**Date information collected:** (mm-dd-yyyy format) \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

1. **Location of acute hospital discharge:**

Home with no in-home services

Home with home care services

Another family member’s/ friend's home

Intensive Inpatient rehabilitation facility (IRF) including distinct rehabilitation units of a hospital: three hours or greater of therapy per day

Skilled nursing facility (SNF)/ subacute rehab: less than two hours a day of therapy

Medicare certified long-term care hospital (LTCH)

Hospice- home or medical facility providing hospice level of care

Other not defined above:

Expired

1. **Resource Utilization Group Version IV (RUG IV):**(please specify 3-letter alpha-numeric code)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Acute Hospital Rehabilitation Services

1. **Assessed for rehabilitation services?**  Yes  No (Skip to 6)  Unknown (Skip to 6)
2. **Were rehabilitation therapy/services received?** (choose all that apply)

Received rehabilitation therapy during hospitalization

Did not receive rehabilitation therapy because symptoms resolved

Ineligible to receive rehabilitation therapy due to impairment severity or medical issues

Referred to rehabilitation services following discharge

Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Type, location and amount of therapies** (choose all that apply)

| **Type(s) of rehabilitation therapy/ services received:** | **Where were rehabilitation services received?** | **Estimated amount of rehabilitation therapy:** | **\*\*\*Start Date:** |
| --- | --- | --- | --- |
| Speech/ Language | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Occupational | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Vocational | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Physical | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Psychological/Cognitive | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Dietary | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Recreational | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |
| Other, specify | Inpatient  Acute Hospital  Rehabilitation Facility  Outpatient (following acute hospital discharge) | Estimated number of weeks \_\_\_\_\_  Estimated number of sessions/week\_\_\_\_\_  Estimated total sessions\_\_\_\_\_ | (mm/dd/yyyy) |

1. **Provided with assistive devices?**  Yes  No  Unknown

IF YES, current type(s) of assistive devices: (choose all that apply)

AFO/ brace/ prosthetic/ orthotic/ splints

Cane (Straight/ Tripod/ Quad)

Walker

Power wheelchair

Scooter

Manual wheelchair

Adaptive or Activities of Daily Living (ADL) equipment (e.g. modified eating utensils, reachers, etc.)

Other, specify:

1. **Received or receiving adjunctive treatments?**  Yes  No  Unknown

IF YES, type(s) of adjunctive treatments: (choose all that apply)

Feeding/ gastrostomy tube placement

Botulinum toxin for spasticity

Intrathecal baclofen

Functional electrical stimulation

Tracheostomy

Tendon lengthening or transfer

Contracture release

Surgical procedure or injections for drooling, specify:

Potential function enhancing drugs (SSRIs, stimulants, antidepressants)

Other, specify:

1. **\*\*\*Provided with supportive medical equipment?**   Yes  No  Unknown

\*\*\*IF YES, type(s) of supportive medical equipment: (choose all that apply)

Bedside commode

Hospital bed

Bathroom grab bars

Stair lifts

Raised toilet seats

Shower seats

Suction devices

Oxygen

Ramps

Other, specify:

## Follow-up Care

1. **\*\*Follow-up care from the following specialists?** (choose all that apply)

Neurologist, non-vascular

Vascular neurologist

Primary care provider

PM&R or other rehabilitation physician

Other, specify:

## General Instructions

This case report form (CRF) contains data elements related to rehabilitation therapies and other follow-up care the participant/subject receives for the index stroke event. Most of the data elements are meant to be collected after the participant/ subject is discharged from the acute hospital stay following treatment for the index stroke event.

Some of the CDEs are Supplemental- Highly Recommended based on study type, disease stage and disease type or Exploratory as indicated by asterisks below. Please refer to Start-Up document for details.

\*\*Element is classified as Supplemental – Highly Recommended

\*\*\*Element is classified as Exploratory

The remaining data elements are Supplemental and should only be collected if the research team considers them appropriate for their study.

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.

The CRF includes most of the instructions available for the data elements at this time. One element has some additional instructions not included on the CRF:

* Location of acute discharge – It is suggested that this data element be collected at 3, 6, and twelve months post-acute discharge.
* Rehabilitation therapy start date – Investigators can choose to include this item if it is relevant to the study.