Study number: | Date of inclusion: ____/____/___

Patient sticker/label;

OR:

Patient name: _____ +

Patient ID: _____

DUTCH ICH Surgery trial (pilot) Clinical follow up CRF

Vital parameters at 1, 6 and 12 hours

Name examiner:_____
Date of examination: __/___/_____

Vital parameters at 1 hour after arrival in ER:				*Round numbers*
Systolic blood pressure	_____ mm Hg	Diastolic blood pressure	_____ mm Hg	
Heart rate	_____ /min			

Name examiner:_____
Date of examination: __/___/_____

Vital parameters at 6 hours:				*Round numbers*
Systolic blood pressure	_____ mm Hg	Diastolic blood pressure	_____ mm Hg	
Heart rate	_____ /min			

Name examiner:_____
Date of examination: __/___/_____

Vital parameters at 12 hours:				*Round numbers*
Systolic blood pressure	_____ mm Hg	Diastolic blood pressure	_____ mm Hg	
Heart rate	_____ /min			

(S)AE Check at baseline

Did the patient experience one or more (serious) adverse event(s)?	□ No □ Yes **(if Yes, please complete (S)AE form(s))**

Study number: | Date of inclusion: ____/____/___

Patient sticker/label;

OR:

Patient name: _____ +

Patient ID: _____

24 hour follow-up

Physical examination at 24 hours

Name examiner:_____
Date of examination: ___/___/_____

Vital parameters at 24 hours: *Round numbers*

Systolic blood pressure _____ mm Hg
Diastolic blood pressure _____ mm Hg
Heart rate _____ /min

NIHSS at 24 hours

Name examiner: _____
Date of examination: ___/___/_____

1A Level of consciousness (LOC)	**1B LOC Questions**
□ **0** – Alert	□ **0** – Answers both questions correctly
□ **1** – Not alert, but arousable	□ **1** – Answers one question correctly
□ **2** – Not alert, requires repeated stimulation	□ **2** – Answers neither questions correctly
□ **3** – Comatose	
1C LOC Commands	**2 Best gaze**
□ **0** – Performs both tasks correctly	□ **0** – Normal
□ **1 –** Performs one task correctly	□ **1** – Partial gaze palsy
□ **2** – Performs neither tasks correctly	□ **2** – Forced deviation
3 Visual	**4 Facial palsy**
□ **0** – No visual loss	□ **0** – Normal
□ **1** – Partial hemianopia	□ **1** – Minor paralysis
□ **2** – Complete hemianopia	□ **2** – Partial paralysis
□ **3** – Bilateral hemianopia	□ **3** – Complete paralysis
5A Motor left arm	**5B Motor right arm**
□ **0** – No drift	□ **0** – No drift
□ **1** – Drift	□ **1** – Drift
□ **2** – Some effort against gravity	□ **2** – Some effort against gravity
□ **3** – No effort against gravity	□ **3** – No effort against gravity
□ **4** – No movement	□ **4** – No movement
□ **0** – Untestable, explain reason: _____	□ **0** – Untestable, explain reason: _____
6A Motor left leg	**6B Motor right leg**
□ **0** – No drift	□ **0** – No drift
□ **1** – Drift	□ **1** – Drift
□ **2** – Some effort against gravity	□ **2** – Some effort against gravity
□ **3** – No effort against gravity	□ **3** – No effort against gravity
□ **4** – No movement	□ **4** – No movement
□ **0** – Untestable, explain reason: _____	□ **0**– Untestable, explain reason: _____
7 Limb ataxia	**8 Sensory**
□ **0** – Absent	□ **0** – Normal
□ **1** – Present in one limb	□ **1** – Mild to moderate sensory loss
□ **2** – Present in two limbs	□ **2** – Severe or total sensory loss
9 Best language	**10 Dysarthria**
□ **0** – No aphasia (normal)	□ **0** – Normal
□ **1** – Mild to moderate aphasia	□ **1** – Mild to moderate dysarthria
□ **2** – Severe aphasia	□ **2** – Severe dysarthria, anarthria, mute
□ **3** – Mute, global aphasia	□ **0** – Intubated, or other, explain:_____
11 Extinction and inattention	
□ **0** – No abnormality	
□ **1** – Inattention 1 modality /extinction	*(modalities: visual/tactile/auditory/spatial/personal)*
□ **2** – Profound hemi-inattention or extinction	

(S)AE Check at 24 hours

Did the patient experience one or more (serious) adverse event(s)? □ No □ Yes **(if Yes, please complete (S)AE form(s))**

Study number: | Date of inclusion: ____/____/___

Patient sticker/label;

OR:

Patient name: _____ +

Patient ID: _____

7-day (or discharge, if earlier) follow-up

Name examiner:_____
Date of examination: ___/___/_____

Vital parameters at 7 days or discharge: *Round numbers*

Systolic blood pressure _____ mm Hg
Diastolic blood pressure _____ mm Hg
Heart rate _____ /min

Name examiner:_____
Date of examination: ___/___/_____

modified Rankin Scale (mRS) score at 7 days or discharge

□ **0** No symptoms
□ **1** Minor symptoms, no limitations
□ **2** Slight disability, no help needed
□ **3** Moderate disability, requires some help but able to walk on assistance
□ **4** Moderate severe disability
□ **5** Severe disability, completely dependent
□ **6** Death Date of death: ___/___/_____ **(please fill out SAE form)**

NIHSS at 7 days or discharge

Name examiner: _____
Date of examination: ___/___/_____

1A Level of consciousness (LOC)	**1B LOC Questions**
□ **0** – Alert	□ **0** – Answers both questions correctly
□ **1** – Not alert, but arousable	□ **1** – Answers one question correctly
□ **2** – Not alert, requires repeated stimulation	□ **2** – Answers neither questions correctly
□ **3** – Comatose	
1C LOC Commands	**2 Best gaze**
□ **0** – Performs both tasks correctly	□ **0** – Normal
□ **1 –** Performs one task correctly	□ **1** – Partial gaze palsy
□ **2** – Performs neither tasks correctly	□ **2** – Forced deviation
3 Visual	**4 Facial palsy**
□ **0** – No visual loss	□ **0** – Normal
□ **1** – Partial hemianopia	□ **1** – Minor paralysis
□ **2** – Complete hemianopia	□ **2** – Partial paralysis
□ **3** – Bilateral hemianopia	□ **3** – Complete paralysis
5A Motor left arm	**5B Motor right arm**
□ **0** – No drift	□ **0** – No drift
□ **1** – Drift	□ **1** – Drift
□ **2** – Some effort against gravity	□ **2** – Some effort against gravity
□ **3** – No effort against gravity	□ **3** – No effort against gravity
□ **4** – No movement	□ **4** – No movement
□ **0** – Untestable, explain reason: _____	□ **0** – Untestable, explain reason: _____
6A Motor left leg	**6B Motor right leg**
□ **0** – No drift	□ **0** – No drift
□ **1** – Drift	□ **1** – Drift
□ **2** – Some effort against gravity	□ **2** – Some effort against gravity
□ **3** – No effort against gravity	□ **3** – No effort against gravity
□ **4** – No movement	□ **4** – No movement
□ **0** – Untestable, explain reason: _____	□ **0**– Untestable, explain reason: _____
7 Limb ataxia	**8 Sensory**
□ **0** – Absent	□ **0** – Normal
□ **1** – Present in one limb	□ **1** – Mild to moderate sensory loss
□ **2** – Present in two limbs	□ **2** – Severe or total sensory loss
9 Best language	**10 Dysarthria**
□ **0** – No aphasia (normal)	□ **0** – Normal
□ **1** – Mild to moderate aphasia	□ **1** – Mild to moderate dysarthria
□ **2** – Severe aphasia	□ **2** – Severe dysarthria, anarthria, mute
□ **3** – Mute, global aphasia	□ **0** – Intubated, or other, explain:_____

Study number: _____ Date of inclusion: ____/____/___

Patient sticker/label;

OR:

Patient name: _____ +

Patient ID: _____

11 Extinction and inattention

□ **0** – No abnormality
□ **1** – Inattention 1 modality /extinction *(modalities: visual/tactile/auditory/spatial/personal)*
□ **2** – Profound hemi-inattention or extinction

Discharge

Neuroimaging

Other neuroimaging performed during clinical follow-up? □ No □ Yes

If yes, specify:
- NCCT □ No □ Yes
- CT-a □ No □ Yes
- MRI □ No □ Yes
- MRA □ No □ Yes
- DSA □ No □ Yes

Interventions and diagnoses during hospital stay

Neurological deterioration	□ No □ Yes	**(please fill out SAE form)**
Recurrent intracerebral hemorrhage	□ No □ Yes	If yes, specify: **(please fill out SAE form)**
		Symptomatic □ No □ Yes
		Rebleed □ No □ Yes
Diagnoses of (new) cancer	□ No □ Yes	
Intracranial infection	□ No □ Yes	**(please fill out SAE form)**
Seizure(s)	□ No □ Yes	**(please fill out SAE form)**
Intubation (excluding intubation for surgery)	□ No □ Yes	**(please fill out SAE form)**
Surgical intervention (excluding study surgery)	□ No □ Yes	
If yes, specify:		**(please fill out SAE form)**
External ventricular drain (EVD)	□ No □ Yes	Date of intervention: __/__/____
Hemicraniectomy	□ No □ Yes	Date of intervention: __/__/____
Hematoma evacuation	□ No □ Yes	Date of intervention: __/__/____
ICP monitoring	□ No □ Yes	Date of intervention: __/__/____
Burr hole(s)	□ No □ Yes	Date of intervention: __/__/____
Other: _____		If yes, **fill out SAE form** and describe: _____
Other major medical intervention: _____		Date of intervention: __/__/____

Antihypertensive medication during hospital stay

Any type of antihypertensive medication	□ No □ Yes:		*If applicable:*
ACE inhibitor	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Angiotensin II receptor antagonist	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Beta blocker	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Calcium channel blocker	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Diuretic	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Intravenous labetalol	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Other: _____		Start date __ /__ /____	Stop date __ /__ /____

Platelet inhibitor(s) during hospital stay

Any type of platelet inhibitor	□ No □ Yes		*If applicable:*
Acetylsalicylic acid/carbasalate calcium	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Clopidogrel	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Dipyridamol	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Ticagrelor	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Other: _____		Start date __ /__ /____	Stop date __ /__ /____

Direct oral anticoagulant (DOAC) during hospital stay

Any type of DOAC	□ No □ Yes		*If applicable:*
Apixaban (Eliquis®)	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Dabigatran (Pradaxa®	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Edoxaban (Lixiana®)	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Rivaroxaban (Xarelto®)	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____

Study number: | Date of inclusion: ____/____/___

Patient sticker/label;

OR:

Patient name: _____ +

Patient ID: _____

Other: _____		Start date __ /__ /____	Stop date __ /__ /____
Vitamin K antagonist(s) during stay	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Heparin during hospital stay			*If applicable:*
Any type of heparin	□ No □ Yes:		
Prophylactic heparin	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Therapeutic heparin	□ No □ Yes	Start date __ /__ /____	Stop date __ /__ /____
Admission			
Was the patient admitted to the:		Total number of days in:	
- ICU	□ No □ Yes	- ICU	_____
- Medium care	□ No □ Yes	- Medium care	_____
- Stroke Unit	□ No □ Yes	- Stroke Unit	_____
- General ward (not stroke unit)	□ No □ Yes	- General ward	_____
Discharge (dead or alive)			
Was the patient discharged	□ No □ Yes	Discharge destination:	
Date of discharge (dead or alive)	__ /__ /____	□ **0** - Patient died **(please fill out SAE form)**	
		□ **1** - Home	
		□ **2** - Other hospital	
		□ **3** - Geriatric rehabilitation	
		□ **4** - Nursing home long stay	
		□ **5** - Rehabilitation center	
		□ **6** - Other:_____	
		□ **9** - Unkown	

(S)AE Check at discharge

Did the patient experience one or more (serious) adverse event(s) during hospital stay?	□ No □ Yes (if Yes, please complete (S)AE form(s))