**Patient Name** **:** FORENAME SURNAME  **Patient DOB:** D D / M M / Y Y Y Y **NHS No.:** **Hospital No.:**

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| 8.1 Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | No | | | | No but | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | | |
| **The following questions are only for patients in whom “YES” has been answered:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8.1.1 What was the date of follow-up? | | | | | | | | | | | | | | | | | | | | | | D D / M M / Y Y Y Y | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | | |
| 8.1.2 How was the follow-up carried out: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In person | | By telephone | | | | | | | | | Online | | | | | | | | | | By post | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |  | | |
| 8.1.3 Which of the following professionals carried out the follow-up assessment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP | | | | | | | | | | | | | Voluntary Services employee | | | | | | | | | | | | | | | | | | | |
| Stroke coordinator | | | | | | | | | | | | | Secondary care clinician | | | | | | | | | | | | | | | | | | | |
| Therapist | | | | | | | | | | | | | Other | | | | | | | | | | | | | | | | | | | |
| District/community nurse | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 8.1.4 If other, please specify | | Free text (30-character limit) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| 8.1.5 Did the patient give consent for their identifiable information to be included in SSNAP?\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes, patient gave consent | | | | | | | No, patient refused consent | | | | | | | | | | | | Patient was not asked | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| 8.2Was the patient screened for mood, behaviour or cognition since discharge using a validated tool? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | No | | | | No but | | |
| 8.2.1 If yes, Was the patient identified as needing support? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | No | | | |
| 8.2.2 If yes, Has this patient received psychological support for mood, behaviour or cognition since discharge? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | No | | | | No but | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | |  |
| 8.3 Where is this patient living? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home | | | | | | | Care home | | | | | | | | | | | | Other | | | | | | | | | | | | | |
| 8.3.1 If other, please specify | | Free text (30-character limit) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8.4 What is the patient’s modified Rankin Scale score? | | | | | | | | | | | 0 - 6 | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | |  |
| 8.5 Is the patient in persistent, permanent or paroxysmal atrial fibrillation? | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | |
|  |  | |  | | | | | | |  | | | |  | | | | | | | | |  | | | |  | | | | | |
| 8.6 Is the patient taking: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8.6.1. Antiplatelet: | | | | Yes | | | | No | | | | | | 8.6.2. Anticoagulant: | | | | | | | | | | Yes | | | | | | | No | |
| 8.6.3. Lipid Lowering: | | | | Yes | | | | No | | | | | | 8.6.4. Antihypertensive: | | | | | | | | | | Yes | | | | | | | No | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8.7 Since their initial stroke, has the patient had any of the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8.7.1 Stroke | | | | | Yes | | | | No | | | | | | 8.7.2 Myocardial infarction | | | | | | | | | | Yes | | | | | | No | |
| 8.7.3 Other illness requiring hospitalisation | | | | | | Yes | | | | | | No | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | |  | | | | |  | | | | | | | | | | | | | | | |
| \*8.1.5. This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 8.8 Employment status prior to stroke: | | |
| Working full-time | Studying or Training | |
| Working part-time | Unemployed | |
| Retired | Other | |
| 8.8.1 Employment status currently: | | |
| Working full-time | Studying or Training | |
| Working part-time | Unemployed | |
| Retired | Other | |
|  | | |
| 8.9 EQ5D-5L score six months after stroke | | |
| 1. Mobility Type or select 1-5. | | Missing value |
| 1. Self-care Type or select 1-5. | | Missing value (9) |
| 1. Usual activities (work/study) Type or select 1-5. | | Missing value (9) |
| 1. Pain/discomfort Type or select 1-5. | | Missing value (9) |
| 1. Anxiety/depression Type or select 1-5. | | Missing value (9) |
| 1. How is your health today? Type or select 1-100. | | Missing value (999) |
|  | | |
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