Study number: _____ Date of inclusion: ___/___/___

DEFERRED TREATMENT CRF

Where was the decision regarding the deferred treatment strategy made:	o Intervention center o Referring center	o Other, _____
What was the deferred treatment strategy:	o Carotid Endarterectomy (CEA) o Best medical therapy o Carotid artery stenting (CAS)	

General procedure information

Date and time of procedure:	___/___/___ ___:___	
Carotid artery treated:	o Left	o Right

Anticoagulation/antiplatelet therapy (multiple options possible):

Preprocedural: started on ward before procedure, During procedure: administered in anesthetic room or angiography suite, Post-procedural: Given on ward immediately after procedure.

Pre-procedural:	During procedure:	Post-procedural:
o Aspirin	o Aspirin	o Aspirin
o Dipyramidole	o Dipyramidole	o Dipyramidole
o Clopidogrel	o Clopidogrel	o Clopidogrel
o Ticlodopine	o Ticlodopine	o Ticlodopine
o Warfarin	o Warfarin	o Warfarin
o Heparin or LMWH (therapeutic dose)	o Heparin or LMWH (therapeutic dose)	o Heparin or LMWH (therapeutic dose)
o Heparin or LMWH (prophylactic dose)	o Heparin or LMWH (prophylactic dose)	o Heparin or LMWH (prophylactic dose)
o Other antithrombotic; _____	o Other antithrombotic; _____	o Other antithrombotic; _____

Carotid Endarterectomy

Duration of procedure:	___:___	
Type of anesthetic used:	o General anesthesia o Local/Regional anesthesia o Combined local/regional and general anesthesia	
Type of reconstruction used:	o Standard endarterectomy o Eversion endarterectomy o Vein interposition	
Was a shunt used:	o No	o Yes
Occlusion time:	___:___	(Do not include shunt time if used)
Was intra-operative neuromonitoring performed?	o EEG o Transcranial doppler (TCD) o EEG + TCD o No intra-operative neuromonitoring performed	
Did the patient experience one or more (serious) adverse events during CEA:	o No	o Yes **If yes, please complete (S)AE form(s) in Castor and report to sponsor!**

Best medical therapy

What was the reason this option was chosen:	o Patient did not recover well from stroke o Patient did not consent to intervention o Patient did not have high grade stenosis o There was no carotid stenosis/occlusion left after EVT o During follow-up, there was a complete carotid artery occlusion o Other, please specify: _____

Study number: _____ Date of inclusion: ___/___/___

DEFERRED TREATMENT CRF

Carotid Artery Stenting

What was the reason this option was chosen: _____		
Duration of procedure:	___:___	
Anesthetic management:	o None (local only) o None + bolus short working opiates o Moderate sedation	o Deep sedation o General anesthesia

Moderate sedation= patient is asleep, but wakes up when spoken to or touched
Deep sedation = patients sleeps, no intubation
General anesthesia = intubation

Was PTA performed, and if so when:	o PTA performed before CAS o PTA performed after CAS	o PTA both before and after CAS o No PTA performed
Balloon measurements:	Diameter:_____mm	Length:_____mm
What was the type of stent used? If other, please specify (Multiple options possible)	o Roadsaver (Terumo) o Casper (Microvention) o CGuard (Inspire MD) o Wallstent (Boston Scientific o Xact (Abbott)	o Acculink (Abbott) o NexStent (EndoTex) o Protégé RX (Medtronic) o Precise Pro Rx (Cordis) o Other: _____
Stent measurements:	Diameter:_____mm	Length:_____mm
Was the stent successfully deployed:	o No	o Yes
Was a cerebral protection device used during CAS?	o No	o Yes
If yes, what type of cerebral perfusion protection was used:	o Proximal protection device Please specify: _____	o Distal protection device
Did any of the following events occur during the procedure:	o Bradycardia o Hypotension o Carotid stent thrombosis o Embolization in new vascular territories o None of the above	
If carotid stent thrombosis, was escape medication (tirofiban [Aggrastat] bolus 25microg/kg followed by 0,15microg/kg/min) used: administered:	o No	o Yes
Did the patient experience one or more (serious) adverse events during CAS:	o No	o Yes **If yes, please complete (S)AE form(s) in Castor and report to sponsor!**

Review all Data for this Visit

Physician Date: ___/___/___ Signature: _____	Study Nurse Date: ___/___/___ Signature: _____

Other, comments:_____
_____
_____
_____