

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 CENTRECENTRE 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) **Non-urban / Rural Areas**

House No.

House No. and Ward

Road / Street Name

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

Area / Locality

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

Ward / Corporation / Division

Name of PHC / Sub Centre

Name of City / Town.....

Name of District * (In Capitals) Postal Pin Code

Telephone No(s): Off. Res.

Mobile Email ID

UNIQUE IDENTIFICATION 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 CLINICAL INFORMATION

10.1 CRITICAL CLINICAL FINDINGS AT ONSET (tick (✓) if present)

Unilateral or bilateral sensory impairment	<input type="checkbox"/>	Aphasia/dysphasia (non-fluent speech)	<input type="checkbox"/>
Hemianopia (half-sided impairment of visual fields)	<input type="checkbox"/>	Forced gaze (conjugate deviation)	<input type="checkbox"/>
Apraxia of acute onset	<input type="checkbox"/>	Ataxia of acute onset	<input type="checkbox"/>
Perception deficit of acute onset	<input type="checkbox"/>	Unilateral or bilateral motor impairment (including lack of coordination)	<input type="checkbox"/>

10.2 OTHERS

Dizziness, vertigo	<input type="checkbox"/>	Localised headache	<input type="checkbox"/>	Blurred vision of both eyes	<input type="checkbox"/>
Diplopia	<input type="checkbox"/>	Dysarthria (slurred speech)	<input type="checkbox"/>	Impaired consciousness	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Dysphagia	<input type="checkbox"/>	Impaired cognitive function (including confusion)	<input type="checkbox"/>

III 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

IV 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

V 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