**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: |  |  |
| 9.050 | Hydration problems | Yes / No / Not documented |  |
| 9.060 | Nutrition problems | Yes / No / Not documented |  |
| 9.063 | Dysphagia | Yes / No / Not documented |  |
|   | ***Assessment and management of fever*** |  |  |
| 10.070 | Was temperature recorded at least four times on day one of ward admission? | Yes/ No/ Not documented |  |
| 10.080 | Was temperature recorded at least four times on day two of ward admission? | Yes/ No/ Not documented |  |
| 10.090 | Was temperature recorded at least four times on day three of ward admission? | Yes/ No/ Not documented |  |
| 10.100 | In the first 72 hours following admission did the patient develop a fever ≥ 37.5⁰C? | Yes / No / Not documented |  |
| 10.110 | Date | DDMMYYYY |  |
| 10.120 | Date accuracy  | Accurate / Estimate |  |
| 10.130 | Time  | hh:mm (24 hr) |  |
| 10.140 | Time accuracy  | Accurate / Estimate |  |
| 10.150 | If yes to 10.100, was paracetamol for the first elevated temperature administered within 1 hour? | Yes/ No/ Already received regular paracetamol/ Contraindicated/ Not documented |  |
| 10.160 | Date | DDMMYYYY |  |
| 10.170 | Date accuracy  | Accurate / Estimate |  |
| 10.180 | Time  | hh:mm (24 hr) |  |
| 10.190 | Time accuracy  | Accurate / Estimate |  |
|   | ***Assessment and management of hyperglycaemia***  |  |  |
| 10.200 | Was a venous blood glucose level sample collected and sent to laboratory while patient was in the ED? | Yes/ No/ Not documented |  |
| 10.210 | Was finger-prick blood glucose level recorded at least four times on day one of ward admission? | Yes/ No/ Not documented |  |
| 10.220 | Was finger-prick blood glucose level recorded at least four times on day two of ward admission? | Yes/ No/ Not documented |  |
| 10.230 | Was finger-prick blood glucose level recorded at least four times on day three of ward admission? | Yes/ No/ Not documented |  |
| 10.240 | In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal 10 mmols/l?  | Yes / No / Not documented |  |
| 10.250 | If yes, was insulin administered within 1 hour of the first elevated finger-prick glucose (>=10 mmol/L)?  | Yes / No / Not documented |  |
| 10.260 | Date | DDMMYYYY |  |
| 10.270 | Date accuracy  | Accurate / Estimate |  |
| 10.280 | Time  | hh:mm (24 hr) |  |
| 10.290 | Time accuracy  | Accurate / Estimate |  |
| 10.300 | Route | Subcutaneous / IV / Not documented |  |
|   | ***Allied health assessments*** |  |  |
| 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 |  |
| 10.650 | 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 |  |
|   | **COMPLICATIONS ON / DURING HOSPITAL ADMISSON**  |  |
| L11.01 | Did the patient have any of the following complications **on** admission: |  |  |
| 11.010 | Aspiration pneumonia | Yes/ No |  |
| 11.040 | Fever | Yes/ No |  |
| 11.110 | Malnutrition | Yes/ No |  |
| L11.16 | Did the patient have any of the following complications **during** their admission: |  |  |
| 11.160 | Aspiration pneumonia | Yes/ No |  |
| 11.190 | Fever | Yes/ No |  |
| 11.280 | Malnutrition | Yes/ No |  |
| 11.370 | Were any of the above complications severe (i.e. incapacitating, life threatening and prolongs hospital admission and patient acuity)? | Yes / No / 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) |  |