NATIONAL CENTRE FOR DISEASE INFORMATICS AND RESEARCH

Indian Council of Medical Research

POPULATION BASED STROKE REGISTRY

Core Form - Incidence / Mortality Data

I IDENTIFYING INFORMATION

1. Name of Participating Centre ..... Centre Code

2. Incidence Registration Number
(First 2 digits are for year of registration and the next 5 digits for actual registration number)
Year / Reg. No

3.1 (a) Name of Source of Registration ..... Code
(Reporting Institution (RI) / Hospital)

(b) Name of Department / Unit / Physician etc. ..... Code

3.2 Hospital Registration Number

3.3 Date of Registration at Source of Registration /
Date of Reporting at this Hospital
dd / mm / yy

4. Date of Diagnosis of First Ever Stroke
(Date of first attendance to any hospital for this disease - generally the earliest of dates)

5. Full Name of Patient *(At least one name is compulsory)*
....
First / Second / Last

6. Place Of Residence: Place of Usual Residence *(where the person has been residing for the past one year (at least))*

Urban Areas (Town / Cities)

House No. .....

Road / Street Name .....

Area / Locality .....

Ward / Corporation / Division

Name of City / Town .....

Non-urban / Rural Areas

House No. and Ward .....

Name of Gram Panchayat / Village, etc:
.....

Name of Sub-Unit of District (Taluk / Tehsil / Other):
.....

Name of PHC / Sub Centre .....

Name of District * *(In Capitals)* ..... Postal Pin Code

Telephone No(s).: Off. ..... Res. .....

Mobile ..... Email ID .....

Unique Identification (Aadhaar) Number .....

7. Duration of Stay *(At the place of usual residence (in years))*

8. Age *(In years)* Date of Birth

9. Sex Male Female Others

II PAST HISTORY

	Yes	No	If yes, duration *(in years)*
Hypertension			.....
Diabetes			.....
Any Tobacco Use			.....

III CLINICAL INFORMATION

10.1 Critical Clinical Findings at Onset *(tick (✓) if present)*

- Unilateral or bilateral sensory impairment ☐
- Hemianopia (half-sided impairment of visual fields) ☐
- Apraxia of acute onset ☐
- Perception deficit of acute onset ☐
- Aphasia/dysphasia (non-fluent speech) ☐
- Forced gaze (conjugate deviation) ☐
- Ataxia of acute onset ☐
- Unilateral or bilateral motor impairment *(including lack of coordination)* ☐

10.2 Others

- Dizziness, vertigo ☐
- Diplopia ☐
- Seizures ☐
- Localised headache ☐
- Dysarthria (slurred speech) ☐
- Dysphagia ☐
- Blurred vision of both eyes ☐
- Impaired consciousness ☐
- Impaired cognitive function (including confusion) ☐

IV IMAGING STUDIES

11.1 CT Findings

Done ☐ Not Done ☐

If done, Date of CT ☐☐☐☐☐☐

- Hypodense Areas ☐
- Hyperdense Areas ☐
- Neither / Normal ☐
- Others (specify.....) ☐
- Unknown ☐

Impression _____

ICD-10 I ☐☐•☐

11.2 MRI Findings

Done ☐ Not Done ☐

If done, Date of MRI ☐☐☐☐☐☐

- Hypointense Areas ☐
- Hyperintense Areas ☐
- Isointense Areas ☐
- None of the ..... ☐
- Others ☐
- Unknown ☐

Impression _____

ICD-10 I ☐☐•☐

V DIAGNOSIS

12.1 Basis Of Diagnosis

Clinical Only ☐ Clinical + CT ☐ Clinical + CT + MRI ☐ Others (specify.....) ☐ Unknown ☐

12.2 Final Diagnosis

Not a Stroke ☐ Pre Stroke ☐ Non vascular Stroke ☐ Others ☐

Unknown ☐ Confirmed Stroke *(Specify diagnosis in words and record ICD-10 code including sub-site)* ☐

_____ (ICD-10) I ☐☐•☐

VI FOLLOW-UP *(28 days since date of diagnosis)*

13.1 Due Date for Follow up (28 days) ☐☐☐☐☐☐ Date of Actual Follow-up ☐☐☐☐☐☐

13.2 Method of Follow-up

No follow-up ☐ Hospital visit ☐ By post ☐ Through telephone ☐

Home visit ☐ Others (specify)..... ☐ Unknown ☐

13.3 Vital Status

Alive ☐ Dead ☐ Unknown ☐

14. If Dead,

14.1 Date of Death ☐☐☐☐☐☐

14.2 Place Of Death

Hospital ☐ Nursing Home ☐ Residence ☐ Others *(specify)* ..... ☐

If Hospital / Nursing Home : Name .....

☐☐☐ *Code* ☐☐☐☐☐☐☐☐☐☐ *Registration Number*

14.3 Certification Of Death:

Death Certified by

- Not Certified ☐
- Allopathic Practitioner ☐
- Non-Allopathic Practitioner ☐
- Coroner / Medical Autopsy ☐
- Others *(specify)*..... ☐
- Unknown ☐

Autopsy Report: Yes ☐ Name, Title And Address Of Person Certifying Death.....

14.4 Cause of Death

- As a result of stroke ☐
- Most probably due to stroke ☐
- Intercurrent Death ☐
- Treatment related Death ☐
- Others (specify)..... ☐
- Unknown ☐

15. For Matched Deaths Yes ☐

16. Name of Person Completing Form *(in capitals)* .....

Signature ..... Date ☐☐☐☐☐☐