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| **RIGHT:** 90-Day Follow Up  Rapid Intervention with GTN in Hypertensive Stroke Trial |

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| TRIAL NUMBER |  |
| PATIENTS INITIALS |  |
| DATE OF BIRTH |  |
| SEX |  |

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| --- | --- |
| Has the patient died? | Yes No Lost to follow-up |
| Who is answering the questions? | Patient Carer |
| What is the current disposition of the patient | Residential Home  Nursing Home  Home alone  Home with spouse/carer  Carers home  Still an inpatient  Readmitted to hospital |
| Has the patient had an event since discharge that has hospitalised them (*please tick all that apply if discharged)* | Recurrent Stroke/Heart Attack  Angina/Other hospitalisation  No |
| Details of other hospitalisations |  |
| Has the patient undergone Carotid endarterctomy or carotid stenting? | Yes  No  Not applicable |

**EUROQOL- 5D**

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

|  |  |
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| **Mobility** | Please circle the appropriate box |
| I have no problems in walking about | 1 |
| I have some problems in walking about | 2 |
| I am confined to bed | 3 |
| **Self-Care** | |
| I have no problems with self care | 1 |
| I have some problems with washing or dressing | 2 |
| I am unable to wash or dress myself | 3 |
| **Usual Activities** ( e.g work,study,housework,family or leisure activities) | |
| I have no problems performing my usual activities | 1 |
| I have some problems performing usual activities | 2 |
| I am unable to perform my usual activities | 3 |
| **Pain/Discomfort** | |
| I have no pain or discomfort | 1 |
| I have moderate pain or discomfort | 2 |
| I have extreme pain or discomfort | 3 |
| **Anxiety/Depression** | |
| I am not anxious or depressed | 1 |
| I am moderately anxious or depressed | 2 |
| I am extremely anxious or depressed | 3 |

**EUROQOL-VAS**

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state today is.

100

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70

90

80

**Your own health state today**

**ZUNG DEPRESSION RATING SCALE (short)**

The next set of questions is asking about your mood and how you feel in yourself. Answer these questions by placing a circle around the number in each group below. Please indicate which mood describes you best today**.**

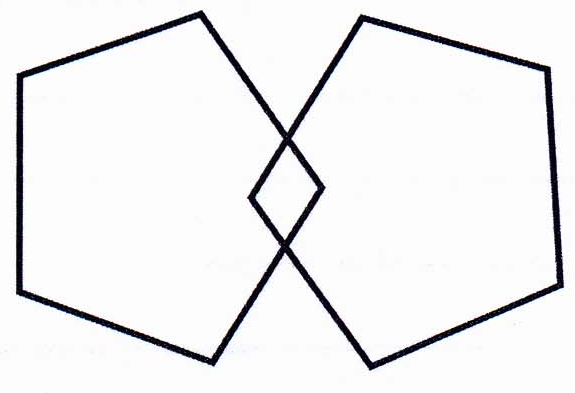
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| --- | --- | --- | --- | --- |
|  | Seldom or never | Some of the time | Good part of the time | Most of the time |
| I feel down-hearted and blue | 1 | 2 | 3 | 4 |
| I have trouble sleeping at night | 1 | 2 | 3 | 4 |
| Morning is when I feel best | 4 | 3 | 2 | 1 |
| I can eat as much as I used to | 4 | 3 | 2 | 1 |
| I get tired for no reason | 1 | 2 | 3 | 4 |
| I find it easy to make decisions | 4 | 3 | 2 | 1 |
| I feel hopeful about the future | 4 | 3 | 2 | 1 |
| I feel that I am useful and needed | 4 | 3 | 2 | 1 |
| My life is pretty full | 4 | 3 | 2 | 1 |
| I still enjoy the things I used to do | 4 | 3 | 2 | 1 |

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| **MODIFIED RANKIN SCALE** | |
| No symptoms at all | 0 |
| No significant disability despite symptoms; able to carry out all usual duties and activities | 1 |
| Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance | 2 |
| Moderate disability; requiring some help, but able to walk without assistance | 3 |
| Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance | 4 |
| Severe disability; bedridden, incontinent and requiring constant nursing care and attention | 5 |

**MINI MENTAL STATUS EXAMINATION**

The next set of questions are about your memory and thinking.

|  |  |  |
| --- | --- | --- |
| Cognitive Domain/Questions | Maximum Score | Patient Score |
| **Orientation** |  |  |
| What is the (year) (season) (date) (day) (month)? | 5 |  |
| Where are we (country) (county) (town) (hospital) (floor)? | 5 |  |
| **Registration** |  |  |
| Name 3 objects (pencil, cow, house) taking a second to say each. Ask patient to recall after you have said. Give 1 point for each correct answer. Repeat them until he/she learns all 3 if not correct on first attempt | 3 |  |
| **Attention and Calculation** |  |  |
| Serial 7’s. 1 point for each correct answer. Stop after 5 answers. Alternatively spell “world” backward. | 5 |  |
| **Recall** |  |  |
| Ask for the 3 objects repeated above. Give 1 point for each correct answer. | 3 |  |
| **Language** |  |  |
| Show object and ask them to name a pencil and a watch | 2 |  |
| Repeat the following ‘NO IFS ANDS, OR BUTS’ | 1 |  |
| Follow a 3 stage command: ‘TAKE A PAPER IN YOUR HAND, FOLD IT IN HALF, AND PUT IT ON THE FLOOR’. | 3 |  |
| Read and obey the following: ‘CLOSE YOUR EYES’ | 1 |  |
| Write a sentence: Space provided below | 1 |  |
| Copy the design below | 1 |  |
| Total Score | 30 |  |



CLOSE YOUR EYES

**WRITE A SENTENCE:**

**BARTHEL INDEX (BI)**

In the last week please state which of the following you have actually done:

|  |  |  |
| --- | --- | --- |
| Task | Criteria | Score |
| Bowels | Incontinent  Occasional accident (once per week)  Continent | 0  5  10 |
| Bladder | Incontinent, or catheterised and unable to manage alone  Occasional accident (maximum once per 24 hours)  Continent | 0  5  10 |
| Grooming | Needs help with personal care  Independent face/hair/teeth/shaving (implements provided) | 0  5 |
| Toilet use | Dependent  Needs some help, but can do something alone  Independent (on and off, dressing, wiping) | 0  5  10 |
| Feeding | Unable  Needs help cutting, spreading butter, etc.  Independent | 0  5  10 |
| Transfer (bed to chair and back) | Unable, no sitting balance  Major help (1 or 2 people, physical), can sit  Minor help (verbal or physical)  Independent | 0  5  10  15 |
| Mobility | Immobile  Wheelchair independent, including corners  Walks with help of one person (verbal or physical)  Independent (but may use any aid: for example stick) | 0  5  10  15 |
| Dressing | Dependent  Needs help but can do about half unaided  Independent (including buttons, zips, laces, etc.) | 0  5  10 |
| Stairs | Unable  Needs help (verbal, physical, carrying aid)  Independent | 0  5  10 |
| Bathing | Dependent  Independent (or in shower) | 0  5 |

|  |  |
| --- | --- |
| DATE OF CRF COMPLETION |  |
| NAME OF INVESTIGATOR |  |
| SIGNATURE OF INVESTIGATOR |  |