

Bradmar Label

Hospital Admission Number: _____

Date of Birth: __/__/__

Sex: M F

Admission

1. The **CURRENT ADMISSION** was determined to be ;
2. When, approximately did the **STROKE EVENT** occur?
3. Hospital **ADMISSION/ EMERGENCY** presentation:
4. Admission to a **WARD** occurred at:
5. Was the patient initially admitted to the **STROKE WARD**?

- Infarct**
 Haemorrhage
 TIA/RIND
 Non-Stroke Event
 (If a Non-Stroke Event: complete MDS 2, 3, 4, 5, 6, 7, 8, 9 14, 20, 21, 23 only)

Date __/__/__ Time:__:__

Date __/__/__ Time:__:__

Date __/__/__ Time:__:__

Yes No:

Patient Services

6. Was an **INTERPRETER** required?
7. If **yes**, who was the interpreter used?
8. Has a **STAFF LIAISON** person been appointed?
- 8A: If **yes**, please identify who:
9. Has a **PATIENT LIAISON** person been appointed?
10. Has a formal discussion between staff and patient liaison persons been held prior to discharge?

- Yes No
 Professional **Other**
 Yes No

- Neurologist**
 Nurse
 Medical resident
 Other

Yes No

Yes No

Assessments

11. **PRE-STROKE RANKIN** score
12. **ADMISSION NIH** score: (0 – 72 hrs)
13. **DISCHARGE NIH** score at discharge or Day 7
14. **MODIFIED BARTHEL INDEX** at discharge or Day 7

__ / 5

___ / 100

Date __/__/__

Date __/__/__



Classification	<p>15. Has the patient had a stroke prior to this admission?</p> <p>16. If the event was an INFARCT, please classify as follows: <i>(according to the Oxfordshire classification)</i></p> <p>17. If the event was a HAEMORRHAGE, please classify as follows:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> TACI <input type="checkbox"/> PACI <input type="checkbox"/> POCI <input type="checkbox"/> LACI</p> <p><input type="checkbox"/> Lobar <input type="checkbox"/> Basal ganglia <input type="checkbox"/> Intertentorial /Subdural</p>
Admission Outcomes	<p>18. Were any ADVERSE EVENTS recorded for this patient?</p> <p>18A. If yes, please specify:</p> <p>19. Did the patient have any EPISODES OF BLEEDING:</p> <p>19A. If yes, please specify:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> DVT <input type="checkbox"/> Subluxed shoulder <input type="checkbox"/> Pressure area <input type="checkbox"/> Confirmed aspiration</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Haemorrhagic Transformation of Infarct <input type="checkbox"/> Other Intracranial <input type="checkbox"/> Gastrointestinal</p>
Patient Residence	<p>20. ARRIVED from:</p> <p><input type="checkbox"/> Private residence - living independently <input type="checkbox"/> Private residence plus support <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Nursing Home <input type="checkbox"/> Acute care hospital transfer <input type="checkbox"/> Other</p> <p>20A: If DECEASED, please state date of death:</p>	<p>DISCHARGED to:</p> <p><input type="checkbox"/> Private residence - living independently <input type="checkbox"/> Private residence plus support <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Nursing Home <input type="checkbox"/> Acute care hospital transfer <input type="checkbox"/> Death (go to 20A) <input type="checkbox"/> Other</p> <p>Date: ____/____/____</p>
Discharge	<p>21. When the clinical team deemed the patient was READY FOR DISCHARGE or Transfer</p> <p>22. Patient ACCEPTED for Discharge or Transfer</p> <p>23. Patient DISCHARGED or Transferred:</p>	<p>Date: ____/____/____</p> <p>Date: ____/____/____</p> <p>Date: ____/____/____</p>

