NATIONAL CENTRE FOR DISEASE INFORMATICS AND RESEARCH

Indian Council of Medical Research

POPULATION BASED STROKE REGISTRY

Core Form for Incidence and Mortality

I. IDENTIFYING INFORMATION

1. NAME OF PARTICIPATING CENTRE * ..... CENTRE CODE ☐☐☐

2. INCIDENCE REGISTRATION NUMBER *
(First 2 digits are for year of registration and the next 5 digits for actual registration number) ☐☐☐☐☐☐☐ Year Reg. No

3.1 (a) NAME OF SOURCE OF REGISTRATION * ..... CODE ☐☐☐
(Reporting Institution (RI) / Hospital)

(b) NAME OF DEPARTMENT / UNIT / PHYSICIAN etc..... CODE ☐☐☐

3.2 HOSPITAL REGISTRATION NUMBER * ☐☐☐☐☐☐☐☐☐☐

3.3 DATE OF REGISTRATION AT SOURCE OF REGISTRATION / DATE OF REPORTING AT THIS HOSPITAL ☐☐☐☐☐☐

4.1 DATE OF ONSET OF STROKE EVENT ☐☐☐☐☐☐

4.2 DATE OF DIAGNOSIS OF FIRST EVER STROKE * ☐☐☐☐☐☐
(Date of first attendance to any hospital for this disease - generally the earliest of dates)

5. FULL NAME OF PATIENT *(At least one name is compulsory)* *

....
FIRST *SECOND* *LAST*

6. PLACE OF RESIDENCE: [*Place of Usual Residence (where the person has been residing for the past one year (at least))*] *

○ ***Urban Areas (Town / Cities)***

House No. .....

Road / Street Name .....

Area / Locality .....

Ward / Corporation / Division * ☐☐☐

Name of City/Town .....

○ ***Non-urban / Rural Areas***

House No. and Ward .....

Name of Gram Panchayat / Village, etc.: .....

Name of Sub-Unit of District (*Taluk / Tehsil / Other*):.....

.....

Name of PHC/Sub Centre .....

Name of District (*in capitals*) * .....Postal Pin Code * ☐☐☐☐☐☐

Telephone No(s).: Off. ..... Res. .....

Mobile No ..... Email Id : .....

Aadhaar (*Unique Identification*) Number ☐☐☐☐☐☐☐☐☐☐☐☐

7. DURATION OF STAY [*At the place of usual residence (in years)*] * ☐☐

8. AGE (*in years*) * ☐☐ DATE OF BIRTH ☐☐☐☐☐☐

9. SEX * Male ○ Female ○ Others ○

II. PAST HISTORY

	Yes	No	Unknown	[If yes, duration (*in years*)]
Hypertension	○	○	○	.....
Diabetes	○	○	○	.....
Current Tobacco Use	○	○	○	.....

III. CLINICAL INFORMATION

10.1 CRITICAL CLINICAL FINDINGS AT ONSET (*tick (✓) if present*) *

- Unilateral or bilateral motor impairment (*including lack of coordination*) ☐
- Unilateral or bilateral sensory impairment ☐
- Hemianopia (*half-sided impairment of visual fields*) ☐
- Apraxia of acute onset ☐
- None ☐
- Aphasia/dysphasia (*non-fluent speech*) ☐
- Forced gaze (*conjugate deviation*) ☐
- Ataxia of acute onset ☐
- Perception deficit of acute onset ☐

10.2 OTHERS:

- Dizziness, Vertigo ☐
- Localised headache ☐
- Blurred vision of both eyes ☐
- Diplopia ☐
- Dysarthria (slurred speech) ☐
- Impaired consciousness ☐
- Seizures ☐
- Dysphagia ☐
- Impaired cognitive function (*including confusion*) ☐
- Any other ..... ☐

IV. IMAGING STUDIES

11.1 CT FINDINGS Done ○ Not Done ○

If done, Date of CT ☐☐☐☐☐☐

- Hypodense Areas ☐
- Hyperdense Areas ☐
- Neither / Normal ☐
- Others (*Specify*.....) ☐
- Unknown ☐

Impression.....

ICD-10: I ☐☐•☐

11.2 MRI FINDINGS Done ○ Not Done ○

If done, Date of MRI ☐☐☐☐☐☐

- Hypointense Areas ☐
- Hyperintense Areas ☐
- Isointense Areas ☐
- None of the above / Normal ☐
- Others (*Specify*.....) ☐
- Unknown ☐

Impression.....

ICD-10: I ☐☐•☐

V. DIAGNOSIS

12.1 BASIS OF DIAGNOSIS * Clinical ☐ CT ☐ MRI ☐ DCO ☐ Others (specify.....) ☐

12.2 FINAL DIAGNOSIS OF CONFIRMED STROKE *.....

12.3 TYPE OF STROKE *

Ischemic ☐ Subarachnoid Haemorrhage ☐ Intracerebral Haemorrhage ☐ Venous ☐ Others, (*specify*.....) ☐

12.4 ICD -10 Description..... ICD-10 Code: I ☐☐•☐

VI. FOLLOW-UP

13.1 DUE DATE FOR FOLLOW UP ☐☐☐☐☐☐ DATE OF ACTUAL FOLLOW-UP ☐☐☐☐☐☐

(28 days since date of onset of stroke event / Date of Diagnosis)

13.2 METHOD OF FOLLOW-UP

- No Follow-up ☐
- Hospital visit ☐
- By post ☐
- Through telephone ☐
- Home visit ☐
- Others (*specify*)..... ☐
- Unknown ☐

13.3 VITAL STATUS * Alive ○ Dead ○ Unknown ○

VII. IF DEAD

14.1 DATE OF DEATH * ☐☐☐☐☐☐

14.2 PLACE OF DEATH Hospital ○ Nursing Home ○ Residence ○ Others (*specify*) ..... ○

IF HOSPITAL / NURSING HOME: NAME .....

Code ☐☐☐ Registration Number ☐☐☐☐☐☐☐☐☐☐

14.3 CERTIFICATION OF DEATH

Death Certified by Not Certified ○ Allopathic Practitioner ○ Non-Allopathic Practitioner ○ Coroner/Medical Autopsy ○

Verbal Autopsy ○ Others (*specify*)..... ○ Unknown ○

14.4 CAUSE OF DEATH * Related to stroke ○ Not related to stroke ○ Others (*specify*)..... ○ Unknown ○

14.5 ANTECEDENT EVENTS BEFORE DEATH.....

.....

15 NAME OF PERSON COMPLETING FORM (*in capitals*) *.....

SIGNATURE..... DATE ☐☐☐☐☐☐