International study of stroke prevention procedures (Annual questionnaire; please complete BOTH pages)

Today's date ☐☐ ☐☐ ☐☐

Patient name (please **PRINT**)

Address (please **PRINT**), if different from that on the letter

(incl. tel & email, if known)

Patient ID ☐☐☐-☐☐☐-☐☐☐ (from letter, to avoid mix-ups)

Please tick a box to say who filled out this form ☐ Patient ☐ Carer ☐ Friend/relative ☐ Other

We hope you have been well since leaving hospital after the neck artery procedure (CEA/CAS) you had when you first joined the study, but if not then please tell us.

1. Since you were last contacted ☐☐ ☐☐ ☐☐ have you had a stroke?

Tick ☐ **Yes, or** ☐ **No.** If **YES**, what was the approximate date? d d m m y y

Which side of your body was affected? ☐ Left ☐ Right ☐ Neither side ☐ Both sides ☐ Don't know

Where were you treated? (can tick more than 1) ☐ Home ☐ Hospital/Clinic ☐ Other (eg, nursing home)

In total, how long were you in a hospital, clinic or nursing home because of it?

☐☐ days, or ☐☐ weeks, or ☐☐ months, or ☐ tick if still there

Do you know the name and address of a doctor who saw you (or of the hospital you went to)?

Name (PRINT):

Address (PRINT):

2. If you have had a stroke, how are you now? (Tick ONE box)

☐ No symptoms from the stroke
☐ Minor problems, but I can carry out everything I usually do
☐ A few problems from the stroke, but I can manage without help
☐ Problems from the stroke, I now need help with things
☐ Because of the stroke I now need help with most things

Anything else you'd like to tell us?

3. Since your first CEA/CAS, have you had any further neck artery procedures?

Tick box if **YES**:

☐ Operation (CEA) on my LEFT neck artery — Date ☐☐/☐☐ (month/year, approx)
☐ Stent (CAS) in my LEFT neck artery — Date ☐☐/☐☐ (month/year, approx)
☐ Operation (CEA) on my RIGHT neck artery — Date ☐☐/☐☐ (month/year, approx)
☐ Stent (CAS) in my RIGHT neck artery — Date ☐☐/☐☐ (month/year, approx)

If any answer is **YES**, did you have a stroke within the first month after the procedure? Yes or No ☐

4. Which medications do you take regularly?

Please **PRINT** the **NAMES** and **DOSAGES** of all prescription medicines you take regularly (i.e., on most days), or state **NOT KNOWN**

continued over the page…

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5. Contact details

You gave us this information when you joined this study. We may need to contact one of these people if we cannot contact you when we write to you again next year.

Your family doctor	Your first friend or relative (1)	Your second friend or relative (2)

Please give new contact details, if they differ from those above
(thereby renewing your permission for us to contact them if necessary)

New name or contact details* for my family doctor (**PRINT**)	Newnameorcontactdetails* for my first friend or relative (**PRINT**)	Newnameorcontactdetails* for my second friend or relative (**PRINT**)

* ***(including tel. & email, if known)***

Thank you very much. Do you have any comments, further information or questions?

Name of person completing this form,signature and date

Patient ID- ____-____ ____

Please put this form in the prepaid envelope provided (no stamp is needed),

OR post it in another envelope (with a stamp) to [redacted]