STOP II TRIAL

QUASI-ADJUDICATION 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. Center # ☐☐
☐ **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	☐	☐	

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	☐	☐	☐
C3.i Other	☐	☐	☐

↓

C3.i1 Specify _____

_____

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

_____

_____

D. RESULTS OF IMAGING AND ULTRASOUND TESTS PERFORMED TO EVALUATE <u>THIS EVENT</u>: (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 COPIES OF LOCAL REPORTS FOR ALL IMAGING STUDIES COMPLETED

E. NEUROLOGICAL EVALUATION

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

☐ **1. NO**

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

F. MANAGEMENT AND COMPLICATIONS

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

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

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

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. TCD received: ☐ **1. NO** ☐ **2. YES** ☐ **-1. NA (Not Done)**