ICSS MAJOR EVENT REPORT
(Stroke or Myocardial infarction)
Please complete this form, AS WELL AS A FOLLOW UP FORM, for any patient having a stroke or MI

Centre ..... Investigator ..... ICSS No __ __ __ __
Family Name ..... Forename .....D o B __ __/__ __/__ __

day/month/year

Please complete all sections as appropriate.

STROKE REPORT

Date of onset day__ __/month__ __/year__ __

Was the stroke: Non-fatal ☐ Fatal ☐ (complete death report)

Pathology of stroke	**Yes**	**No**
Was CT/MRI scan done to confirm diagnosis	☐	☐
Ischaemic stroke[1]	☐	☐
Intracerebral haemorrhage	☐	☐
Subarachnoid haemorrhage	☐	☐
Subdural haematoma	☐	☐

[1]If stroke was ischaemic then please give classification, TOAST Criteria (please tick one box):

- Large vessel atherosclerosis ☐
- Small-vessel occlusion (lacunar) ☐
- Cardioembolic ☐
- Other determined cause ☐ Give details of type……
- Unknown cause ☐

NB Haemrrhagic transformation of an initial infarction should be classified as an ischaemic stroke

Precipitating Events (please tick probable event):

Complication of angiography	☐
Complication of carotid procedure (surgery or stenting)	☐
Hypotension or cardiac arrhythmia	☐

Territory of stroke (please tick probable territory, or territories - if more than one):

Right retinal/ophthalmic artery	☐
Left retinal/opthalmic artery	☐
Right middle or anterior cerebral artery	☐
Left middle or anterior cerebral artery	☐
Right posterior cerebral artery	☐
Left posterior cerebral artery	☐
Vertebrobasilar artery (excluding posterior cerebral artery)	☐
Unknown territory	☐

HYPERPERFUSION SYNDROME

Was syndrome non fatal ☐ fatal ☐ **(Please complete death report)**

Was syndrome complicated by stroke **Yes** ☐ **No** ☐

If yes complete section above for stroke

IMAGING PERFORMED AFTER STROKE ONSET OR HYPER PERFUSION SYNDROME:

		Yes	**No**	Date day/month/year
Carotid Ultrasound performed		☐	☐	__ __/__ __/__ __
CT performed		☐	☐	__ __/__ __/__ __
MRI performed		☐	☐	__ __/__ __/__ __
Angiography	IA	☐	☐	__ __/__ __/__ __
	IVDSA	☐	☐	__ __/__ __/__ __
	MRA (non-enhanced)	☐	☐	__ __/__ __/__ __
	CEMRA	☐	☐	__ __/__ __/__ __
	CTA	☐	☐	__ __/__ __/__ __

Please complete ultrasound form (if done)

Please send copy of all FILMS and REPORTS to ICSS office

ICSS No __ __ __ __

Modified RANKIN scale at 30 days after event (estimate if not seen then): Date:__/__/__ :

0 ☐ Asymptomatic

1 ☐ Non-disabling symptoms which do not interfere with lifestyle

2 ☐ Minor disability-symptoms which lead to some restriction in lifestyle but do not interfere with the patients capacity to look after themselves.

3 ☐ Moderate disability-symptoms which significantly interfere with lifestyle or prevent totally independent existence**, but able to walk without assistance**.

4 ☐ Moderately severe disability-symptoms which clearly prevent independent existence. **Unable to walk without assistance** but does not need constant attention day and night.

5 ☐ Severely disabled-totally dependent requiring constant attention day and night

6 ☐ Dead

Is any disability rated above caused by medical condition/s other than stroke Yes☐ No ☐

If Yes give details……..……

Was the patient seen more than 6 months after event Yes☐ No ☐

If yes give modified Rankin score at 6 months (estimate if not seen then)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

If No please schedule follow up for 6 months after stroke onset

MYOCARDIAL INFARCTION REPORT Date of event __ __/__ __/__ __

Was MI: Non-fatal ☐ Fatal ☐ (please complete death report)

	Yes	**No**
Cardiac enzymes elevated 2x normal	☐	☐
Chest discomfort for >than 30 minutes	☐	☐
Diagnostic ECG	☐	☐
Other reasons for diagnosis	☐	☐ If yes give details……..

NB. Two out of three of above required for diagnosis (see protocol)

Description of outcome event: Please give brief description of onset, duration and results of relevant investigations especially CT and MRA findings and any evidence indicating aetiology. **If stroke occurred within thirty days of surgery or stenting** please describe;

1) If anything unusual was noted (e.g. blood pressure, results of monitoring etc.)
2) Exactly what was being done when the stroke occurred if it did so during the procedure
3) Whether the stroke could be attributed to any particular technical factor or complication

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Form completed by (PRINT) ..... Date __ __/__ __/__ __

PLEASE COPY FOR YOUR FILES THEN POST OR FAX THIS FORM TO THE ICSS OFFICE TOGETHER WITH COPIES OF ANY RELEVANT IMAGING FILMS AND/OR REPORTS.

[redacted]