

# STOP II TRIAL

## EVENT CT SCAN

\*\*\*AFFIX PATIENT'S LABEL HERE\*\*\*

**SUBMIT THIS FORM AND FOUR COPIES (ORIGINALS IF AVAILABLE) OF EACH CT FILM OF HEAD ONLY IF:**

- 1) CT SCAN (BUT NO MRI) WAS PERFORMED FOLLOWING A NEUROLOGICAL EVENT
- 2) PATIENT HAD AN INTRACRANIAL HEMORRHAGE
- 3) PRINCIPAL INVESTIGATOR FEELS CT SCAN IS CRITICAL TO UNDERSTANDING THE EVENT

**THIS FORM IS TO BE COMPLETED BY PRINCIPAL INVESTIGATOR OR STUDY COORDINATOR**

A1. Person completing form (Name): \_\_\_\_\_

(Initials): 

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A2. Date of CT scan (Month/Day/Year):

\_\_\_\_/\_\_\_\_/\_\_\_\_

A3. Date of Neurological Event for which CT scan was performed (Month/Day/Year):

\_\_\_\_/\_\_\_\_/\_\_\_\_

A4. Reason CT films submitted (**CHECK NO OR YES FOR EACH OF a THROUGH c**)

a. Was an MRI performed?

1. NO     2. YES



A4.a1. **IF NO**, specify reason

\_\_\_\_\_

b. Did the patient have an intracranial hemorrhage?

1. NO     2. YES

c. Did the Principal Investigator request a review?

1. NO     2. YES



A4.c1. **IF YES**, specify reason

\_\_\_\_\_

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**SECTIONS B - C TO BE COMPLETED BY READERS (F15J)**

B1. Readers: a. (Name): \_\_\_\_\_ (Initials): 

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b. (Name): \_\_\_\_\_ (Initials): 

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B2 Date read (Month/Day/Year): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

B3. Study acceptable for interpretation?  1. NO  2. YES



B3.a. Reason: _____ _____
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**B4. SCAN QUALITY (CHECK ONE):**

- 1. Excellent
- 2. Slight Artifact/Motion, Adequate
- 3. Severe Artifact/Motion, Inadequate

**C1. ATROPHY ON CT SCAN (CHECK ONE):**

1. No atrophy     2. Atrophy     3. Equivocal

Type of atrophy:

**a1. GENERAL:**                       1. NO                       2. YES

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a. Sulcal	<input type="checkbox"/> 1. NO	<input type="checkbox"/> 2. YES
b. Ventricular	<input type="checkbox"/> 1. NO	<input type="checkbox"/> 2. YES
c. Level of severity	<input type="checkbox"/> 1. MILD	<input type="checkbox"/> 2. MODERATE <input type="checkbox"/> 3. SEVERE

**a2. FOCAL:**                               1. NO                               2. YES

↓

a. Sulcal	<input type="checkbox"/> 1. NO	<input type="checkbox"/> 2. YES
b. Ventricular	<input type="checkbox"/> 1. NO	<input type="checkbox"/> 2. YES
c. Specify Area(s): c1. _____		

**C2. Does the CT scan show evidence of intracranial hemorrhage?**     1. NO     2. YES

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Type:	1. NO	2. YES
a. Subarachnoid	<input type="checkbox"/>	<input type="checkbox"/>
b. Intraventricular	<input type="checkbox"/>	<input type="checkbox"/>
c. Subdural	<input type="checkbox"/>	<input type="checkbox"/>
d. Epidural	<input type="checkbox"/>	<input type="checkbox"/>
e. Intraparenchymal	<input type="checkbox"/>	<input type="checkbox"/>

**C3. DISCRETE FINDINGS ON CT SCAN (COMPLETE TABLE FOR UP TO 7 LESIONS USING THE CODES BELOW)**

SIDE:	TYPE:	SIZE:	LOCATION:	STATUS:
R = Right L = Left	H = Hemorrhage I = Infarct HI = Hemorrhagic Infarct	0 = Small (Punctate) (few mm) 1 = Medium (ovoid) (0.5 - 1.5 cm) 2 = Large (geographic) (≥ 1.5 cm)	0 = Frontal 1 = Temporal 2 = Parietal 3 = Occipital 4 = Basal ganglia or Thalamic (caudate, putamen, globus pallidus) 5 = Cortex 6 = Capsular/Corona 7 = Deep white matter or periventricular 8 = Brain stem 9 = Cerebellum 10 = Subarachnoid 11 = Intraventricular	A = Acute B = Subacute C = Chronic

LESION NUMBER	LOCATION(S)								STATUS
	a.	b.	c.	d.	e.	f.	g.	h.	
	SIDE	TYPE	SIZE	1	2	3	4		
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**C4. COMMENTS:**

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