**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; unknown  accurate/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 hospital Discharge/transfer to a residential aged care service, unless this is the usual place of residence Statistical discharge - type change Left against medical advice/discharge at own risk  Died Other  Usual residence (e.g. home) with support  Usual residence (e.g. home) without support Inpatient rehabilitation Transitional 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) |  |