STOP II TRIAL

NEUROLOGICAL EVENT FORM

AFFIX PATIENT LABEL HERE

A1. Person completing form (Name): _____(Initials): [ ][ ][ ]

A2. Date of neurological event (Month/Day/Year): ____ ____/____ ____/____ ____ ____ ____

B. PRESENTATION

B1. Where was the patient first seen for this event?
[ ] **1. STOP II Center** → B1.a. [ ][ ]
[ ] **2. Other** → B1.b _____

B2. Were signs or symptoms first reported at a quarterly visit? [ ] **1. NO** [ ] **2. YES**
↓
B2.a Date of Quarterly Progress Report (Month/Day/Year): ____ ____/____ ____/____ ____ ____ ____

B3. What signs or symptoms occurred?
(CHECK NO OR YES BOX FOR EACH OF B3.a-l)

	1. NO	2. YES	
B3.a Loss of consciousness	[ ]	[ ]	
B3.b Change in mental status	[ ]	[ ]	
B3.c Loss of or difficulty with speech	[ ]	[ ]	
B3.d Paralysis or weakness	[ ]	[ ]	→ B3.d1 SIDE: [ ] **1. RIGHT** [ ] **2. LEFT** [ ] **3. BOTH**
B3.e Difficulty with swallowing	[ ]	[ ]	
B3.f Difficulty with vision	[ ]	[ ]	→ B3.f1 SIDE: [ ] **1. RIGHT** [ ] **2. LEFT** [ ] **3. BOTH**
B3.g Loss of balance or dizziness	[ ]	[ ]	
B3.h Seizure	[ ]	[ ]	
B3.i Headache	[ ]	[ ]	→ B3.i1 LOCATION: [ ] **1. DIFFUSE** [ ] **2. FOCAL** ↓ B3.i1a SPECIFY: _____
B3.j New sensory disturbance	[ ]	[ ]	→ B3.j1 SIDE: [ ] **1. RIGHT** [ ] **2. LEFT** [ ] **3. BOTH**
B3.k Change in behavior	[ ]	[ ]	
B3.l Change in gait or coordination	[ ]	[ ]	

[ ] ML [ ] DE

B4. Was patient hospitalized for this event?

☐ **1. NO** ☐ **2. YES →**

B4.a Date of Hospital Admission (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

B4.b Date of Hospital Discharge (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

B4.c Where was patient hospitalized? _____

_____

C. HISTORY

C1. Person interviewed **(SELECT PERSON PROVIDING MAJORITY OF RESPONSES)**

☐ **1. Patient** ☐ **2. Parent** ☐ **3. Other** → C1.a Specify: _____

C2. Did person interviewed witness suspected event? ☐ **1. NO** ☐ **2. YES**

C3. Did the patient experience any of the following during the two weeks prior to the neurological event?

(CHECK NO OR YES BOX FOR EACH OF C3.a - i)	**1. NO**	**2. YES**	**3. DON'T KNOW**
C3.a Acute febrile event	☐	☐	☐
C3.b Painful event	☐	☐	☐
C3.c Acute Chest Syndrome	☐	☐	☐
C3.d Acute anemia	☐	☐	☐
C3.e General anesthesia	☐	☐	☐
C3.f Priapism	☐	☐	☐
C3.g Head injury with loss of consciousness	☐	☐	☐
C3.h Transfusion	☐	☐ ↓	☐
		COMPLETE TRANSFUSION FORM	
C3.i Other	☐	☐ ↓	☐
		C3.i1 Specify _____ _____	

C4. DESCRIBE PERTINENT CLINICAL DETAILS OF CLINICAL EVENTS WHICH OCCURRED WITHIN THE TWO WEEKS PRECEDING THE NEUROLOGICAL EVENT

_____

_____

**** COMPLETE A NEUROLOGICAL EVENT FORM FOR EACH EVENT (C3.a – f OR C3.i) FOR WHICH "YES" IS CHECKED"**

D. RESULTS OF IMAGING AND ULTRASOUND TESTS PERFORMED TO EVALUATE THIS EVENT:
(CHECK APPROPRIATE BOX FOR EACH OF D1 - 7)

D1. MRI of brain ☐ **1. NOT DONE** ☐ **2. DONE**

D1.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D1.b Was DWI performed? ☐ **1. NO** ☐ **2. YES**

D2. CT scan of brain ☐ **1. NOT DONE** ☐ **2. DONE**

D2.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D3. PET scan of brain ☐ **1. NOT DONE** ☐ **2. DONE**

D3.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D4. MRA of brain ☐ **1. NOT DONE** ☐ **2. DONE**

D4.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D5. Arteriogram ☐ **1. NOT DONE** ☐ **2. DONE**

D5.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D6. Transcranial Doppler ☐ **1. NOT DONE** ☐ **2. DONE**

D6.a Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

D7. Other → D7.a Specify_____

☐ **1. NOT DONE** ☐ **2. DONE**

D7.b Date performed (month/day/year): ___ ___/___ ___/___ ___ ___ ___

**** ATTACH REPORTS FOR ALL IMAGING AND ULTRASOUND TESTS PERFORMED ****
**** SEND FORMS 15 AND 19 AND STOP II OPTICAL DISK WITH MRI, DWI, AND MRA DATA TO DCC ****
**** IF TCD WAS PERFORMED, SEND TCD IMAGE FILE AND FORM 2 TO DCC****

E. NEUROLOGICAL EVALUATION

E1. Was a neurological evaluation performed by the STOP Neurology Consultant?

☐ **1. NO →** **SCHEDULE EVALUATION BY STOP NEUROLOGY CONSULTANT**

☐ **2. YES →** E1.a Date of exam (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

SEND STOP NEUROLOGICAL CONSULTANT REPORT TO THE DCC

F. MANAGEMENT AND COMPLICATIONS

F1. Were there other events associated with this neurological event? ☐ **1. NO** ☐ **2. YES**

COMPLETE A SEPARATE NON-NEUROLOGICAL EVENT FORM FOR EACH UNIQUE ASSOCIATED EVENT

F2. Was the patient transfused for this neurological event ? ☐ **1. NO** ☐ **2. YES**

COMPLETE TRANSFUSION FORM

F3. Did the patient die as a complication of this event ? ☐ **1. NO** ☐ **2. YES**

COMPLETE CAUSE OF DEATH FORM

G. FINAL LOCAL DIAGNOSIS

G1. Type of neurological event:

☐ **1. Cerebral Infarction** ☐ **2. Intracranial Hemorrhage** ☐ **3. TIA** ☐ **4. Seizure** ☐ **5. Other**

↓

G1.a Specify: _____

Signature of Study Coordinator:_____ Date: ___ ___/___ ___/___ ___ ___ ___

H. FOR OFFICE USE

H1. Imaging/ultrasound reports received:	☐ **1. NO**	☐ **2. YES**
H2. Optical disk with MR data received:	☐ **1. NO**	☐ **2. YES**
H3. Imaging films received:	☐ **1. NO**	☐ **2. YES**
H4. TCD received:	☐ **1. NO**	☐ **2. YES**