A trial to **e**valuate an e**xt**ended **r**eh**a**bilitation service for **s**troke patients (**EXTRAS**)

# PATIENT RECRUITMENT ASSESSMENT

**Version 3: 11 February 2014**

**Patient Name:** _____

**Centre Number:** _____

**Assessment date:** ☐☐/☐☐/☐☐☐☐

**Assessor (print name):** _____

**Assessor contact number:** _____


**Chief Investigator:** **Professor Helen Rodgers**

**Address:** **Stroke Research Group**
**Institute for Ageing & Health**
**Newcastle University**
**3-4 Claremont Terrace**
**NE2 4AE**

**Telephone:** **0191 208 6779**

**Fax:** **0191 208 5540**

**Email:** **helen.rodgers@ncl.ac.uk**

## GENERAL INSTRUCTIONS

The form should only be completed by members of staff who have received training about the EXTRAS trial.

Please write clearly using a black ballpoint pen.

Always make sure that the "YES/NO" square box answers are completed with a tick.

**Errors**

If an error needs to be rectified after the forms have been completed:

1. Draw a single line through the error, do not obscure the original entry
2. Enter the correct data beside
3. Initial and date the change and add a comment if necessary
4. Never use correction fluids.

**Missing Data**

Please do not leave blank boxes where a response is expected.

If data is missing the following should apply:

1. **ND** (for not done) should be entered into the field for all tests and examinations which should have been carried out but were omitted.
2. **NA** (for not applicable) should be entered into the field for missing data if a question does not apply to a patient status.
3. **NK** (for not known) should be entered when historical information, such as dates of onset of medical conditions is not known/not available.

**Time**

Please use the 24 hour clock eg: 15:30 (and not 3.30pm).

**Dates**

Please record a date as follows: DD/MM/YYYY.
If part of a date is unknown, please complete the corresponding boxes with NK.

**Patient Identification**

Please complete the header of all pages with the patient's initials and centre number.

Three boxes are made available to record the patient's initials.
Generally, each patient will be identified by the first letter of his/her first name, followed by the first letter of his/her middle name, and then followed the first letter of his/her family name.
If the patient has a double-barrelled name or split surname (eg. Williams-Smith or O'Regan) the first letter of the first part of the surname should be used (eg. W and O respectively in the two examples given).

# INFORMED CONSENT

Has the patient or patient's consultee (in the case of mental incapacity) given written informed consent to take part in the study?

Yes ☐ Date of consent: ☐☐/☐☐/☐☐☐☐

No ☐ The patient **MUST NOT** be included in the study until consent has been obtained.

Who gave the consent (please tick one box)?

Patient ☐

Consultee ☐

If a consultee gave consent please record their name: _____

If the patient gave consent, was the study discussed and consent obtained using (tick one box):

Standard patient information sheet and consent form ☐

Easy access patient information sheet and consent form ☐

# CONFIRMATION OF STUDY ELIGIBILITY

| | No | Yes |
|---|---|---|
| 1. Is the patient aged over 18? | ☐ | ☐ |
| 2. Is there a confirmed diagnosis of new stroke? | ☐ | ☐ |
| 3. Is the patient being discharged from hospital under the care of an Early Supported Discharge team or currently receiving ESD? | ☐ | ☐ |
| 4. Is the patient able to participate in a rehabilitation programme which focuses upon extended activities of daily living? | ☐ | ☐ |

***The answer must be YES to all of questions 1-4. If the answer is NO to any of questions 1-4, the patient is NOT eligible to participate in the EXTRAS trial. If the answer is NO to any question, please do NOT continue with this recruitment assessment form.***

# PATIENT DETAILS

Name: _____

Address: _____

_____

Tel No: _____

Email address: _____

NHS Number: _____

Date of birth: ☐☐/☐☐/☐☐☐☐ Age: ☐☐☐

Sex:

Male ☐

Female ☐

Pre-admission residence:

Own house/flat ☐

Living with family/friends ☐

Sheltered housing ☐

Residential care/nursing home ☐

Other – please state ☐

_____

Did he/she live alone prior to current stroke? No ☐ Yes ☐

**General Practitioner Details**

Name: _____

Tel No: _____

Address: _____

_____

Email: _____

**Stroke Consultant Details**

Name: _____

Tel No: _____

Address: _____

_____

Email: _____

**Next of Kin Details**

Name: _____

Tel No: _____

Address: _____

_____

Email: _____

Relationship to patient: _____

# STROKE DETAILS

Please record date of admission to hospital: ☐☐/☐☐/☐☐☐☐

Please record date of current stroke: ☐☐/☐☐/☐☐☐☐

Did patient have stroke while an in-patient? No ☐ Yes ☐

**Stroke type (of current stroke)**

Cerebral infarct ☐
Primary intracerebral haemorrhage ☐
Subarachnoid haemorrhage ☐
Unknown ☐

**What was the <u>INITIAL</u> neurological impairment at the time of current stroke?**
**Please obtain details from history and medical notes and tick as appropriate and note side of body affected if "Yes".**

| | No | Yes | R or L |
|---|---|---|---|
| Unilateral weakness affecting face | | | |
| Unilateral weakness affecting arm/hand | | | |
| Unilateral weakness affecting leg/ foot | | | |
| Sensory deficit affecting face | | | |
| Sensory deficit affecting arm/hand | | | |
| Sensory deficit affecting leg/foot | | | |
| Homonymous hemianopia | | | |
| Visuospatial disorder e.g. sensory inattention | | | |
| Dysphasia | | | |
| Brainstem/cerebellar signs | | | |
| Other deficit<br>If yes please explain below: | | | |

**Stroke subtype**

Total Anterior Circulation Stroke (TACS) ☐
Partial Anterior Circulation Stroke (PACS) ☐
Lacunar Stroke (LACS) ☐
Posterior Circulation Stroke (POCS) ☐
Uncertain ☐

Was this a first ever stroke? No ☐ Yes ☐

If no, did the patient have any residual neurological deficit following previous stroke(s)? No ☐ Yes ☐

Please describe the neurological deficit and severity of deficit from previous strokes:

_____

_____

## COMORBIDITY

**Does the patient have a history of any of the following?**

| | **No** | **Yes** |
|---|---|---|
| Ischemic heart disease | | |
| Myocardial infarction | | |
| Peripheral arterial occlusive disease | | |
| Transient Ischaemic Attack | | |
| Diabetes mellitus | | |
| Hypertension | | |
| Hyperlipidemia | | |
| Atrial fibrillation | | |
| Congestive heart failure | | |
| Deep venous thrombosis | | |
| Valvular disease | | |

**Other significant medical or surgical history**

Does the patient have any other significant medical or surgical conditions?

| **Diagnosis** | **Year of Diagnosis** | **Currently Active? (No/Yes)** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# PRE-STROKE HEALTH

## Pre-Stroke Nottingham Extended Activities of Daily Living Index

For each question below, please ask the patient which answer best describes them **BEFORE** the current stroke and tick the box. They should be asked to report what they actually could do, not what they feel they ought to have been able to do or would have liked to have done.

| | ***No*** | ***With help*** | ***On my own with difficulty*** | ***On my own*** |
|---|---|---|---|---|
| ***a) Mobility*** | | | | |
| Did you: | | | | |
| • walk around outside? | ☐ | ☐ | ☐ | ☐ |
| • climb stairs? | ☐ | ☐ | ☐ | ☐ |
| • get in and out of the car? | ☐ | ☐ | ☐ | ☐ |
| • walk over uneven ground? | ☐ | ☐ | ☐ | ☐ |
| • cross roads? | ☐ | ☐ | ☐ | ☐ |
| • travel on public transport? | ☐ | ☐ | ☐ | ☐ |
| ***b) In the kitchen*** | | | | |
| Did you: | | | | |
| • manage to feed yourself? | ☐ | ☐ | ☐ | ☐ |
| • manage to make yourself a hot drink? | ☐ | ☐ | ☐ | ☐ |
| • take hot drinks from one room to another? | ☐ | ☐ | ☐ | ☐ |
| • do the washing up? | ☐ | ☐ | ☐ | ☐ |
| • make yourself a hot snack? | ☐ | ☐ | ☐ | ☐ |
| ***c) Domestic tasks*** | | | | |
| Did you: | | | | |
| • manage your own money when you were out? | ☐ | ☐ | ☐ | ☐ |
| • wash small items of clothing? | ☐ | ☐ | ☐ | ☐ |
| • do your own housework? | ☐ | ☐ | ☐ | ☐ |
| • do your own shopping? | ☐ | ☐ | ☐ | ☐ |
| • do a full clothes wash? | ☐ | ☐ | ☐ | ☐ |
| ***d) Leisure Activities*** | | | | |
| Did you: | | | | |
| • read newspapers or books? | ☐ | ☐ | ☐ | ☐ |
| • use the telephone? | ☐ | ☐ | ☐ | ☐ |
| • write letters? | ☐ | ☐ | ☐ | ☐ |
| • go out socially? | ☐ | ☐ | ☐ | ☐ |
| • manage your own garden? | ☐ | ☐ | ☐ | ☐ |
| • drive a car? | ☐ | ☐ | ☐ | ☐ |

# Pre Stroke Oxford Handicap Scale

Please ask the patient which **ONE** statement below best describes them **BEFORE** the current stroke:

Tick ***one box***.

0 I had no symptoms at all and coped well with life..... ☐

1 I had a few symptoms but these did not interfere with my everyday life..... ☐

2 I had symptoms which had caused some changes in my life but I was still able to look after myself ..... ☐

3 I had symptoms which had significantly changed my life and prevented me from coping fully, and I needed some help in looking after myself ..... ☐

4 I had quite severe symptoms which meant that I needed to have help from other people but I was not so bad as to need attention day and night ..... ☐

5 I had major symptoms which severely handicapped me and I needed constant attention day and night ..... ☐

# PRE-STROKE RESOURCE USAGE

## Client Service Receipt Inventory

Please ask the patient the questions below. Please try not to record the same thing twice across different areas. If you feel that an answer to any of the following questions fits into two or more places, just report it once.

**1. In the 3 months before your current stroke did you spend any time living in a residential care home?**

*If your stay was in a nursing home, rather than a residential home, then please tell us about this in question 2 instead of here.*

**No** ☐ **If no,** please go to question 2

**Yes** ☐ **If yes,** how many nights did you stay there altogether? ……

**2. In the 3 months before your current stroke did you spend any time living in a nursing home?**

**No** ☐ **If no**, please go to question 3

**Yes** ☐ **If yes,** how many nights did you stay there altogether? .....

**3. In the 3 months before your current stroke did you visit an Accident & Emergency department (sometimes called A&E or casualty) because of any illness/injury?**

*Please include visits which took place immediately before any admissions to hospital.*

No ☐ **If no,** please go to question 4

Yes ☐ **If yes,** how many times? ……..

**4. In the 3 months before your current stroke did you visit hospital for outpatient appointments (to see a doctor or for a test) because of any illness/injury?**

*An outpatient appointment is when you are referred for a test or to see a hospital consultant for a specialist opinion (which could be part of follow-up care after you've had a hospital admission) and you do not need to stay in hospital. Please exclude any hospital appointments for physiotherapy, occupational therapy or speech and language therapy – you can tell us about these later in question 7.*

No ☐ **If no**, please go to question 5

Yes ☐ **If yes,** please tell us more about this below

*For each episode (that is, a group of visits related to a particular problem), please write in brief the main medical reason for it (for example, the illness/injury you had) and how many appointments you have had. If you had just one visit related to a particular problem, treat that visit as one episode.*

| Stay | Main reason for the appointment(s) | Number of appointments |
|---|---|---|
| 1st episode | | |
| 2nd episode | | |
| 3rd episode | | |
| 4th episode | | |

**5. In the 3 months before your current stroke did you stay in hospital <u>overnight</u> because of any illness/injury?**

**No** ☐ **If no**, please go to question 6

**Yes** ☐ **If yes,** please tell us more about this below

*Please tell us about your hospital stays below. For each stay, please write in brief the main medical reason for it (for example, the illness/injury you had) and how many nights you stayed.*
*If you were treated as a day patient (in other words, you did not have to stay in hospital overnight), then please tell us about this in question 6 rather than here.*

| Stay | Reason for going into hospital | Number of nights |
|---|---|---|
| 1st stay | | |
| 2nd stay | | |
| 3rd stay | | |
| 4th stay | | |

**6. In the 3 months before your current stroke did you have any hospital treatment as a <u>day patient</u> because of any illness/injury?**

*Being a day patient means needing a hospital bed for tests or surgery for a half day or full day, but not needing to stay overnight (also known as a day case). This is different to an outpatient appointment, which is usually a shorter visit. If you have had to stay overnight, please tell us about this in question 5 instead of here. If you think you have had an outpatient appointment, or a short visit as part of a series of outpatient appointments, then please tell us about this in question 4 instead of here.*

No ☐ **If no**, please go to question 7

Yes ☐ **If yes**, please tell us more about this below

*Please tell us about your day patient visits below. For each visit, please write in brief the main medical reason for it (for example, the illness/injury you had) and tick whether it was for a half or full day.*

| Visit | Reason for going into hospital | Half day | Full day |
|---|---|---|---|
| 1st visit | | ☐ | ☐ |
| 2nd visit | | ☐ | ☐ |
| 3rd visit | | ☐ | ☐ |
| 4th visit | | ☐ | ☐ |

## 7. In the 3 months before your current stroke did you use any of these other NHS or social services because of any illness/injury?

*Many of these services are based in the community. If your contact was in a hospital, please check whether your answer fits into any of the questions above before writing it here. Please tick 'yes' or 'no' for each line. If you answer 'yes' to any of them, please tell us how many times you used that service altogether in the three months before your current stroke. If you feel that an answer fits in two or more places on this form, just report it in one place.*

| **Services at your local GP surgery/health centre** | **No** | **Yes** | **Total number of visits/calls in the three months before current stroke** |
|---|---|---|---|
| Saw GP at the surgery/health centre | | | |
| Saw GP at home | | | |
| Phoned GP, practice nurse or NHS Direct for advice | | | |
| Saw practice nurse at the surgery/health centre | | | |

| **Physiotherapist (do not include private visits)** | **No** | **Yes** | **Total number of visits in the three months before current stroke** |
|---|---|---|---|
| Saw at a hospital | | | |
| Saw at home (do not include private visits) | | | |
| Saw at the GP surgery/health centre | | | |
| Saw elsewhere (do not include private visits) | | | |

| **Occupational therapist (do not include private visits)** | **No** | **Yes** | **Total number of visits in the three months before current stroke** |
|---|---|---|---|
| Saw at a hospital | | | |
| Saw at home (do not include private visits) | | | |
| Saw at the GP surgery/health centre | | | |
| Saw elsewhere (do not include private visits) | | | |

| **Speech and language therapist (do not include private visits)** | **No** | **Yes** | **Total number of visits/calls in three months before current stroke** |
|---|---|---|---|
| Saw at a hospital | | | |
| Saw at home (do not include private visits) | | | |
| Saw at the GP surgery/health centre | | | |
| Saw elsewhere (do not include private visits) | | | |

| **Community based health care professionals** | **No** | **Yes** | **Total number of visits/calls in three months before current stroke** |
|---|---|---|---|
| Community or district nurse | | | |
| Health visitor | | | |
| Geriatrician | | | |
| Psychiatrist | | | |
| Psychologist | | | |
| Chiropodist | | | |
| Optician | | | |

| **Social services** | **No** | **Yes** | | **Total in three months before current stroke** |
|---|---|---|---|---|
| Got meals on wheels | | | Number of meals | |
| Home help visited to help me with personal care | | | Number of home visits | |
| Home help visited to help me with household tasks | | | Number of home visits | |
| Home help did shopping for me | | | Number of times | |

**8. In the 3 months before your current stroke did you use any other NHS or social services because of any illness/injury that have not been covered above?**

No ☐ **If no,** please go to question 9

Yes ☐ **If yes,** please tell us more about this below

*Please tell us about any other services you used below. For each one, please describe in brief what it was and how many times you used it altogether in the three months before your current stroke.*

| | Brief description of service | Total contacts in the three months before current stroke |
|---|---|---|
| 1st other service | | |
| 2nd other service | | |
| 3rd other service | | |
| 4th other service | | |

**9. In the 3 months before your current stroke did you receive any health related benefits?**

*Please note that any information that you provide in this question will be treated in confidence and will only be used within this study to help us measure the effect of a stroke on a person's finances.*

No ☐ **If no**, you have completed this set of questions

Yes ☐ **If yes,** please tell us more about this below

*Please tick the boxes that apply to you:*

**Attendance Allowance**

Higher Rate ☐

Lower Rate ☐

**Disability Living Allowance**

Care component ☐

Mobility component ☐

**Other Allowance**

No ☐

Yes ☐

If yes, please state

Please complete the **CURRENT** NIH stroke scale score:

| NIH stroke scale | | |
|---|---|---|
| **1a. Level of consciousness** | Alert | 0 |
| | Not alert, but arousable with minimal stimulation | 1 |
| | Not alert, requires repeated stimulation to attend | 2 |
| | Coma | 3 |
| **1b. LOC questions** Ask patient the month and their age | Answers both correctly | 0 |
| | Answers one correctly | 1 |
| | Both incorrect | 2 |
| **1c. LOC commands** Ask patient to open/close eyes and form/release fist | Obeys both correctly | 0 |
| | Obeys one correctly | 1 |
| | Both incorrect | 2 |
| **2. Best gaze** Only horizontal eye movement | Normal | 0 |
| | Partial gaze palsy | 1 |
| | Forced gaze palsy | 2 |
| **3. Visual field testing** | No visual field loss | 0 |
| | Partial hemianopia | 1 |
| | Complete hemianopia | 2 |
| | Bilateral hemianopia (blind, incl. cortical blindness) | 3 |
| **4. Facial palsy** Ask patient to show teeth or raise eyebrows and close eyes tightly | Normal symmetrical movement | 0 |
| | Minor paralysis (flattened nasolabial fold, asymmetry on smiling) | 1 |
| | Partial paralysis (total or near total paralysis of lower face) | 2 |
| | Complete paralysis of one or both sides (absence of facial movement in the upper and lower face) | 3 |

| | | | |
|---|---|---|---|
| **5. Motor function arm** | Normal (extends arm 90° or 45° for 10 sec without drift) = 0 | Right | 0 |
| | Drift = 1 | | 1 |
| | Some effort against gravity = 2 | | 2 |
| | | | 3 |
| | | | 4 |
| | | | 9 |
| | No effort against gravity = 3 | Left | 0 |
| | No movement = 4 | | 1 |
| | Untestable (joint fused or limb amputated) = 9 (should not be added in total score) | | 2 |
| | | | 3 |
| | | | 4 |
| | | | 9 |
| **6. Motor function leg** | Normal (holds leg in 30° position for 5 sec without drift) = 0 | Right | 0 |
| | Drift = 1 | | 1 |
| | | | 2 |
| | | | 3 |
| | | | 4 |
| | Some effort against gravity = 2 | | 9 |
| | No effort against gravity = 3 | Left | 0 |
| | No movement = 4 | | 1 |
| | | | 2 |
| | | | 3 |
| | | | 4 |
| | Untestable (joint fused or limb amputated) = 9 (should not be added in total score) | | 9 |
| **7. Limb ataxia** | No ataxia | | 0 |
| | Present in one limb | | 1 |
| | Present in two limbs | | 2 |
| **8. Sensory** Use pinprick to test arms, legs, trunk and face, compare side to side | Normal | | 0 |
| | Mild to moderate decrease in sensation | | 1 |
| | Severe to total sensory loss | | 2 |

| | | |
|---|---|---|
| **9. Best language**<br>Ask patient to describe picture, name items | No aphasia | 0 |
| | Mild to moderate aphasia | 1 |
| | Severe aphasia | 2 |
| | Mute | 3 |
| **10. Dysarthria**<br>Ask patient to read several words | Normal articulation | 0 |
| | Mild to moderate slurring of words | 1 |
| | Near unintelligible or unable to speak | 2 |
| | Intubated or other physical barrier<br><br>(should not be added in total score) | 9 |
| **11. Extinction and inattention**<br>Use visual double stimulation or sensory double stimulation | Normal | 0 |
| | Inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities | 1 |
| | Severe hemi-inattention or hemi-inattention to more than one modality | 2 |
| | **Total Score:** | **/42** |

Please indicate who answered the questions in this questionnaire:

Patient alone ☐

Patient with help from a relative or friend ☐

Relative or friend on behalf of patient ☐

Other – please state _____

The patient recruitment assessment is complete. Please now:

1. Give the patient a 'change of circumstances form'.
2. Inform the trial co-ordinating team that this patient has been recruited. Telephone 0191 208 6779
3. Complete and post the patient GP letter.
4. Enter the patient recruitment data on to the study electronic database.
5. File this paper record in the study investigator site file.

Thank you for your contribution to the EXTRAS trial.

**Contact for further information:**

If you have any queries or require further information about the EXTRAS trial please contact:

Stroke Research Group
Institute for Ageing & Health
Newcastle University
3-4 Claremont Terrace
Newcastle NE2 4AE
Tel: 0191 208 6779