

- | | | | |
|-----|---|--------------------|-----------------------------|
| 9. | <i>TRANSCRANIAL DOPPLER (TCD)</i> | Yes | <input type="checkbox"/> 1 |
| | | No, (go to Q 10) | <input type="checkbox"/> 2 |
| | | Yes, but no report | <input type="checkbox"/> 3 |
| 10. | <i>MAGNETIC RESONANCE ANGIOGRAPHY (MRA)</i> | Yes | <input type="checkbox"/> 1 |
| | | No (go to Q 11) | <input type="checkbox"/> 2 |
| | | Yes, but no report | <input type="checkbox"/> 3 |
| 11. | <i>CT ANGIOGRAPHY</i> | Yes | <input type="checkbox"/> 1 |
| | | No (go to Q 12) | <input type="checkbox"/> 2 |
| | | Yes, but no report | <input type="checkbox"/> 3 |
| 12. | <i>ANGIOGRAPHY</i> | Yes | <input type="checkbox"/> 1 |
| | | No, (go to Q 13) | <input type="checkbox"/> 2 |
| | | Yes, but no report | <input type="checkbox"/> 3 |

D. STROKE DEFICIT

- | | | | |
|-----|--|-------|--------------------------|
| 13. | MODIFIED RANKIN SCALE
(Code Maximal Severity Within 7 Days of Stroke) | (0-6) | <input type="checkbox"/> |
|-----|--|-------|--------------------------|

- 0 = no symptoms at all
 1 = no significant disability despite symptoms: able to carry out all usual duties and activities
 2 = slight disability: unable to carry out all previous activities but able to look after own affairs without assistance
 3 = moderate disability: requiring some help, but able to walk without assistance
 4 = moderately severe disability: unable to walk without assistance, and unable to attend to own bodily needs without assistance
 5 = severe disability: bedridden, incontinent, and requiring constant nursing care and attention
 6 = death
 9 = information insufficient for coding
-
-
-

E. STROKE TREATMENT

- | | | | |
|-----|--|-----|-----------------------------|
| 14. | Intravenous thrombolysis | Yes | <input type="checkbox"/> 1 |
| | | No | <input type="checkbox"/> 2 |
| 15. | Presentation within 3 hours from symptom onset | Yes | <input type="checkbox"/> 1 |
| | | No | <input type="checkbox"/> 2 |

F. BRAIN EXAMINATION AT AUTOPSY

- | | |
|-----|-----------------------------|
| Yes | <input type="checkbox"/> 1 |
| No | <input type="checkbox"/> 2 |



Yes, but no report

|_|3

ADMINISTRATIVE INFORMATION:

Reviewer code:

|_|_|_|

Review date:

|_|_|/|_|_|/|_|_|_|_|
Month day year

If you have any comments on this case, please use the space below:

