NATIONAL CENTRE FOR DISEASE INFORMATICS AND RESEARCH

Indian Council of Medical Research

POPULATION BASED STROKE REGISTRY (PBSR)

Registration Form to be Completed by Potential Participating Centres / Individuals

1. Name of the Institution / Health Care Facility :

   Postal Address :

   Postal Pincode :

   Telephone, FAX, e-mail :

2. Would you be willing to participate :

3. Principal Investigator :
   Co-Principal Investigator (if any) :
   Faculty in Charge (if applicable) :
   Name of Co-workers who are willing to participate :

4. Brief profile of the Institution:

Year	***2009***	***2010***	***2011***
Number of In-Patient Beds	_____	_____	_____
Total Out-patient attendance	_____	_____	_____
Total Registrations	_____	_____	_____
Total Proved Cases of Stroke	_____	_____	_____

5. Is there in-house Department of Radiology / Imaging? Yes ☐ No ☐ If no, is imaging available outside for your patients. Yes/No
   If yes in either question, please fill the section below. If no to both, go to item 6._____
   Number of CT Scans / MRI done during the year 2011:

	Total	**Stroke**
CT – Head	_____	_____
MRI – Brain – Head	_____	_____
Total	**_____**	**_____**

6. Number of stroke patients treated in your institution during the year 2011 at Departments of:
   Neurology ____ Neurosurgery (SAH,ICH)___ Medicine ____ Others ____

7. One critical and important item of patient information for patients diagnosed with stroke is the <u>correct, complete and detailed permanent residential address with duration of stay (or living) in that address</u>. This needs to be gathered directly from the patient or patient's representative. When can you obtain this information? *(Please tick ☑ one of the following).*

   i. At initial registration ___
   ii. At the time of CT / MRI / Department of Radiology ___
   iii. From the records (If from the records, please indicate where is the record kept? A common record section ___ Department of Neurology___
   iv. Department of Medicine ___
   v. From the records of other Departments – specify___
   vi. From general medical records___
   vii. Through concerned clinician ___
   viii. Other means ..... ___
   (Please specify the methodologies)

8.1 Maintenance of Medical Records (Please tick √):

a) only In-patient records ___
b) both In and Out-patient records ___
c) no medical records ___

8.2 If you keep records for all visits, specify whether each visit has a different number or the same number _____

8.3 Are medical records in the form of:

i. hard copy ___
ii. computerized ___
iii. both ___

9. Existing computer facilities – Overall: Please elaborate

Hardware – Number of servers, desktops, laptops etc with salient configuration

Software – Platforms, uses etc

Internet Connectivity

Broad Band – Overall
Broad Band for each department
Others

10. Would your Institution/Department be able to obtain the following or funds for the following items, for use in the project *(Please tick ☑).*

		Yes/ Available	***No***	***Required Funds***
i.	Personal Computer	☐	☐	_____
ii.	Independent Telephone Connection	☐	☐	_____
iii.	Internet/e-mail Connection	☐	☐	_____
iv	Contingency/maintenance	☐	☐	_____
v.	Data Collation/Entry etc	☐	☐	_____
	TOTAL			_____

11. Any other relevant information.

Name :
Principal Investigator :
Designation :

The above form complete in all respects may be sent to :

Office of the National Centre for Disease Informatics and Research
Nirmal Bhawan - ICMR Complex (II Floor), Poojanahalli Road, Off NH-7, Adjacent to Trumpet flyover of BIAL, Kannamangala Post, Bangalore – 562 110, Tel: 91 94490 67643, 91 94490 33748, 91 80 28467643; Fax: 91 80 28467644, E-mail: ncrp@ncrpindia.org, ncdir@ncdirindia.org