
   - ☐ Abnormal
   - ☐ Normal

e. Anterior MCA cortex (M1)
   - ☐ Abnormal
   - ☐ Normal

f. MCA cortex lateral to insular ribbon (M2)
   - ☐ Abnormal
   - ☐ Normal

g. Posterior MCA cortex (M3)
   - ☐ Abnormal
   - ☐ Normal

h. Anterior superior to M1, rostral to basal ganglia (M4)
   - ☐ Abnormal
   - ☐ Normal

i. Lateral superior to M2, rostral to basal ganglia (M5)
   - ☐ Abnormal
   - ☐ Normal

j. Posterior superior to M3, rostral to basal ganglia (M6)
   - ☐ Abnormal
   - ☐ Normal

Intracranial hemorrhage:

- ☐ HI-1
- ☐ HI-2
- ☐ PH-1
- ☐ PH-2
- ☐ IVH
- ☐ Subdural
- ☐ Epidural
- ☐ SAH
- ☐ None

CTP infarct volume: _____ mL

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Mechanical Thrombectomy

Was mechanical thrombectomy performed?

- ☐ Yes
- ☐ No

If no, please provide reason:

- ☐ Subject has had partial recanalization
- ☐ Subject has had complete recanalization
- ☐ Unable to access clot
- ☐ Other, specify:

_____

Did the patient receive general anesthesia for the procedure?

- ☐ Yes
- ☐ No

Was there successful groin access?

- ☐ Yes
- ☐ No

Baseline modified TICI score:

- ☐ 0- No flow
- ☐ 1- Penetration, but no distal branch filling
- ☐ 2A- Partial reperfusion with incomplete (<50%) or slow distal branch filling
- ☐ 2B- Partial reperfusion with incomplete (50-99%) or slow distal branch filling
- ☐ 3- Full reperfusion

Date of mechanical thrombectomy: _____

Start time of arterial puncture: _____

Able to access the clot?

- ☐ Yes
- ☐ No

Start date of first contact with clot: _____

Start time of first contact with clot: _____

Final modified TICI score:

- ☐ 0- No flow
- ☐ 1- Penetration, but no distal branch filling

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

- ☐ 2A- Partial reperfusion with incomplete (<50%) or slow distal branch filling
- ☐ 2B- Partial reperfusion with incomplete (50-99%) or slow distal branch filling
- ☐ 3- Full reperfusion

Number of passes to reach final mTICI 2b/3: _____

End date of procedure: _____

End time of procedure: _____

Was recanalization achieved?

- ☐ Yes
- ☐ No

Date of reperfusion: _____

Time of reperfusion: _____

Select all vessels that were occluded at completion of procedure:

- ☐ Proximal ICA (cervical cavernous)
- ☐ MCA- M1
- ☐ MCA- M2
- ☐ Other, specify:

_____

Was intra-arterial thromboytics used:

- ☐ Yes
- ☐ No

Subject ID: _____

Date: _____

Vital Signs

Were vital signs collected?	☐ Yes	☐ No
Time of Vital Signs (24-hour clock):		
Date of Vital Signs:		
Weight:		☐ kg
		☐ lb
Systolic Blood Pressure (mmHg):		
Diastolic Blood Pressure (mmHg):		
Measurement location-side of body	☐ Right	☐ Left
Pulse (beats/min):		
Temperature (Celsius):		☐ Oral
		☐ Rectal
		☐ Aural/Tympanic
		☐ Axillary
Respirations (breath/min):		

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Hematology Local Labs

Date collected (dd-mon-yyyy):	
Time collected (24-hour clock):	
WBC:	
RBC:	
Hemoglobin:	
Hematocrit:	
Platelets:	

Coagulation Local Labs

Date collected (dd-mon-yyyy):	
Time collected (24-hour clock):	
INR:	
PT:	
aPTT:	

Chemistry Local Labs

Date collected (dd-mon-yyyy):	
Time collected (24-hour clock):	
Glucose:	
Sodium:	
Potassium:	

Subject ID: _____

Date: _____

Study Drug Administration

Was study drug administered?

- ☐ Yes
- ☐ No

If no, reason not administered:

- ☐ Adverse event
- ☐ Other, specify:

_____

Date administered: _____

Time administered: _____

Kit ID administered: _____

Dose administered: _____ mg

Total volume administered: _____ mL

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: ___________________

Date: ___________________

Medical History

Targeted Medical History (list below if applicable):

Myocardial infarction, hypertension, atrial fibrillation, hypercholesterolemia, diabetes, prior stroke (excluding the qualifying stroke)

Myocardial infarction	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Hypercholesterolemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Prior stroke	☐ Yes	☐ No

Medical Condition	Ongoing at baseline?
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No

Subject ID: _____

Date: _____

Social History

Alcohol Use History

- ☐ Never
- ☐ Current
- ☐ Previous

If *previous* was indicated, what was the month and year of last use: _____

If current or previous:

How many years did the subject consume alcohol: _____

Average number of drinks per week: _____

Substance abuse history

Current substance use?

- ☐ Yes
- ☐ No

If yes:

- ☐ Cannabinoids
- ☐ Amphetamines
- ☐ Opiates
- ☐ Caffeine
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Cocaine

Tobacco use history

- ☐ Never
- ☐ Current
- ☐ Previous

If *previous* was indicated, what was the month and year of last use: _____

Subject ID: _____

Date: _____

If current or previous:

Average number of cigarettes per day: _____

Average number of cigars per day: _____

Average number of pipes per day: _____

Average number of packs of chewing tobacco per day: _____

How many years is/was subject a smoker: _____

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Hospital arrival

Date of qualifying stroke: _____

Time of qualifying stroke (defined as time LKN): _____

Did stroke symptoms start during hospitalization:

- ☐ Yes
- ☐ No

Randomization hospital:

- ☐ ECC (HUP)
- ☐ nECC (PPMC, PAH)

Was subject transferred from nECC hospital:

- ☐ Yes
- ☐ No

Date of arrival at nECC hospital: _____

Time of arrival at nECC hospital: _____

Date of arrival at ECC hospital: _____

Time of arrival at ECC hospital: _____

Is mechanical thrombectomy planned:

- ☐ Yes
- ☐ No

If no, please provide reason:

- ☐ Subject has M2 occlusion
- ☐ Other, specify:

_____

_____

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

Time: ___ ___:___ ___ [ ]am [ ]pm

Person Administering Scale _____

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
1a. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.	0 = **Alert;** keenly responsive. 1 = **Not alert**; but arousable by minor stimulation to obey, answer, or respond. 2 = **Not alert**; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.	_____
1b. LOC Questions: The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not "help" the patient with verbal or non-verbal cues.	0 = **Answers** both questions correctly. 1 = **Answers** one question correctly. 2 = **Answers** neither question correctly.	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.	0 = **Performs** both tasks correctly. 1 = **Performs** one task correctly. 2 = **Performs** neither task correctly.	_____
2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.	0 = **Normal.** 1 = **Partial gaze palsy;** gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present. 2 = **Forced deviation,** or total gaze paresis not overcome by the oculocephalic maneuver.	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.	0 = **No visual loss.** 1 = **Partial hemianopia.** 2 = **Complete hemianopia.** 3 = **Bilateral hemianopia** (blind including cortical blindness).	_____
4. Facial Palsy: Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.	0 = **Normal** symmetrical movements. 1 = **Minor paralysis** (flattened nasolabial fold, asymmetry on smiling). 2 = **Partial paralysis** (total or near-total paralysis of lower face). 3 = **Complete paralysis** of one or both sides (absence of facial movement in the upper and lower face).	_____
5. Motor Arm: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** limb holds 90 (or 45) degrees for full 10 seconds. 1 = **Drift;** limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. 2 = **Some effort against gravity;** limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity. 3 = **No effort against gravity;** limb falls. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **5a. Left Arm** **5b. Right Arm**	_____ _____
6. Motor Leg: The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** leg holds 30-degree position for full 5 seconds. 1 = **Drift;** leg falls by the end of the 5-second period but does not hit bed. 2 = **Some effort against gravity;** leg falls to bed by 5 seconds, but has some effort against gravity. 3 = **No effort against gravity;** leg falls to bed immediately. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **6a. Left Leg** **6b. Right Leg**	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

7. Limb Ataxia: This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.	0 = **Absent.** 1 = **Present in one limb.** 2 = **Present in two limbs.** UN = **Amputation** or joint fusion, explain: _____	_____
8. Sensory: Sensation or grimace to pinprick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas (arms [not hands], legs, trunk, face) as needed to accurately check for hemisensory loss. A score of 2, "severe or total sensory loss," should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will, therefore, probably score 1 or 0. The patient with brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a coma (item 1a=3) are automatically given a 2 on this item.	0 = **Normal;** no sensory loss. 1 = **Mild-to-moderate sensory loss;** patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. 2 = **Severe to total sensory loss;** patient is not aware of being touched in the face, arm, and leg.	_____
9. Best Language: A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, the patient is asked to describe what is happening in the attached picture, to name the items on the attached naming sheet and to read from the attached list of sentences. Comprehension is judged from responses here, as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for the patient with stupor or limited cooperation, but a score of 3 should be used only if the patient is mute and follows no one-step commands.	0 = **No aphasia;** normal. 1 = **Mild-to-moderate aphasia;** some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response. 2 = **Severe aphasia;** all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. 3 = **Mute, global aphasia;** no usable speech or auditory comprehension.	_____
10. Dysarthria: If patient is thought to be normal, an adequate sample of speech must be obtained by asking patient to read or repeat words from the attached list. If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.	0 = **Normal.** 1 = **Mild-to-moderate dysarthria;** patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = **Severe dysarthria;** patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric. UN = **Intubated** or other physical barrier, explain:_____	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

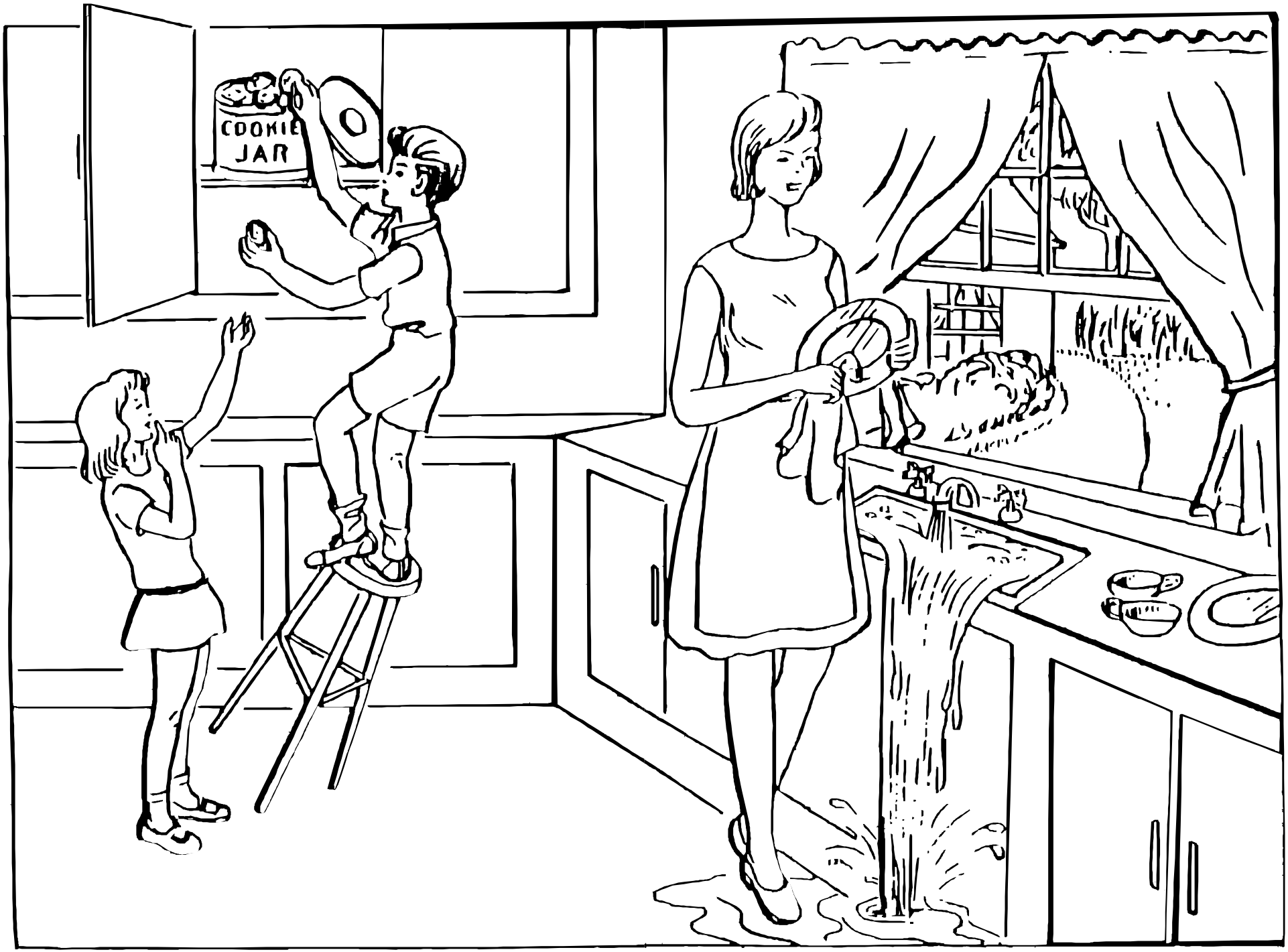
Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

11. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.	0 = **No abnormality.** 1 = **Visual, tactile, auditory, spatial, or personal inattention** or extinction to bilateral simultaneous stimulation in one of the sensory modalities. 2 = **Profound hemi-inattention or extinction to more than one modality;** does not recognize own hand or orients to only one side of space.	_____

_____

_____


COOKIE
JAR

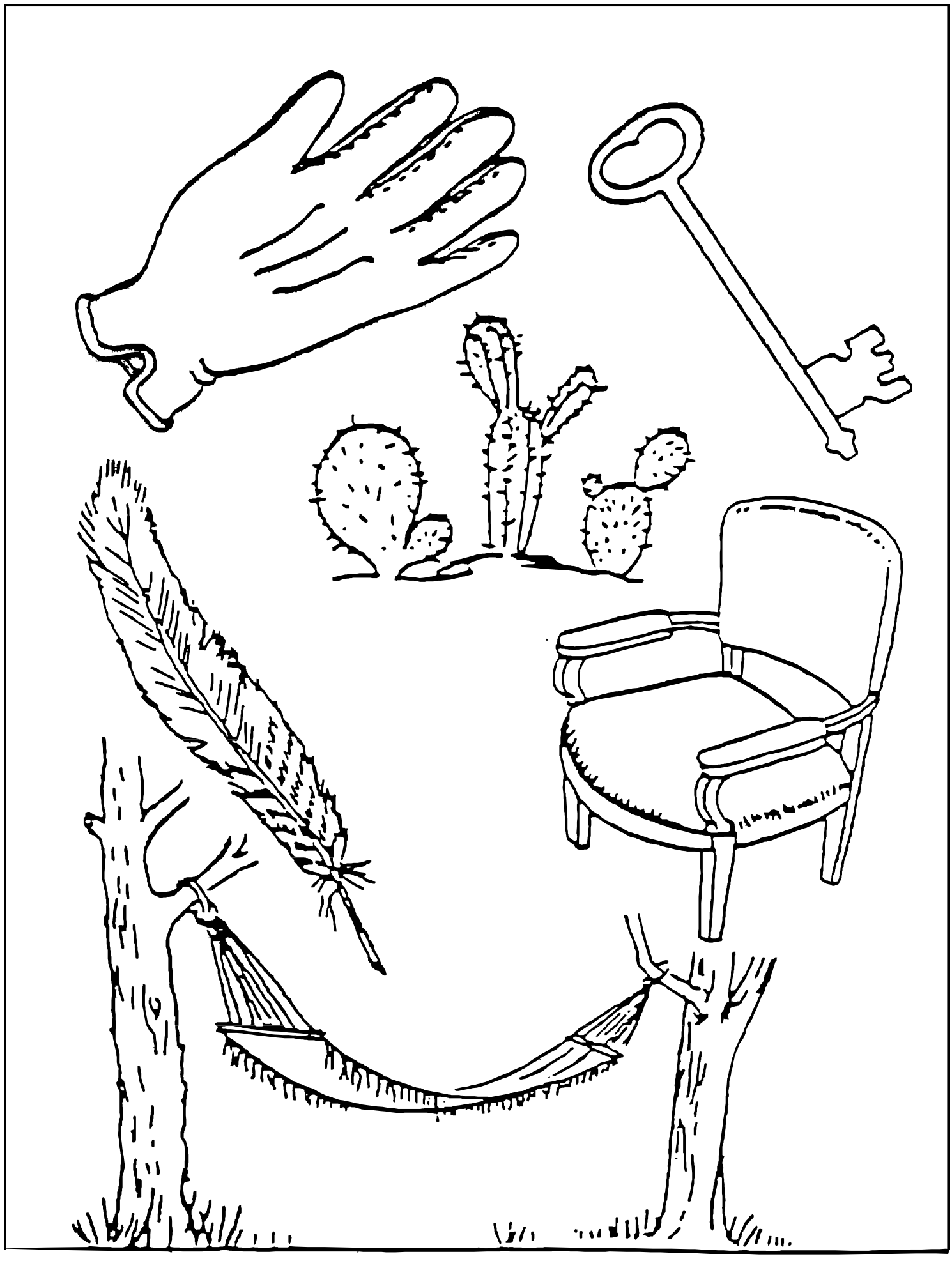
You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.



MAMA

TIP – TOP

FIFTY – FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

Subject # _____

Site # _____

Date _____

Name of Assessor: _____

Q01	Modified Rankin Scale		O (0) No symptoms at all O (1) No significant disability despite symptoms; able to carry out all usual duties and activities O (2) Slight disability; unable to carry out all previous activities but able to look after own affairs without assistance O (3) Moderate disability requiring some help, but able to walk without assistance O (4) Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance O (5) Severe disability; bedridden, incontinent, and requiring constant nursing care and attention
Q02	First/Given name of mRS assessor (50 character max)		
Q03	Last/Family name of mRS assessor (50 character max)		
Q04	*If visit is 'Day 30' or 'Day 90'*	Was the assessor blinded to treatment received?	O No O Yes
General Comments:			

Structured assessment of modified Rankin scale

Has the patient made a complete recovery with **absolutely no** residual signs or symptoms of stroke?

YES → **mRS score = 0**

NO ↓

Can the patient perform every regular activity that they could undertake prior to the stroke? Regular is defined as more frequently than monthly; includes work, social and leisure activities (eg driving a car, dancing, reading or working)

YES → **mRS score = 1**

Please briefly document what neurological symptoms/signs are present?

_____

NO ↓

Can the patient perform all their activities of daily living without assistance?
ie mobility, dressing, bathing, toileting, feeding, preparing simple meals, travelling locally without supervision.
Can the patient be safely left alone for a period of at least 1 week?

YES → **mRS score = 2**

What usual activities have ceased?

_____

NO ↓

Can the patient mobilise (with gait aid if necessary) and perform activities of daily living independently BUT requires supervision or assistance for more complex tasks e.g. shopping, cooking, cleaning, managing finances that means they need to be visited more frequently than weekly

YES → **mRS score = 3**

What activities require assistance?

_____

NO ↓

Does the patient require assistance for personal activities of daily living (walking, dressing, feeding, toileting) but can be safely left alone for a period of a few hours during the day?

YES → **mRS score = 4**

What activities require assistance?

_____

How long could the patient manage without a visit?

_____

NO ↓

Does the patient have severe disability requiring 24hr/day carer availability?

YES →

mRS score = 5

Death = mRS score 6

If in doubt, the more severe score should be allocated and please provide as much information as possible.

General Comments:

Subject ID: _____

Date: _____

Follow up CT

Date of imaging: _____

Start time of imaging: _____

Side of lesion:

- ☐ Left
- ☐ Right

Type of occlusion:

- ☐ ICA
- ☐ MCA-M1
- ☐ MCA-M2
- ☐ Other, specify:

_____

From the RAPID software, please provide ischemic core volume, mismatch ratio, absolute mismatch volume, and Tmax >6s Lesion volume.

Ischemic Core Volume: _____ mL

Mismatch Ratio: _____

Absolute Mismatch Volume: _____ mL

Tmax >6s Lesion Volume: _____ mL

Intracranial hemorrhage:

- ☐ HI-1
- ☐ HI-2
- ☐ PH-1
- ☐ PH-2
- ☐ IVH
- ☐ Subdural
- ☐ Epidural
- ☐ SAH
- ☐ None

Degree of recanalization:

- ☐ No recanalization
- ☐ Partial recanalization
- ☐ Complete recanalization
- ☐ Not applicable

If response is not applicable, choose one:

- ☐ Image not obtained
- ☐ Image of insufficient quality
- ☐ Lesion not present or rated at baseline

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Follow up MRI

Date of imaging: _____

Start time of imaging: _____

Side of lesion:

- ☐ Left
- ☐ Right

Type of occlusion:

- ☐ ICA
- ☐ MCA-M1
- ☐ MCA-M2
- ☐ Other, specify:

_____

From the RAPID software, please provide ischemic core volume, mismatch ratio, absolute mismatch volume, and Tmax >6s Lesion volume.

Ischemic Core Volume: _____ mL

Mismatch Ratio: _____

Absolute Mismatch Volume: _____ mL

Tmax >6s Lesion Volume: _____ mL

Intracranial hemorrhage:

- ☐ HI-1
- ☐ HI-2
- ☐ PH-1
- ☐ PH-2
- ☐ IVH
- ☐ Subdural
- ☐ Epidural
- ☐ SAH
- ☐ None

DWI lesion volume: _____ mL

FLAIR:

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, were abnormalities identified:

- ☐ Yes
- ☐ No

GRE:

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, were abnormalities identified:

- ☐ Yes
- ☐ No

Degree of recanalization:

- ☐ No recanalization
- ☐ Partial recanalization
- ☐ Complete recanalization
- ☐ Not applicable

If response is not applicable, choose one:

- ☐ Image not obtained
- ☐ Image of insufficient quality
- ☐ Lesion not present or rated at baseline

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

Time: ___ ___:___ ___ [ ]am [ ]pm

Person Administering Scale _____

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
1a. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.	0 = **Alert;** keenly responsive. 1 = **Not alert**; but arousable by minor stimulation to obey, answer, or respond. 2 = **Not alert**; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.	_____
1b. LOC Questions: The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not "help" the patient with verbal or non-verbal cues.	0 = **Answers** both questions correctly. 1 = **Answers** one question correctly. 2 = **Answers** neither question correctly.	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.	0 = **Performs** both tasks correctly. 1 = **Performs** one task correctly. 2 = **Performs** neither task correctly.	_____
2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.	0 = **Normal.** 1 = **Partial gaze palsy;** gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present. 2 = **Forced deviation,** or total gaze paresis not overcome by the oculocephalic maneuver.	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.	0 = **No visual loss.** 1 = **Partial hemianopia.** 2 = **Complete hemianopia.** 3 = **Bilateral hemianopia** (blind including cortical blindness).	_____
4. Facial Palsy: Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.	0 = **Normal** symmetrical movements. 1 = **Minor paralysis** (flattened nasolabial fold, asymmetry on smiling). 2 = **Partial paralysis** (total or near-total paralysis of lower face). 3 = **Complete paralysis** of one or both sides (absence of facial movement in the upper and lower face).	_____
5. Motor Arm: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** limb holds 90 (or 45) degrees for full 10 seconds. 1 = **Drift;** limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. 2 = **Some effort against gravity;** limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity. 3 = **No effort against gravity;** limb falls. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **5a. Left Arm** **5b. Right Arm**	_____ _____
6. Motor Leg: The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** leg holds 30-degree position for full 5 seconds. 1 = **Drift;** leg falls by the end of the 5-second period but does not hit bed. 2 = **Some effort against gravity;** leg falls to bed by 5 seconds, but has some effort against gravity. 3 = **No effort against gravity;** leg falls to bed immediately. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **6a. Left Leg** **6b. Right Leg**	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

7. Limb Ataxia: This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.	0 = **Absent.** 1 = **Present in one limb.** 2 = **Present in two limbs.** UN = **Amputation** or joint fusion, explain: _____	_____
8. Sensory: Sensation or grimace to pinprick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas (arms [not hands], legs, trunk, face) as needed to accurately check for hemisensory loss. A score of 2, "severe or total sensory loss," should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will, therefore, probably score 1 or 0. The patient with brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a coma (item 1a=3) are automatically given a 2 on this item.	0 = **Normal;** no sensory loss. 1 = **Mild-to-moderate sensory loss;** patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. 2 = **Severe to total sensory loss;** patient is not aware of being touched in the face, arm, and leg.	_____
9. Best Language: A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, the patient is asked to describe what is happening in the attached picture, to name the items on the attached naming sheet and to read from the attached list of sentences. Comprehension is judged from responses here, as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for the patient with stupor or limited cooperation, but a score of 3 should be used only if the patient is mute and follows no one-step commands.	0 = **No aphasia;** normal. 1 = **Mild-to-moderate aphasia;** some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response. 2 = **Severe aphasia;** all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. 3 = **Mute, global aphasia;** no usable speech or auditory comprehension.	_____
10. Dysarthria: If patient is thought to be normal, an adequate sample of speech must be obtained by asking patient to read or repeat words from the attached list. If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.	0 = **Normal.** 1 = **Mild-to-moderate dysarthria;** patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = **Severe dysarthria;** patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric. UN = **Intubated** or other physical barrier, explain:_____	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

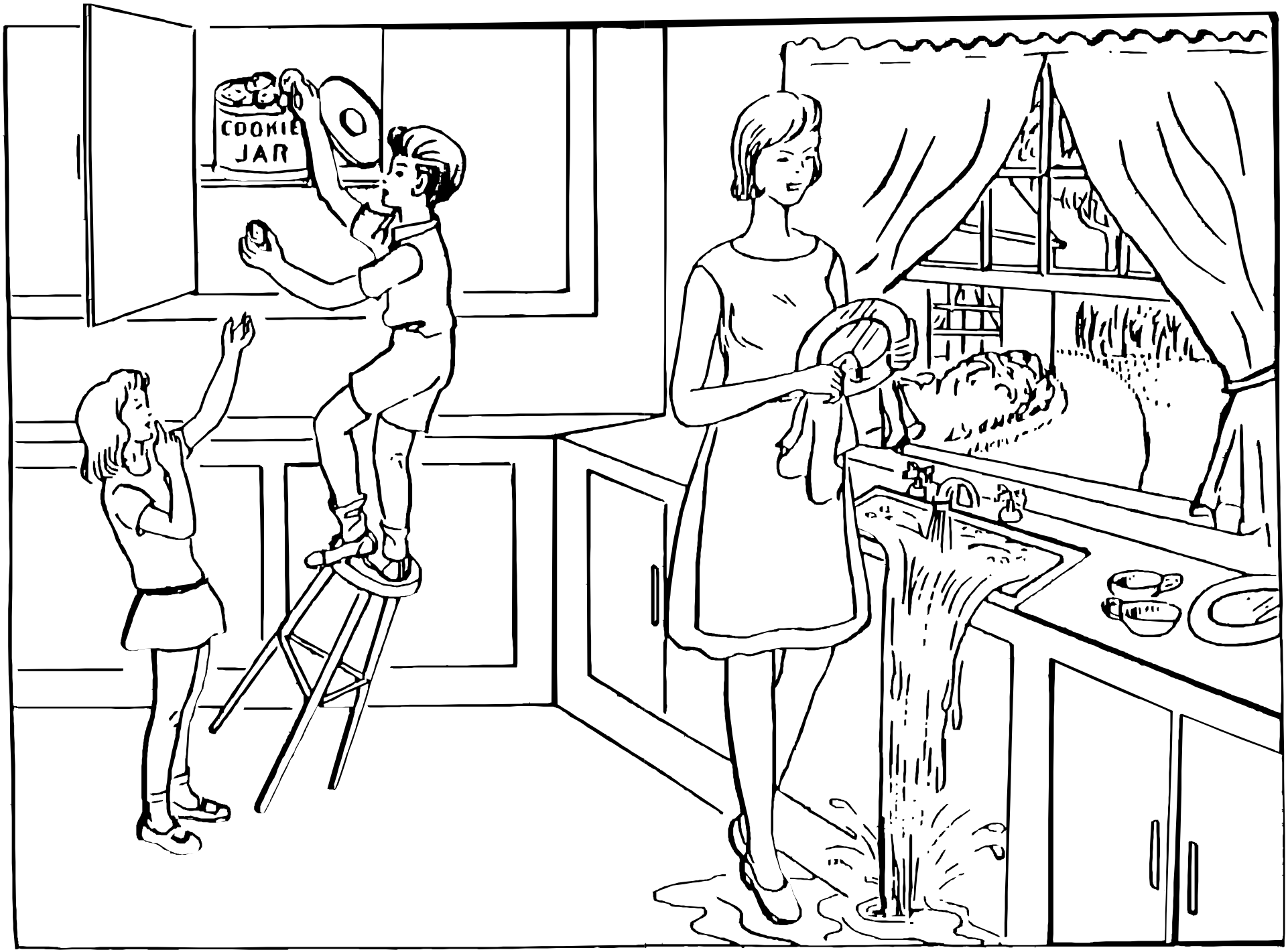
Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

11. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.	0 = **No abnormality.** 1 = **Visual, tactile, auditory, spatial, or personal inattention** or extinction to bilateral simultaneous stimulation in one of the sensory modalities. 2 = **Profound hemi-inattention or extinction to more than one modality;** does not recognize own hand or orients to only one side of space.	_____

_____

_____


COOKIE
JAR

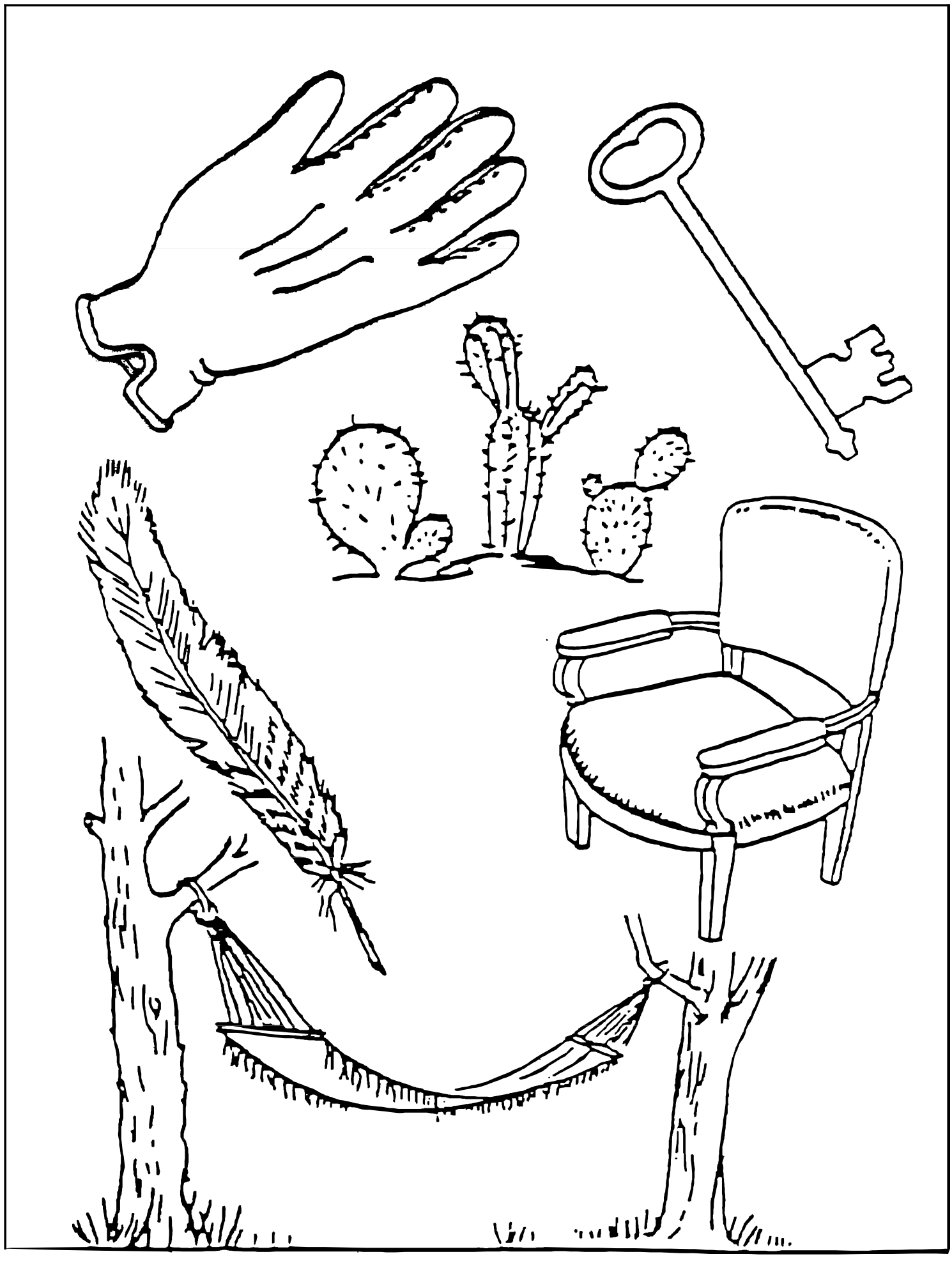
You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.



MAMA

TIP – TOP

FIFTY – FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

Subject ID: _____

Date: _____

Follow up CT

Date of imaging: _____

Start time of imaging: _____

Side of lesion:

- ☐ Left
- ☐ Right

Was an ICH seen?

- ☐ Yes
- ☐ No

Intracranial hemorrhage:

- ☐ HI-1
- ☐ HI-2
- ☐ PH-1
- ☐ PH-2
- ☐ IVH
- ☐ Subdural
- ☐ Epidural
- ☐ SAH
- ☐ None

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

Subject ID: _____

Date: _____

Follow up MRI

Date of imaging: _____

Start time of imaging: _____

Side of lesion:

- ☐ Left
- ☐ Right

Type of occlusion:

- ☐ ICA
- ☐ MCA-M1
- ☐ MCA-M2
- ☐ Other, specify:

_____

From the RAPID software, please provide ischemic core volume, mismatch ratio, absolute mismatch volume, and Tmax >6s Lesion volume.

Ischemic Core Volume: _____ mL

Mismatch Ratio: _____

Absolute Mismatch Volume: _____ mL

Tmax >6s Lesion Volume: _____ mL

Intracranial hemorrhage:

- ☐ HI-1
- ☐ HI-2
- ☐ PH-1
- ☐ PH-2
- ☐ IVH
- ☐ Subdural
- ☐ Epidural
- ☐ SAH
- ☐ None

DWI lesion volume: _____ mL

FLAIR:

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, were abnormalities identified:

- ☐ Yes
- ☐ No

GRE:

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, were abnormalities identified:

- ☐ Yes
- ☐ No

Degree of recanalization:

- ☐ No recanalization
- ☐ Partial recanalization
- ☐ Complete recanalization
- ☐ Not applicable

If response is not applicable, choose one:

- ☐ Image not obtained
- ☐ Image of insufficient quality
- ☐ Lesion not present or rated at baseline

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy)

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

Time: ___ ___:___ ___ [ ]am [ ]pm

Person Administering Scale _____

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
1a. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.	0 = **Alert;** keenly responsive. 1 = **Not alert**; but arousable by minor stimulation to obey, answer, or respond. 2 = **Not alert**; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.	_____
1b. LOC Questions: The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not "help" the patient with verbal or non-verbal cues.	0 = **Answers** both questions correctly. 1 = **Answers** one question correctly. 2 = **Answers** neither question correctly.	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.	0 = **Performs** both tasks correctly. 1 = **Performs** one task correctly. 2 = **Performs** neither task correctly.	_____
2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.	0 = **Normal.** 1 = **Partial gaze palsy;** gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present. 2 = **Forced deviation,** or total gaze paresis not overcome by the oculocephalic maneuver.	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.	0 = **No visual loss.** 1 = **Partial hemianopia.** 2 = **Complete hemianopia.** 3 = **Bilateral hemianopia** (blind including cortical blindness).	_____
4. Facial Palsy: Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.	0 = **Normal** symmetrical movements. 1 = **Minor paralysis** (flattened nasolabial fold, asymmetry on smiling). 2 = **Partial paralysis** (total or near-total paralysis of lower face). 3 = **Complete paralysis** of one or both sides (absence of facial movement in the upper and lower face).	_____
5. Motor Arm: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** limb holds 90 (or 45) degrees for full 10 seconds. 1 = **Drift;** limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. 2 = **Some effort against gravity;** limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity. 3 = **No effort against gravity;** limb falls. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **5a. Left Arm** **5b. Right Arm**	_____ _____
6. Motor Leg: The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** leg holds 30-degree position for full 5 seconds. 1 = **Drift;** leg falls by the end of the 5-second period but does not hit bed. 2 = **Some effort against gravity;** leg falls to bed by 5 seconds, but has some effort against gravity. 3 = **No effort against gravity;** leg falls to bed immediately. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **6a. Left Leg** **6b. Right Leg**	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

7. Limb Ataxia: This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.	0 = **Absent.** 1 = **Present in one limb.** 2 = **Present in two limbs.** UN = **Amputation** or joint fusion, explain: _____	_____
8. Sensory: Sensation or grimace to pinprick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas (arms [not hands], legs, trunk, face) as needed to accurately check for hemisensory loss. A score of 2, "severe or total sensory loss," should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will, therefore, probably score 1 or 0. The patient with brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a coma (item 1a=3) are automatically given a 2 on this item.	0 = **Normal;** no sensory loss. 1 = **Mild-to-moderate sensory loss;** patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. 2 = **Severe to total sensory loss;** patient is not aware of being touched in the face, arm, and leg.	_____
9. Best Language: A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, the patient is asked to describe what is happening in the attached picture, to name the items on the attached naming sheet and to read from the attached list of sentences. Comprehension is judged from responses here, as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for the patient with stupor or limited cooperation, but a score of 3 should be used only if the patient is mute and follows no one-step commands.	0 = **No aphasia;** normal. 1 = **Mild-to-moderate aphasia;** some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response. 2 = **Severe aphasia;** all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. 3 = **Mute, global aphasia;** no usable speech or auditory comprehension.	_____
10. Dysarthria: If patient is thought to be normal, an adequate sample of speech must be obtained by asking patient to read or repeat words from the attached list. If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.	0 = **Normal.** 1 = **Mild-to-moderate dysarthria;** patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = **Severe dysarthria;** patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric. UN = **Intubated** or other physical barrier, explain:_____	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

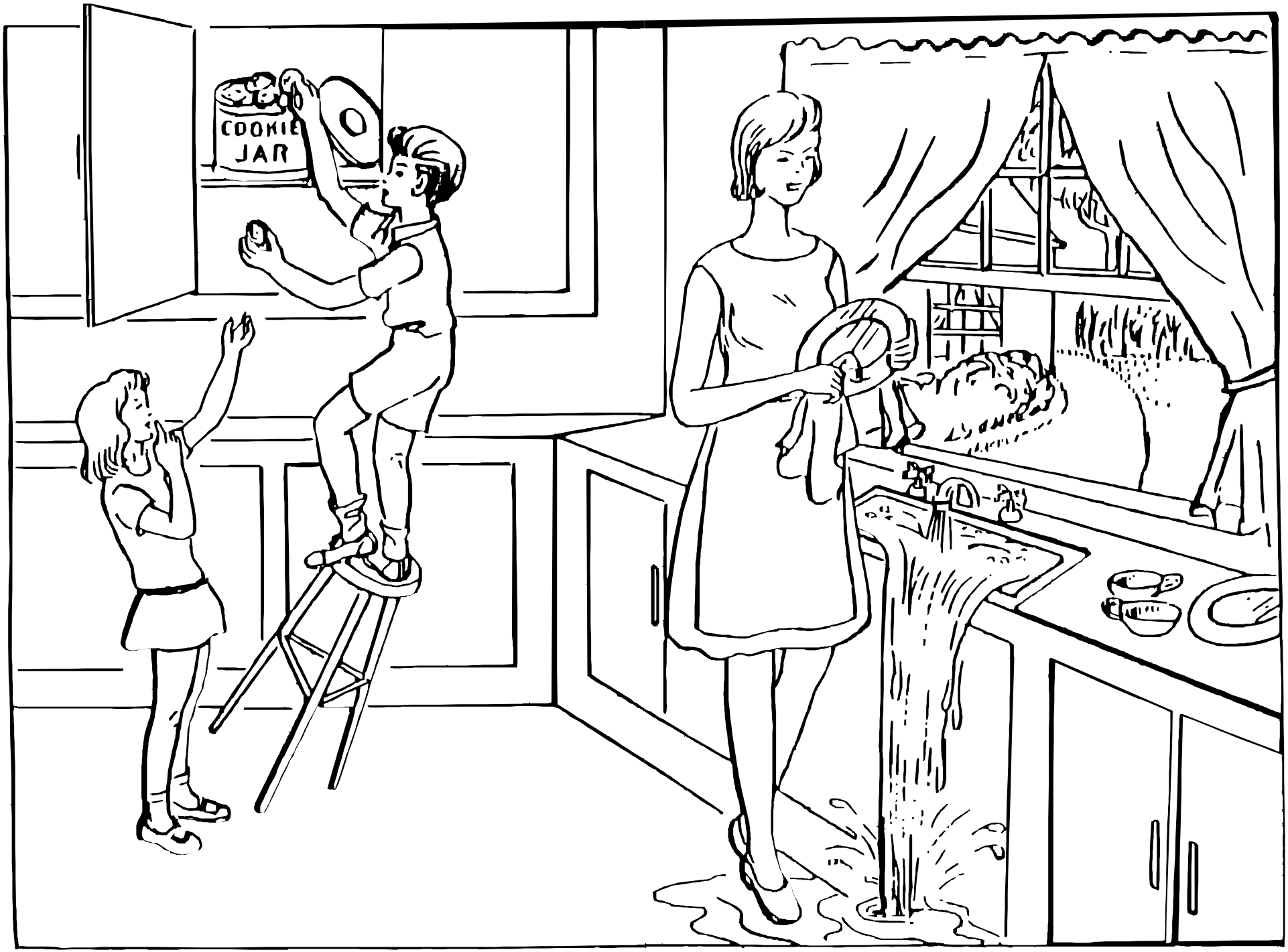
Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

11. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.	0 = **No abnormality.** 1 = **Visual, tactile, auditory, spatial, or personal inattention** or extinction to bilateral simultaneous stimulation in one of the sensory modalities. 2 = **Profound hemi-inattention or extinction to more than one modality;** does not recognize own hand or orients to only one side of space.	_____

_____

_____


COOKIE
JAR

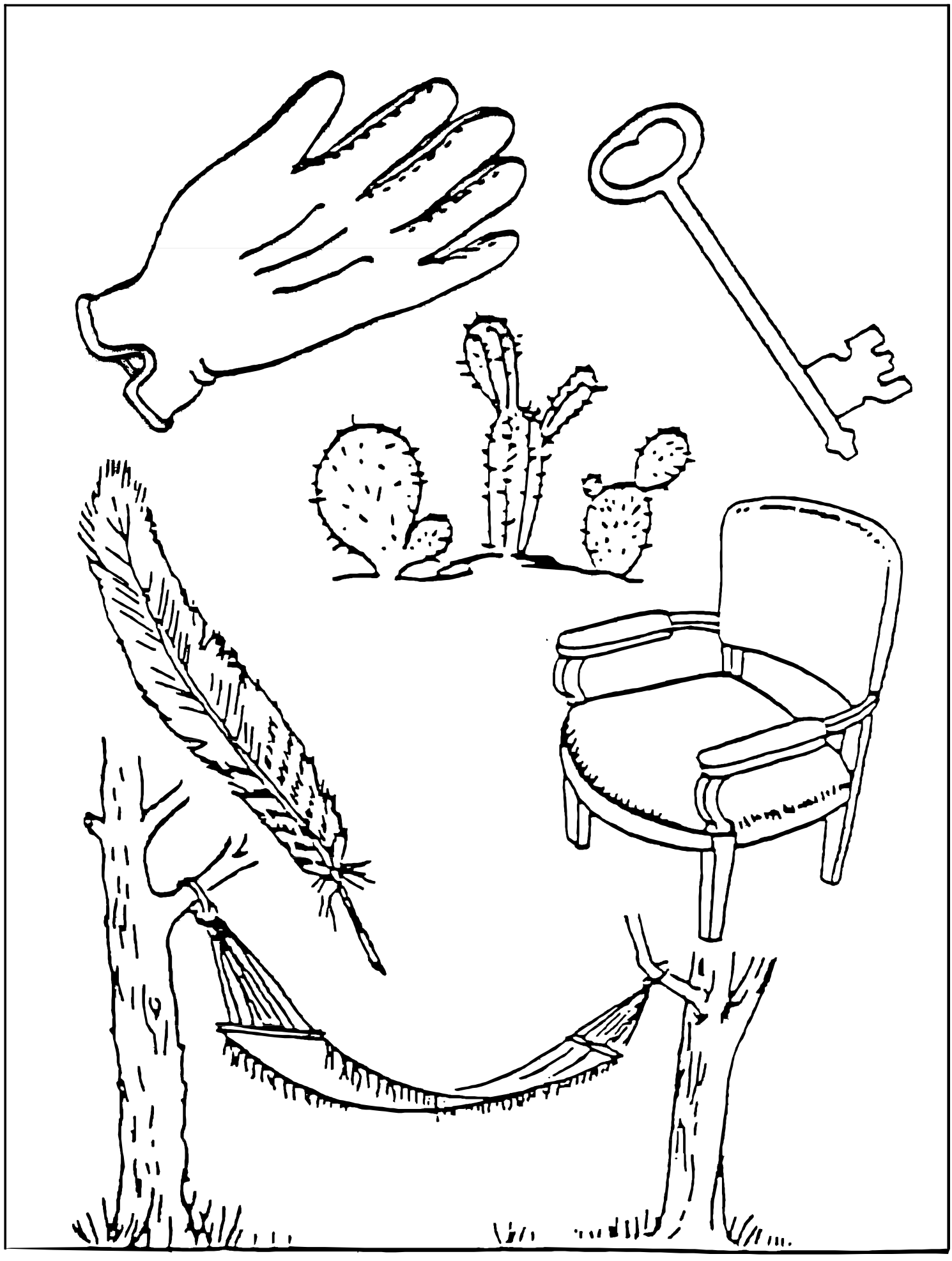
You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.



MAMA

TIP – TOP

FIFTY – FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

Subject ID: _____

Date: _____

Hospital Discharge

Date of discharge: _____

Time of discharge: _____

Discharge destination:

- ☐ Home
- ☐ Acute rehab
- ☐ Skilled nursing facility
- ☐ Death
- ☐ Other, specify

_____

Stroke etiology:

- ☐ Large artery atherosclerosis
- ☐ Cardioembolism
- ☐ Small vessel occlusion
- ☐ Stroke of undetermined etiology
- ☐ Stroke of other determined etiology, specify _____

mRS Assessment

Was the assessment completed?

- ☐ Yes
- ☐ No

Date of Assessment: _____

Assessment score: _____

Rater's name: _____

NIHSS Assessment

Was the assessment completed?

- ☐ Yes
- ☐ No

Date of Assessment: _____

Assessment score: _____

Rater's name: _____

Subject ID: _____

Date: _____

Glasgow Outcome Score Assessment

Was the assessment completed?

☐ Yes
☐ No

Date of Assessment: _____

Assessment score: _____

Signature of Study Staff Member Collecting Data: Date (dd-mon-yyyy

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

Time: ___ ___:___ ___ [ ]am [ ]pm

Person Administering Scale _____

Administer stroke scale items in the order listed. Record performance in each category after each subscale exam. Do not go back and change scores. Follow directions provided for each exam technique. Scores should reflect what the patient does, not what the clinician thinks the patient can do. The clinician should record answers while administering the exam and work quickly. Except where indicated, the patient should not be coached (i.e., repeated requests to patient to make a special effort).

Instructions	Scale Definition	Score
1a. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.	0 = **Alert;** keenly responsive. 1 = **Not alert**; but arousable by minor stimulation to obey, answer, or respond. 2 = **Not alert**; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.	_____
1b. LOC Questions: The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner not "help" the patient with verbal or non-verbal cues.	0 = **Answers** both questions correctly. 1 = **Answers** one question correctly. 2 = **Answers** neither question correctly.	_____
1c. LOC Commands: The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.	0 = **Performs** both tasks correctly. 1 = **Performs** one task correctly. 2 = **Performs** neither task correctly.	_____
2. Best Gaze: Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of a partial gaze palsy.	0 = **Normal.** 1 = **Partial gaze palsy;** gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present. 2 = **Forced deviation,** or total gaze paresis not overcome by the oculocephalic maneuver.	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
[ ] 3 months [ ] Other _____(___ ___)

3. Visual: Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.	0 = **No visual loss.** 1 = **Partial hemianopia.** 2 = **Complete hemianopia.** 3 = **Bilateral hemianopia** (blind including cortical blindness).	_____
4. Facial Palsy: Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.	0 = **Normal** symmetrical movements. 1 = **Minor paralysis** (flattened nasolabial fold, asymmetry on smiling). 2 = **Partial paralysis** (total or near-total paralysis of lower face). 3 = **Complete paralysis** of one or both sides (absence of facial movement in the upper and lower face).	_____
5. Motor Arm: The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** limb holds 90 (or 45) degrees for full 10 seconds. 1 = **Drift;** limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. 2 = **Some effort against gravity;** limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity. 3 = **No effort against gravity;** limb falls. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **5a. Left Arm** **5b. Right Arm**	_____ _____
6. Motor Leg: The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.	0 = **No drift;** leg holds 30-degree position for full 5 seconds. 1 = **Drift;** leg falls by the end of the 5-second period but does not hit bed. 2 = **Some effort against gravity;** leg falls to bed by 5 seconds, but has some effort against gravity. 3 = **No effort against gravity;** leg falls to bed immediately. 4 = **No movement.** UN = **Amputation** or joint fusion, explain: _____ **6a. Left Leg** **6b. Right Leg**	_____

NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

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NIH STROKE SCALE

Patient Identification. ___ ___-___ ___ ___-___ ___ ___

Pt. Date of Birth ___ ___/___ ___/___ ___

Hospital _____(___ ___-___ ___)

Date of Exam ___ ___/___ ___/___ ___

Interval: [ ] Baseline [ ] 2 hours post treatment [ ] 24 hours post onset of symptoms ±20 minutes [ ] 7-10 days
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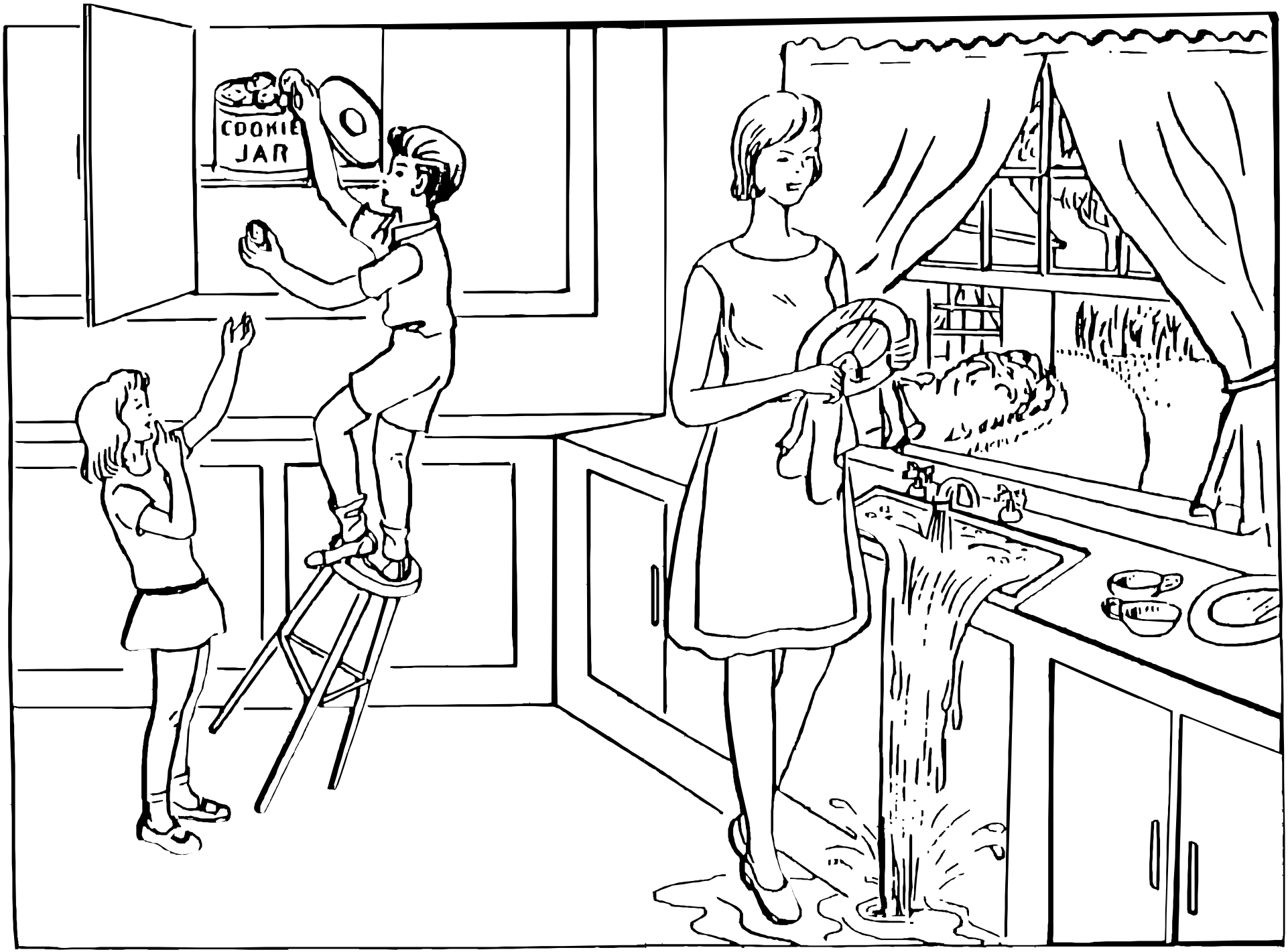
_____

_____


COOKIE
JAR

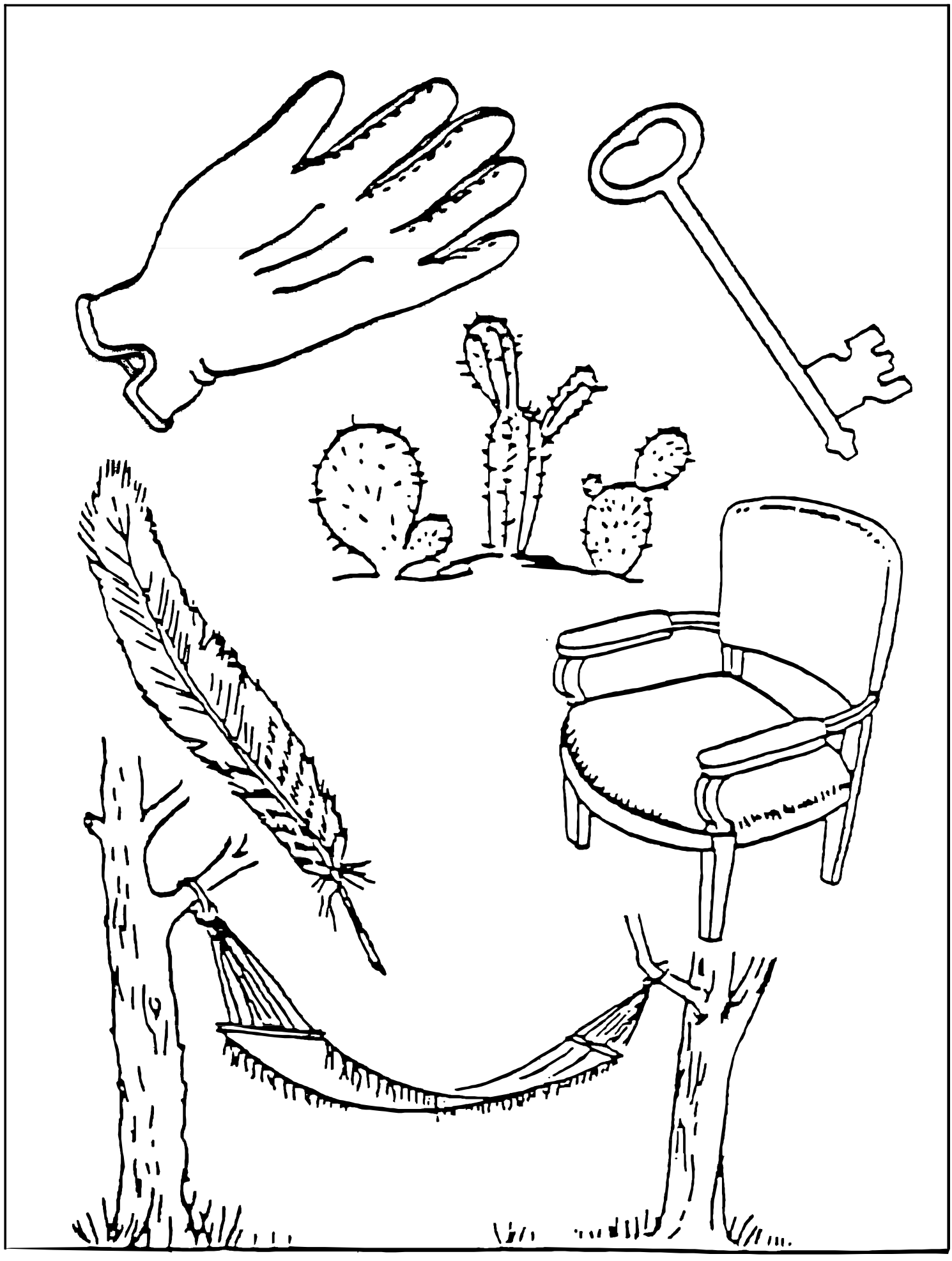
You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.



MAMA

TIP – TOP

FIFTY – FIFTY

THANKS

HUCKLEBERRY

BASEBALL PLAYER

GLASGOW OUTCOME SCALE

Site #: _____

Subject #: _____

Date: _____

Name of Assessor: _____

Note: The scale presented here is based on the original article by Jennett and Bond. It has become common practice in clinical trial administration, however, to use a modified version that places the scores in reverse order (i.e., "good recovery" = 1, "moderate disability" =2, etc.).

Score	Description
1	DEATH
2	PERSISTENT VEGETATIVE STATE Patient exhibits no *obvious cortical* function.
3	SEVERE DISABILITY (Conscious but disabled). Patient depends upon others for daily support due to mental or physical disability or both.
4	MODERATE DISABILITY (Disabled but independent). Patient is independent as far as daily life is concerned. The disabilities found include varying degrees of dysphasia, hemiparesis, or ataxia, as well as intellectual and memory deficits and personality changes.
5	GOOD RECOVERY Resumption of normal activities even though there may be minor neurological or psychological deficits.

TOTAL (1–5): _____

References

Jennett B, Bond M. "Assessment of outcome after severe brain damage."
Lancet 1975 Mar 1;1(7905):480-4

THE BARTHEL INDEX

Site #: _____
Subject #: _____
Date: _____
Name of Assessor: _____

Activity	Score

FEEDING
0 = unable
5 = needs help cutting, spreading butter, etc., or requires modified diet
10 = independent _____

BATHING
0 = dependent
5 = independent (or in shower) _____

GROOMING
0 = needs to help with personal care
5 = independent face/hair/teeth/shaving (implements provided) _____

DRESSING
0 = dependent
5 = needs help but can do about half unaided
10 = independent (including buttons, zips, laces, etc.) _____

BOWELS
0 = incontinent (or needs to be given enemas)
5 = occasional accident
10 = continent _____

BLADDER
0 = incontinent, or catheterized and unable to manage alone
5 = occasional accident
10 = continent _____

TOILET USE
0 = dependent
5 = needs some help, but can do something alone
10 = independent (on and off, dressing, wiping) _____

TRANSFERS (BED TO CHAIR AND BACK)
0 = unable, no sitting balance
5 = major help (one or two people, physical), can sit
10 = minor help (verbal or physical)
15 = independent _____

MOBILITY (ON LEVEL SURFACES)
0 = immobile or < 50 yards
5 = wheelchair independent, including corners, > 50 yards
10 = walks with help of one person (verbal or physical) > 50 yards
15 = independent (but may use any aid; for example, stick) > 50 yards _____

STAIRS
0 = unable
5 = needs help (verbal, physical, carrying aid)
10 = independent _____

Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." *Maryland State Med Journal* 1965;14:56-61. Used with permission.

TOTAL (0–100): _____

Subject # _____

Site # _____

Date _____

Name of Assessor: _____

Q01	Modified Rankin Scale		O (0) No symptoms at all O (1) No significant disability despite symptoms; able to carry out all usual duties and activities O (2) Slight disability; unable to carry out all previous activities but able to look after own affairs without assistance O (3) Moderate disability requiring some help, but able to walk without assistance O (4) Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance O (5) Severe disability; bedridden, incontinent, and requiring constant nursing care and attention
Q02	First/Given name of mRS assessor (50 character max)		
Q03	Last/Family name of mRS assessor (50 character max)		
Q04	*If visit is 'Day 30' or 'Day 90'*	Was the assessor blinded to treatment received?	O No O Yes
General Comments:			

Structured assessment of modified Rankin scale

Has the patient made a complete recovery with **absolutely no** residual signs or symptoms of stroke?

YES → **mRS score = 0**

NO ↓

Can the patient perform every regular activity that they could undertake prior to the stroke? Regular is defined as more frequently than monthly; includes work, social and leisure activities (eg driving a car, dancing, reading or working)

YES → **mRS score = 1**

Please briefly document what neurological symptoms/signs are present?

_____

NO ↓

Can the patient perform all their activities of daily living without assistance?
ie mobility, dressing, bathing, toileting, feeding, preparing simple meals, travelling locally without supervision.
Can the patient be safely left alone for a period of at least 1 week?

YES → **mRS score = 2**

What usual activities have ceased?

_____

NO ↓

Can the patient mobilise (with gait aid if necessary) and perform activities of daily living independently BUT requires supervision or assistance for more complex tasks e.g. shopping, cooking, cleaning, managing finances that means they need to be visited more frequently than weekly

YES → **mRS score = 3**

What activities require assistance?

_____

NO ↓

Does the patient require assistance for personal activities of daily living (walking, dressing, feeding, toileting) but can be safely left alone for a period of a few hours during the day?

YES → **mRS score = 4**

What activities require assistance?

_____

How long could the patient manage without a visit?

_____

NO ↓

Does the patient have severe disability requiring 24hr/day carer availability?

YES →

mRS score = 5

Death = mRS score 6

If in doubt, the more severe score should be allocated and please provide as much information as possible.

General Comments: