STOP II TRIAL

OUTCOME OF HOSPITALIZATION FOR STROKE, MENINGITIS, OR HEAD INJURY

****AFFIX PATIENT LABEL HERE****

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

A2. Reason for hospitalization:

- [ ] 1. Neurological Event (stroke) → **COMPLETE FORM 30**
- [ ] 2. Meningitis → **COMPLETE FORM 31**
- [ ] 3. Head Injury → **COMPLETE FORM 31**

A3.a. Date of first hospital admission for event (Month/Day/Year): ___ ___ / ___ ___ / ___ ___ ___ ___

b. Date of hospital discharge (Month/Day/Year): ___ ___ / ___ ___ / ___ ___ ___ ___

c. Name and address of hospital _____

_____

_____

B. DISCHARGE STATUS

B1. Patient discharged to:

- [ ] 1. Home
- [ ] 2. Rehabilitation center
- [ ] 3. Chronic care facility
- [ ] 4. Died during hospitalization

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COMPLETE FORM 40

B2. Disability status at discharge (Modified Rankin Disability Scale):

- [ ] 1. No symptoms
- [ ] 2. Symptoms but no disability (no interference with daily activities)
- [ ] 3. Mild-moderate disability (mostly independent functioning and some interference with daily activities)
- [ ] 4. Major disability (requires help with most or all activities; has limited mobility)

B2.a. Name and Title of person who determined disability status:

_____

_____

C. COMPLICATIONS DURING HOSPITALIZATION (Please answer all items):

	1. NO	2. YES
C1. Recurrent Stroke	☐	☐
C2. Seizure	☐	☐
C3. Brain edema with worsening of symptoms	☐	☐
C4. Infection	☐	☐

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a. Bacterial	☐ **1. NO**	☐ **2. YES**	→ **COMPLETE FORM 31**
b. Viral	☐ **1. NO**	☐ **2. YES**	→ **COMPLETE FORM 31**
c. Other type of infection	☐ **1. NO**	☐ **2. YES**	→ **COMPLETE FORM 31**

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c1. Specify Type: _____

Signature of Study Coordinator:

Date: ___ ___ / ___ ___ / ___ ___ ___ ___