1. Vital status\* (choose one):

[ ]  Alive [ ]  Dead

1. Date and Time of Death (m m /d d/ y y y y):

[ ]  am

[ ]  pm

[ ]  24-hour clock

1. Date of final diagnosis (m m /d d/ y y y y):
2. Cause(s) of Death:

Table 1 Cause(s) of Death

| Cause of Death (List primary cause first) | ICD-10-CM Code |
| --- | --- |
| Data to be filled out by site | Data to be filled out by site |
| Data to be filled out by site | Data to be filled out by site |
| Data to be filled out by site | Data to be filled out by site |
| Data to be filled out by site | Data to be filled out by site |
| Data to be filled out by site | Data to be filled out by site |

1. Is the death a stroke according to the WHO definition?

[ ]  Yes [ ]  No [ ]  Unknown

1. Age at death (years):
2. Death location\*\*\*:

|  |  |
| --- | --- |
| [ ]  Home[ ]  Home with hospice[ ]  Inpatient hospice care[ ]  Nursing home | [ ] Hospital – inpatient stay[ ]  Hospital – emergency room[ ]  Other, specify: |

## General Instructions

This CRF Module is recommended to collect information on death for Stroke studies.

All elements on this CRF are classified as Supplemental, except for Vital Status\* which is recommended as Disease Core and Death location\*\*\* which is recommended as Exploratory.

Specific Instructions

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

* Vital Status – Record the status of participant/subject as alive or dead
* Date and Time of Death – Record the date (and time) of death and verify with the death certificate if possible. The date/time should be recorded to the level of granularity known (e.g., year, year and month, complete date plus hours and minutes, etc.) and in the format acceptable to the study database. If uncertainty exists on the occurrence of death or date of death, confirm death and date of death using vital status search, such as the Social Security Death Index in the US.
* Date of final diagnosis – Enter the Date of participant's/subject's final clinical diagnosis.
* Cause(s) of Death – Record what the death certificate lists as the official cause of death.
* Death cause ICD-10-CM code - Record the cause or causes of death using explanatory text and the associated ICD-10-CM code. Include the primary cause of death first followed by any secondary causes.
* Is the event a stroke according to the WHO definition? – The indicator of whether the death is a stroke according to the WHO definition. World Health Organization definition = Rapidly developing clinical signs of focal, at times global, disturbance of cerebral function, lasting more than 24 hours or leading to death with no apparent cause other than that of vascular origin.
* Age at death (years) – Enter the value of the subject/participant's age at death.
* Death location – Choose one.