**Core (mandatory) questions**

To create a new record within the Australian Stroke Data Tool (AuSDaT) you must enter the following information:

* Patient first name
* Patient surname
* Date of Birth
* Gender

This will create a statistical linkage key and create an episode identification number. First and last name are **NOT** stored or accessed by Stroke Foundation staff at all – this is only entered by site to automatically create episode information and is not identifiable.

| **AuSDaT ref**  | **Question** | **Responses** | **Comment** |
| --- | --- | --- | --- |
|  | **AUDITOR INFORMATION** |  |
| 1.000 | Hospital name | NA | Automatically complete based on login |
| 1.020 | Auditor name  | NA | Automatically complete based on login |
| 1.030 | Auditor email | NA | Automatically complete based on login |
| 1.040 | Auditor contact number  | NA | Automatically complete based on login |
| 1.050 | Auditor discipline: | Doctor; Nurse; Allied health; Manager; Other |  |
|  | **PATIENT / DEMOGRAPHIC INFORMATION** |  |
| 2.000 | Patient episode ID number | NA  | Automatically assigned by AuSDaT |
| 2.060 | First name |  | Used to set up new (or check existing) record. NO DETAILS STORED OR ACCESSED BY SF.  |
| 2.070 | Last name |  | Used to set up new (or check existing) record. NO DETAILS STORED OR ACCESSED BY SF. |
| 2.090 | Date of birth | DDMMYYYY |  |
| 2.100 | Age |  | Derived from DOB automatically |
| 2.130 | Gender | Male, Female, Intersex or indeterminate, Not stated/inadequately described  |  |
| 2.170 | Interpreter needed? | Yes/no |  |
| 2.180 | Is the patient of Aboriginal/Torres Strait Islander origin? | Aboriginal but not Torres Strait Islander origin, Torres Strait Islander but not Aboriginal origin,Both Aboriginal and Torres Strait Islander origin,Neither Aboriginal nor Torres Strait Islander origin,Indigenous not otherwise described,Missing / not stated |  |
|  | **STROKE ONSET AND HOSPITAL STAY** |  |
| 4.000-4.020 | Onset date; accuracy | DDMMYYYY; unknownaccurate/estimate |  |
| 4.030-4.070 | Onset time and accuracy | hh:mm- Known (accurate) time of onset- Estimated time of onset or time last seen normal- Wake up stroke (time last seen normal)- Time unknown |  |
| 4.150 -4.160 | Date of arrival to emergency department; Accuracy | DDMMYYYY accurate/estimate |  |
| 4.170 -4.180 | Time of arrival to emergency department; accuracy;  | hh:mm; accurate/estimate; unknown |  |
| 4.290 | Date of admission to hospital | DDMMYYYY  |  |
| 4.320 / 4.331 | Time of admission to hospital | hh:mm; unknown |  |
| 4.360 – 4.370 | What was the ward for initial admission; other | Stroke Unit, Other neuroscience ward, Medical ward, Surgical ward, Mixed med/surgical ward, Rehabilitation ward, ICU, Unknown, Other |  |
| 4.380 | Was the patient treated in a stroke unit at any time during their stay? | Yes / No / Unknown |  |
| 4.390 | What was the date of admission to stroke unit? | DDMMYYYY |  |
| 4.400 -4.410 | Time of Admission to stroke unit | hh:mm, not documented |  |
| 4.420 | What was the date of discharge from stroke unit? | DDMMYYYY |  |
|   | **PRIOR TO STROKE** |  |
|   | ***Dependency prior to admission*** |  |  |
| 6.470 | Functional status prior to stroke? (mRS) Score 0-5 | 0-5 (unknown or derived if needed) |  |
| 6.540 | Living arrangements prior to admission?  | Home (alone), Home (with others), Supported accommodation e.g. nursing home, hostel, Other |  |
|   | **ACUTE CLINICAL DATA** |  |
| 7.550 | Type of stroke | TIA, Ischaemic, haemorrhage, undetermined |  |
|  | **OTHER CLINICAL INFORMATION** |  |
| L9.000 | On admission were any of the following impairments present: |  |  |
| 9.000 | Sensory deficit | Yes / No / Not documented |  |
| 9.010 | Cognitive deficit | Yes / No / Not documented |  |
| 9.020 | Visual deficit | Yes / No / Not documented |  |
| 9.030 | Perceptual deficit | Yes / No / Not documented |  |
| 9.040 | Speech/communication impairment | Yes / No / Not documented |  |
| 9.050 | Hydration problems | Yes / No / Not documented |  |
| 9.060 | Nutrition problems | Yes / No / Not documented |  |
| 9.061 | Arm deficit | Yes / No / Not documented |  |
| 9.062 | Lower limb deficit | Yes / No / Not documented |  |
| 9.063 | Dysphagia | Yes / No / Not documented |  |
| 9.064 | Continence | Yes / No / Not documented |  |
| 9.065 | Balance | Yes / No / Not documented |  |
|   | ***Early outcome measures*** |  |  |
| 10.381 | Which outcome measure was used? | FIM Modified Barthel Index Other |  |
| 10.390-10.400 | Total Motor FIM score on admission | Score (13-91) / Unknown |  |
| 10.410-10.420 | Total Cognitive FIM score on admission | Score (5-35) / Unknown |  |
| 10.421 | Modified Barthel Index | Free text |  |
| 10.422 | Other (specify) | Free text |  |
| 10.423 | Other (score) | Free text |  |
|   | ***Allied health assessments*** |  |  |
| 10.450 | Was the patient seen by a physiotherapist? | Yes/ No/ Patient declined / Therapist not on staff |  |
| 10.460-10.470 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.480-10.490 | What was the time? | hh:mm/ unknown |  |
| 10.500 | Was the patient seen by an occupational therapist? | Yes/ No/ Not required/ Therapist not on staff |  |
| 10.510-10.520 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.530-10.540 | What was the time? | hh:mm/ unknown |  |
| 10.550 | Was the patient seen by a speech pathologist? | Yes/ No/ Not required/ Therapist not on staff |  |
| 10.560-10.570 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.580-10.590 | What was the time? | hh:mm/ unknown |  |
| 10.600 | Was the patient seen by a social worker? | Yes/ No/ Not required/ Therapist not on staff |  |
| 10.610-10.620 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.630-10.640 | What was the time? | hh:mm/ unknown |  |
| 10.650 | Was the patient seen by a dietitian? | Yes/ No/ Not required/ Therapist not on staff |  |
| 10.660-10.670 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.680-10.690 | What was the time? | hh:mm/ unknown |  |
| 10.700 | Was the patient seen by a psychologist? | Yes/ No/ Not required/ Therapist not on staff |  |
| 10.710-10.720 | If yes, what was the date? | DDMMYYYY/ unknown |  |
| 10.730-10.740 | What was the time? | hh:mm/ unknown |  |
|   | ***Other rehabilitation questions*** |  |  |
| 10.741 | Did the patient commence rehabilitation therapy within 48 hours of initial assessment?  | Yes/ No |  |
| 10.742 | If no, what was the main reason why not? | Patient declined rehabilitation; Patient return to pre-morbid function; Patient in a coma and/or unresponsive (not simply drowsy); Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); Other |  |
| 10.743 | Did the patient undergo treatment based on their identified rehabilitation goal/s during their acute hospital admission? | Yes/ No |  |
| 10.744 | If no, what was the main reason why not? | Patient declined rehabilitation; Patient return to pre-morbid function; Patient in a coma and/or unresponsive (not simply drowsy); Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); Other |  |
|   | **FURTHER REHABILITATION**  |  |
| 12.000 | Was an assessment for rehabilitation performed? | Yes / No / unknown |  |
| 12.010 | If yes, did this use the Assessment of Rehabilitation Tool? | Yes / No / unknown |  |
| 12.020 | Who undertook this assessment? | Rehabilitation specialist; Rehabilitation registrar; Rehabilitation coordinator (nurse or ALH); General physician; Neurologist; Geriatrician; Other medical not specified; Acute stroke coordinator; Other |  |
| 12.030 | Did the assessment identify the need for ongoing rehabilitation? | Yes / No / unknown |  |
| 12.040 | If yes, was a referral made to rehabilitation? | Yes / No / unknown |  |
| 12.050 | If yes, what was the type? | Inpatient rehabilitation Outpatient rehabilitation Community rehabilitation home based Community rehabilitation day hospitalEarly supported discharge service Other |  |
| 12.060 | Other (specify) | Free text |  |
| 12.070 | Date of referral | DDMMYYYY |  |
| 12.080 | If no, why not? | return to pre-morbid function; palliation; coma and/or unresponsive (not just drowsy); declined rehabilitation; plateau in function; rehabilitation goals met; no public service available; other  |  |
| 12.090 | Were they accepted for rehabilitation? | Yes / No / unknown |  |
| 12.110 -12.120 | If no, what was the reason? | service full, service cannot cope with severity; patient/family declined; other (specify) |  |
| 12.130 | Did the patient access further rehabilitation? | Yes / No / unknown |  |
| 12.140-12.150 | If yes, type | Inpatient rehabilitation;Outpatient rehabilitation;Community rehabilitation home based; Community rehabilitation day hospital; Early supported discharge service; Other (specify) |  |
| 12.151 | Was this provided in a private or public service? | Public / private |  |
| 12.160-12.170 | Date of commencing rehabilitation | DDMMYYYY; Unknown |  |
|  | **DISCHARGE AND TRANSFER OF CARE** |  |
| 14.070 | Is the date of discharge known | Yes/ No |  |
| 14.080 | Date of discharge | DDMMYYYY |  |
| 14.160 | What is the discharge destination/mode | Discharge/transfer to (an)other acute hospitalDischarge/transfer to a residential aged care service, unless this is the usual place of residenceStatistical discharge - type changeLeft against medical advice/discharge at own risk DiedOther Usual residence (e.g. home) with support Usual residence (e.g. home) without supportInpatient rehabilitationTransitional care service |  |
| 14.161 | Please specify (if residential aged care) | Low level residential care;High level residential care  |  |
|   | ***Dependency on discharge*** |  |  |
| 14.250 -14.310 | Functional status at discharge? (mRS) Score 0-6 | 0-6 (unknown or derived if needed) |  |