1. Was the participant's/ subject's care restricted to "Comfort Measures Only"?

[ ] Yes [ ] No (Skip to 2) [ ] Unknown

1. Earliest documentation of "Comfort Measures Only":

[ ] Day 1 or 2 [ ] Day 3 or after [ ] Timing unclear [ ] Not Documented (ND)/Unable to Determine (UTD)

1. Type(s) of comfort care measures received: (choose all that apply)

[ ] Eliminating sources of discomfort

[ ] Providing effective pain and symptom management through the use of medications and other therapies

[ ] Offering a quiet, private environment that supports the intimate process of dying

[ ] Encouraging personal rituals that may honor or celebrate the person dying

[ ] Providing support, reassurance, and info about grief, bereavement, and the dying process

[ ] Providing spiritual care as desired

[ ] Offering food and fluids as the dying person desires and is able to take

[ ] Preventing constipation, even if oral intake has been minimal

[ ] Positioning at frequent intervals to prevent bedsores

[ ] Offering frequent mouth care for discomfort from drying

[ ] Instilling artificial tears or eye lubricant for discomfort from drying

[ ] Limiting vital signs to respirations (breathing) and temperature

[ ] Stopping medications that are not essential to promoting comfort, including antibiotics

[ ] Stopping needle sticks and blood draws, including finger sticks for blood sugar

[ ] Removing nonessential equipment that may distract care providers and loved ones from focusing on the one who is dying

[ ] Other, specify:

1. Was the participant/ subject made DNR/ DNI during the hospitalization? [ ] Yes [ ] No (Stop)

(DNR = Do not resuscitate; DNI = Do not intubate)

IF YES, earliest documentation of DNR/ DNI:

[ ] Day 1 or 2

[ ] Day 3 or after

[ ] Timing unclear

[ ] ND/UTD

## General Instructions

This case report form (CRF) contains data elements related to whether the participant/ subject is provided with palliative care (a.k.a., comfort care) and whether the participant/ subject has DNR/ DNI orders during the acute hospital stay for the stroke event. Some of the elements were taken from the Get With The Guidelines® Stroke Patient Management Tool and/or the Paul Coverdell National Acute Stroke Registry.

Important note: None of the data elements included on this CRF is considered Core (i.e., strongly recommended for all stroke/subarachnoid hemorrhage (SAH) clinical studies to collect). Rather, all of the 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.

* Comfort Measures Only – indicates if there is any evidence that the participant's/ subject's care was restricted to "Comfort Measures Only". Commonly referred to as "palliative care" in the medical community and "comfort care" by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient's family.
* Earliest documentation of “Comfort Measures Only” – Select “Timing unclear” if there is physician/APN/PA documentation of comfort measures only during this hospital stay, but the earliest documentation of comfort measures only was on day 1 or 2 OR after day 2 is unclear. Select “Not Documented/ Unable to Determine (ND/UTD)” if there is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.