

Study number:

Date of inclusion: ___/___/___

DISCHARGE INTERVENTION CENTER CRF

Neuroimaging—Intervention center

Any additional neuroimaging performed during hospital stay (excl. study imaging): No Yes
 Send all neuroimaging performed during admission to the study team.

Medication during hospital stay—Intervention center

Antiplatelet agents: No Yes

Acetylsalicylic acid/carbasalate No Yes
 calcium: Start: ___/___/___ Stop (if applicable): ___/___/___

Clopidogrel: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Dipyridamole: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Ticagrelor: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Other: No Yes
 Start: ___/___/___ If yes, please specify; _____
 Stop (if applicable): ___/___/___

Direct Oral Anticoagulants: No Yes

Apixaban (Eliquis): No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Dabigatran (Pradaxa): No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Edoxaban (Lixiana): No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Rivaroxaban (Xarelto): No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Other, _____ No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Vitamin K antagonist: No Yes

Acenocoumarol: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Phenprocoumon: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Heparin: No Yes

Prophylactic heparin: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Therapeutic heparin: No Yes
 Start: ___/___/___ Stop (if applicable): ___/___/___

Other anticoagulants: No Yes
 Start: ___/___/___ If yes, please specify; _____
 Stop (if applicable): ___/___/___

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Interventions and diagnoses during hospital stay—intervention center

Atrial fibrillation de novo:	<input type="radio"/> No	<input type="radio"/> Yes
Aneurysma spurium:	<input type="radio"/> No	<input type="radio"/> Yes
Treatment for aneurysma spurium:	<input type="radio"/> No treatment <input type="radio"/> (Pro) thrombin injection <input type="radio"/> Compression bandage	<input type="radio"/> Surgical intervention <input type="radio"/> Other, _____
Groin hematoma:	<input type="radio"/> No	<input type="radio"/> Yes
Intubation (excl. intubation for EVT):	<input type="radio"/> No	<input type="radio"/> Yes
Hemicraniectomy:	<input type="radio"/> No	<input type="radio"/> Yes
External ventricular drain (EVD):	<input type="radio"/> No	<input type="radio"/> Yes
Major medical/surgical intervention:	<input type="radio"/> No If yes, please specify; _____	<input type="radio"/> Yes

Admissions—intervention center

Patient admitted to the ICU:	<input type="radio"/> No	<input type="radio"/> Yes, total days: _____
Patient admitted to Medium Care:	<input type="radio"/> No	<input type="radio"/> Yes, total days: _____
Patient admitted to Stroke Unit:	<input type="radio"/> No	<input type="radio"/> Yes, total days: _____
Patient admitted to General Ward:	<input type="radio"/> No	<input type="radio"/> Yes, total days: _____

Discharge—intervention center

Was the patient discharged (or did the patient die during admission):	<input type="radio"/> No	<input type="radio"/> Yes
Discharge destination:	<input type="radio"/> Patient died <input type="radio"/> Home <input type="radio"/> Geriatric rehabilitation <input type="radio"/> Nursing home long stay	<input type="radio"/> Rehabilitation center <input type="radio"/> Other hospital (complete discharge second hospital) <input type="radio"/> Other, _____

Date of discharge or death: ___/___/___

(S)AE Check

Did the patient experience one of more (serious) adverse events:	<input type="radio"/> No <input type="radio"/> Yes If yes, please complete (S)AE form(s) in Castor and report to sponsor!
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Review all Data for this Visit

Physician	Study Nurse
Date: ___/___/___	Date: ___/___/___
Signature: _____	Signature: _____
Other, comments: _____	

