RIKSSTROKE
The Swedish Stroke Register

The Swedish Stroke Register - 3 months follow-up

Version 22.1 For registration of patients with onset of acute stroke on or after 01.01.2022

Following section to be completed by the Stroke Unit Nursing Staff

Personal ID. No. I__I___I___I___I___I___I - I___I___I___I___I

Name …….

Reporting hospital I_____I___I___I Department I___I___I___I

Planned follow-up of this questionnaire (year, month, day) I___I___I I___I___I I___I___I

Questionnaire to be completed 3 months after the onset of stroke

Instructions:

- **You can ask another person for help with completing this questionnaire.** If relevant, please indicate under Question 1 who is completing the form on your behalf.
- If you are completing this form on behalf of the person stated above and you do not know the answer to any of the questions without the option 'Don't know', please leave the question blank.
- If you have never been admitted to hospital, please leave all questions relating to hospitalisation blank.
- Select the answer that best applies to you. Only select one answer for each question unless otherwise stated.

Questionnaire completion date I___I___I I_____I_____I I_____I_____I

1. Who is completing this questionnaire?

☐ Myself, in writing

☐ Myself, with the help of a relative/immediate family or nursing staff

☐ Myself (patient), over the telephone

☐ Myself (patient), in connection with a return visit to the hospital/healthcare centre

☐ Only nursing staff

☐ Only immediate family

☐ Other

Living arrangements

2. Where are you currently living?

☐ Live at home without the assistance of home care services (NB! Home care services are not the same as home healthcare or advanced home healthcare)

☐ Live at home with the assistance of home care services (NB! Home care services are not the same as home healthcare or advanced home healthcare)

☐ Special housing (e.g. nursing home, assisted living, short-term housing, group home, intermittent care, respite care or equivalent)

☐ Emergency hospital (e.g. Medical, Neurological, Surgical)

☐ Other _____

☐ Geriatric/Rehab clinic

3. Do you live alone?

☐ Yes, I live alone

☐ No, I share household with my husband/wife/partner or other person(s) such as siblings, children, parents

Activities in your daily life

4. Are you fully recovered from your stroke?

☐ Yes

☐ No

☐ Don't know

5. Have you been able to return to the life and activities you had before the stroke?

☐ Yes completely

☐ Yes but not quite as before

☐ No

☐ Don't know

6. **How is your mobility now?**

   ☐ I am able to move around both indoors and outdoors without the help of another person

   ☐ I am able to move around indoors but need help to move around outdoors

   ☐ I need help to move around both indoors and outdoors

7. **Do you need help when using the toilet?**

   ☐ I can use the toilet without any help

   ☐ I need help when using the toilet

8. **Do you need help when dressing and undressing yourself?**

   ☐ I can dress and undress myself without any help

   ☐ I need help to dress and undress myself

9. **Are you currently dependent on support or help?**

   ☐ Yes completely

   ☐ Yes partly

   ☐ No

   ☐ Don’t know

10. **Can you manage local trips on your own (for example by car, bicycle, public transport or special transport services)?**

    ☐ Yes

    ☐ Yes but not to the same extent as before

    ☐ No

    ☐ Don’t know

Health effects and life after stroke

11. How would you rate your overall health?

- ☐ Very good
- ☐ Fairly good
- ☐ Fairly poor
- ☐ Very poor
- ☐ Don’t know

12. Since your stroke, do you feel more downhearted/depressed or anxious than before?

- ☐ Yes
- ☐ No
- ☐ Don’t know

13. Since your stroke, do you feel more tired than before and does this affect your ability to carry out everyday activities?

- ☐ Yes
- ☐ No
- ☐ Don’t know

14. Since your stroke, are you experiencing any new types of pain?

- ☐ Yes
- ☐ No
- ☐ Don’t know

15. **Since your stroke, have you found it more difficult to gather your thoughts, concentrate and remember things?**

☐ Yes

☐ No

☐ Don't know

If YES on Question 15 – does this affect your ability to carry out everyday activities?

☐ Yes

☐ No

☐ Don't know

Experiences and information from the healthcare services

16. **Have you received stroke prevention advice relating to health and lifestyle changes (for example, exercise, diet, sleep stress and giving up smoking)?**

☐ Yes

☐ No

☐ Don't know

17. **Do you smoke?**

☐ Yes, one or several cigarettes a day

☐ No

☐ Don't know

18. **Have you been offered help to stop smoking after your stroke?**

☐ Not relevant, did not smoke before onset of stroke

☐ Yes

☐ No

☐ Don't know

19. Do you feel that your need for support and help from the healthcare services and municipality has been met following your stroke?

☐ Did not need/want any support or help

☐ Yes completely

☐ Yes partly

☐ No, not at all

☐ Don't know

How satisfied or unsatisfied are you with the rehabilitation/training received whilst being admitted to hospital for stroke?

☐ Very satisfied

☐ Satisfied

☐ Unsatisfied

☐ Very unsatisfied

☐ I did not need rehabilitation or training during my hospital stay

☐ I needed but was not offered any rehabilitation or training during my hospital stay

☐ Don't know

20. How satisfied or dissatisfied are you with the rehabilitation or training received once discharged from hospital following your stroke?

☐ Very satisfied

☐ Satisfied

☐ Dissatisfied

☐ Very dissatisfied

☐ I did not need rehabilitation or training after my hospital stay

☐ I needed but was not offered rehabilitation or training after my hospital stay

☐ Don't know

Rehabilitation or training refers to certain exercises, the purpose of which is to improve or maintain your ability to cope with everyday life (such as your mobility, ability to dress and undress yourself, using the toilet, reading, speaking and counting as well as concentrating, cooking your own food, etc.).

Thank you so much for completing this questionnaire!

Please make sure you have answered all the questions!

Please send in your questionnaire using the enclosed stamped addressed envelope.