



# TIA / STROKE SUMMARY FORM

A-177

NUMBER:             CONTACT YEAR:   FORM CODE:  T  S  R  VERSION: B 01

NAME:                 INITIALS:

Public reporting burden for this collection of information is estimated to average 2 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to Reports Clearance Officer, PHS, 721-H Hubert H. Humphrey Bldg., 200 Independence Ave. SW, Washington, D.C. 20201, Attn. PRA; and to the Office of Management and Budget, Paperwork Reduction Project (OMB 0925-0281), Washington, D.C. 20503.

**INSTRUCTIONS:** This form is completed during the Medical Data Review after all clinical exams are completed. For every positive symptom checked in column (a), check either Yes, No or Unsure in columns (b) and (c). In addition, indicate in column (b) and/or (c) your opinion whether the event(s) correspond to a TIA/Stroke. If one or more events were a TIA/STROKE, the medical data reviewer records the date of most recent event in item 7b.

TIA/STROKE SUMMARY FORM  
(a)

(b)

(c)

Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM {Check Yes or No}	MEDICAL DATA REVIEWER {Check Yes, No or Unsure}	ARIC PHYSICIAN {Check Yes, No or Unsure}
Questions from TIA/Stroke Form		IS THERE A NON-CVD CAUSE?	IS THERE A NON-CVD CAUSE?
	Yes      No	Yes      No      Unsure	Yes      No      Unsure
B. Sudden loss of speech. Question 3 is Yes.	<input type="checkbox"/> <input type="checkbox"/>	1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	9. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
C. Sudden loss of vision. Question 10 is Yes.	<input type="checkbox"/> <input type="checkbox"/>	2. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
D. Sudden double vision. Question 17a is Yes or Don't Know.	<input type="checkbox"/> <input type="checkbox"/>	3. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	11. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	<input type="checkbox"/> <input type="checkbox"/>	4. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
F. Sudden paralysis or weakness. Question 32 is Yes.	<input type="checkbox"/> <input type="checkbox"/>	5. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	13. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	<input type="checkbox"/> <input type="checkbox"/>	6. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	14. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
WAS THIS A TIA/STROKE?		7a. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
DATE OF MOST RECENT TIA/STROKE		7b. <input type="text"/> / <input type="text"/> / <input type="text"/> Month      Year	
H. CODE NUMBER	<input type="text"/> <input type="text"/> <input type="text"/>	8a. <input type="text"/> <input type="text"/> <input type="text"/> (Reviewer)	16. <input type="text"/> <input type="text"/> <input type="text"/> (Reviewer)
DATE OF MEDICAL DATA REVIEW WITH PARTICIPANT		8b. <input type="text"/> / <input type="text"/> / <input type="text"/> month      day      year	

IF ONE OR MORE POSITIVE SYMPTOMS, FILE ORIGINAL IN PARTICIPANT'S FOLDER.

ARIC ID LABEL: \_\_\_\_\_

\_\_\_\_\_

LAST NAME

**TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET:**

**SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)**

1. Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

**SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)**

1. Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

**SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)**

1. Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

(turn over)

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

Please describe this event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_  
\_\_\_\_\_

Date of data collection:     
month day year

Code of person completing this worksheet:

INSTRUCTIONS FOR TIA/STROKE SUMMARY FORM  
TSR, VERSION B, 01/22/90  
PREPARED 05/09/90

**INTRODUCTION**

The TIA/STROKE SUMMARY FORM is completed during the Medical Data Review for all participants. The form has two sections: the header and the review of symptoms. The header consists of the participant's ID number, contact year, name (last and initials) and the date of the TIA/Stroke interview.

The remainder of the form is divided into four columns. The first column lists the three elements which are recorded in columns (a), (b) and (c). These include (1) the symptoms from the TIA/STROKE questionnaire which could be attributable to a non-CVD cause, (2) the verification of a stroke/TIA and (3) the reviewer's administrative ID numbers.

The second column (a) is a check list to use as an aid in preparing the TIA/STROKE medical data review worksheet(s). The Yes/No responses correspond to the categories B-G in the first column. The three blank boxes corresponding to line H in the first column are to record the reviewer's ID number.

The third column (b) is completed by the individual conducting the Medical Data Review. Questions (1-6) document the Reviewer's clinical impression as to whether the positive symptom(s) checked in the second column (a) was attributable to a non-cerebrovascular (non-CVD) cause. Question (7a) records whether the reviewer felt the positive symptom(s) constituted a stroke/TIA. If Question 7a was answered Yes, the date of the most recent TIA/Stroke is recorded in Question 7b. If the participant is unable to give precise information, record approximate date. Question (8a) records the Medical Data Reviewer's ARIC identification code; (8b) documents the date of the interview.

The fourth column (c) is completed by the ARIC physician, if different from the person who performed the Medical Data Review and completed the third column. Questions (9-14) document the physician's clinical impression as to whether the positive symptom(s) checked in the second column (a) was attributable to a non-CVD cause. Question (15) records whether the physician thought the positive event(s) was a TIA/Stroke. Question 16 records the physician's ARIC ID.

POSITIVE SYMPTOM CHECKLIST

After the participant has completed the TIA/stroke interview and before beginning the medical data review, the header section of the TIA/STROKE SUMMARY FORM is completed. A patient ID label can be substituted for hand coded information. Information not printed on the label must be entered by hand.

EXAMPLE OF HEADER OF TIA/STROKE SUMMARY FORM

NUMBER: 

F	0	0	1	2	3	4
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 CONTACT YEAR: 

0	4
---	---

 FORM CODE: 

T	S	R
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 VERSION: B 01-23-90

NAME: 

S	M	I	T	H						
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 INITIALS: 

J	P
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INSTRUCTIONS: This form is completed during the Medical Data Review after all clinical exams are completed. For every positive symptom checked in column (a), check either Yes, No or Unsure in columns (b) and/or (c). In addition, indicate in column (b) and/or (c) your opinion whether the event(s) corresponds to a TIA/Stroke. If one or more events were a TIA/STROKE, the medical data reviewer records the date of most recent event in item 7b.

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The receptionist, interviewer, or designated staff completes the checklist in the second column (a). Symptom categories which are positive, (see the definitions for positive symptom categories) are recorded in the boxes under the YES column. Those which do not meet the definition are recorded in the boxes under the NO column.

EXAMPLE OF FIRST AND SECOND COLUMNS OF TIA/STROKE SUMMARY FORM

(a)

Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM {Check Yes or No}	
Questions from TIA/Stroke Form		
	Yes	No
B. Sudden loss of speech. Question 3 is Yes.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
C. Sudden loss of vision. Question 10 is Yes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Sudden double vision. Question 17a is Yes or Don't Know.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
F. Sudden paralysis or weakness. Question 32 is Yes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. WAS THIS A TIA/STROKE?		
I. DATE OF MOST RECENT TIA/STROKE		
H. CODE NUMBER	9 9 9	
DATE OF REVIEW	8b. <input type="text" value="02"/> <input type="text" value="01"/> <input type="text" value="90"/> month                  day                  year	

IF ONE OR MORE POSITIVE SYMPTOMS, FILE ORIGINAL IN PARTICIPANT'S FOLDER.

MEDICAL DATA REVIEW

The medical Data Reviewer reviews the positive symptom checklist on the TIA/STROKE SUMMARY FORM. If there are any positive symptoms, each positive symptom requires the completion of a positive symptom module on the TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET and the corresponding Yes/No/Unsure box in Column (b) of the SUMMARY FORM.

The TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET provides space to record the participant's impression as to why he/she reported a positive symptom. To complete the WORKSHEET, the Reviewer identifies the category which the participant reported as positive by circling the appropriate symptom at the top of the module. The written set of questions are read to the participant and the answers recorded. If the participant reported more than one positive symptom, a second, third, etc., module is completed.

EXAMPLE OF TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET

ARIC ID LABEL: F001234 SMITH LAST NAME

TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET:

SPEECH VISION DOUBLE VISION NUMBNESS WPAKNESS DIZZINESS (Circle one)

1. Please describe this event: [Handwritten description]

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? [Handwritten explanation]

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: [Handwritten description]

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? [Handwritten explanation]

SPEECH VISION DOUBLE VISION NUMBNESS WEAKNESS DIZZINESS (Circle one)

1. Please describe this event: \_\_\_\_\_

2. Did you see a physician for your problem?   If NO, skip to question 2b.  
Yes No

a. What was the diagnosis?      
TIA Stroke Unk Other: Specify \_\_\_\_\_

b. What is your explanation for this event? \_\_\_\_\_



After the WORKSHEET is completed, it is stapled to the TSR. Then the Reviewer proceeds to complete the third column (b) of the TIA/STROKE SUMMARY FORM. For each positive symptom category checked as positive in the second column, the Reviewer checks Yes/No/Unsure in column (b) to indicate whether, in his/her opinion, the symptom could be attributable to a non-CVD cause. The Reviewer must also check Yes/No/Unsure in Question 7a to document his/her clinical impression of the occurrence of a TIA/stroke. If the answer to 7a is YES, the date of the most recent TIA/STROKE is recorded in Question 7b. Item 7b is not keyed into the data entry system. The date of the most recent event is asked to provide additional information for the clinician to use in deciding whether the reported symptom(s) require(s) referral. The Reviewer completes the column by recording his/her ID code in Question 8a and the date of the interview in Question 8b.

EXAMPLE OF FIRST THREE COLUMNS OF TIA/STROKE SUMMARY FORM

Symptoms from TIA/Stroke Form	(a)		(b)		
	POSITIVE SYMPTOM {Check Yes or No}		MEDICAL DATA REVIEWER {Check Yes, No or Unsure}		
Questions from TIA/Stroke Form			IS THERE A NON-CVD CAUSE?		
	Yes	No	Yes	No	Unsure
B. Sudden loss of speech. Question 3 is Yes.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
C. Sudden loss of vision. Question 10 is Yes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Sudden double vision. Question 17a is Yes or Don't Know.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. <input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
F. Sudden paralysis or weakness. Question 32 is Yes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WAS THIS A TIA/STROKE?			7a. <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DATE OF MOST RECENT TIA/STROKE			7b. <input type="text" value="0"/>	<input type="text" value="7"/>	<input type="text" value="8"/> Year
H. CODE NUMBER	<input type="text" value="9"/> <input type="text" value="9"/> <input type="text" value="9"/>		8a. <input type="text" value="8"/> <input type="text" value="8"/> <input type="text" value="8"/>	(Reviewer)	
DATE OF REVIEW			8b. <input type="text" value="0"/>	<input type="text" value="2"/> <input type="text" value="0"/>	<input type="text" value="1"/> <input type="text" value="9"/> month day year

IF ONE OR MORE POSITIVE SYMPTOMS, FILE ORIGINAL IN PARTICIPANT'S FOLDER.

PHYSICIAN REVIEW

The ARIC physician completes the fourth column of the TIA/STROKE SUMMARY FORM as part of the medical review. If there are no positive symptoms checked in column (a), Questions 9-15 are left blank and the Physician records his/her ID code in Question 16.

If there are positive symptoms checked in the second column, the physician reviews the MEDREU printout and the TIA/STROKE SYMPTOMS MEDICAL DATA REVIEW WORKSHEET. The physician then completes the fourth column (c) of the TIA/STROKE SUMMARY FORM. For each positive symptom category checked as positive in the second column, the Reviewer checks Yes/No/Unsure for Questions 9-14 in column (c) to indicate whether, in his/her opinion, the symptom could be attributable to a non-CVD cause. The Physician also checks Yes/No/Unsure in Question 15 to document his/her clinical impression of the occurrence of a TIA/stroke. The physician completes column (c) by recording his/her ID code in Question 16. In cases where the Medical Data Review and the subsequent medical review are performed by the same ARIC physician, that physician must complete both column (b) and (c).

EXAMPLE OF FIRST FOUR COLUMNS OF TIA/STROKE SUMMARY FORM

	(a)	(b)	(c)
Symptoms from TIA/Stroke Form	POSITIVE SYMPTOM {Check Yes or No}	MEDICAL DATA REVIEWER {Check Yes, No or Unsure}	ARIC PHYSICIAN {Check Yes, No or Unsure}
Questions from TIA/Stroke Form		IS THERE A NON-CVD CAUSE?	IS THERE A NON-CVD CAUSE?
	Yes No	Yes No Unsure	Yes No Unsure
B. Sudden loss of speech. Question 3 is Yes.	<input checked="" type="checkbox"/> <input type="checkbox"/>	1. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	9. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
C. Sudden loss of vision. Question 10 is Yes.	<input type="checkbox"/> <input checked="" type="checkbox"/>	2. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
D. Sudden double vision. Question 17a is Yes or Don't Know.	<input type="checkbox"/> <input checked="" type="checkbox"/>	3. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	11. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
E. Sudden numbness, tingling or loss of feeling. Question 24 is No or Don't Know.	<input checked="" type="checkbox"/> <input type="checkbox"/>	4. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	12. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
F. Sudden paralysis or weakness. Question 32 is Yes.	<input type="checkbox"/> <input checked="" type="checkbox"/>	5. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	13. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G. Sudden dizziness, loss of balance or sensation of spinning. Question 41 is No or Don't Know.	<input type="checkbox"/> <input checked="" type="checkbox"/>	6. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	14. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
WAS THIS A TIA/STROKE?		7a. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
DATE OF MOST RECENT TIA/STROKE		7b. <input type="text" value="0"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/> Month Year	
H. CODE NUMBER	<input type="text" value="9"/> <input type="text" value="9"/> <input type="text" value="9"/>	8a. <input type="text" value="8"/> <input type="text" value="8"/> <input type="text" value="8"/> (Reviewer)	16. <input type="text" value="9"/> <input type="text" value="1"/> <input type="text" value="7"/> (Reviewer)
DATE OF REVIEW		8b. <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="0"/> month day year	

IF ONE OR MORE POSITIVE SYMPTOMS, FILE ORIGINAL IN PARTICIPANT'S FOLDER.