Patient ID ☐☐☐☐ Patient DoB ☐☐/☐☐/☐☐☐☐

FOCUS trial DISCHARGE FORM

Please use a black pen & PRINT IN CAPITALS
Please complete this discharge form as soon after hospital discharge or death as possible.
You MUST complete this form before logging on to the FOCUS website (www.focustrial.org.uk).
Please file this original in your site file.

Today's date (dd/mm/yyyy): ...../...../..... Collaborating Site: .....

Person completing discharge form: ..... Signature: .....

1. FINAL DIAGNOSIS

Was stroke the final diagnosis in this patient? Yes ☐ No ☐
(a normal brain scan is compatible with a diagnosis of ischaemic stroke)

If **NO**, please specify the final diagnosis: _____

2. COMPLIANCE WITH FOCUS MEDICATION (review medication chart)

a. Did the patient receive **ANY** trial medication? Yes ☐ No ☐

If **YES**, date first taken: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

If **NO**, why not: _____

b. Was the patient taking the trial medication at time of discharge or death? Yes ☐ No ☐

c. What date was the last dose given **IN HOSPITAL?** (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

d. Why was the trial medication stopped before discharge or death **(tick one box only)**?

Adverse reaction ☐ End of life care plan ☐
Administrative problem (e.g. accidentally missed off drug prescription chart) ☐
Patient/proxy wished to stop for another reason ☐ Other ☐
*Please give details of reason **in all cases**:* _____

e. How many doses were missed between prescription and discharge or earlier permanent stopping of trial medication (please review the medication chart)? ☐☐☐

Reason(s) for missed doses: _____

3. NON TRIAL MEDICATIONS (at discharge or death in hospital)

When you enter the data into the web form you will be presented with the list of drugs at randomisation and you will be asked to amend this list. Please indicate whether any drugs have been stopped or started since randomisation.

Please list any medications stopped since randomisation?

1.	3.	5.
2.	4.	6.

Please list any medications started since randomisation?

1.	3.	5.
2.	4.	6.

4. ADVERSE EVENTS IN HOSPITAL

Has the patient had any of the following **since** randomisation:

Further stroke (not counting stroke leading to enrolment)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Type of Further Stroke? Ischaemic ☐ Unknown ☐

Haemorrhagic ☐ Other ☐ *Please specify* _____

Acute coronary event (confirmed on ECG and/or Troponin)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Upper gastrointestinal bleed (requiring blood transfusion and/or endoscopy)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Fall with injury (requiring X rays or sutures or other treatment)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

New fracture (confirmed on X Ray)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Definite epileptic seizure (focal or generalised)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

An episode of symptomatic hypoglycaemia (blood sugar < 3mmol/l)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

An episode of hyperglycaemia (blood sugar >22mmol/l)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

New hyponatraemia (Na < 125mmol/l)? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Has the patient been diagnosed with NEW depression? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Has the patient been treated for NEW depression? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Has the patient been prescribed a NEW antidepressant drug? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

4. ADVERSE EVENTS IN HOSPITAL (continued overleaf)

Has the patient attempted suicide/self harm? Yes ☐ No ☐

Date of first (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Details _____

Has the patient had any other adverse events since randomisation which meet our criteria for reporting? **Yes** ☐ **No** ☐ **If YES, please fill out a FOCUS Trial SAE Report Form.**

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5. DETAILS OF DISCHARGE OR DEATH

Responsible Consultant at time of discharge/death:

Forename: _____ Surname: _____

Has the patient died since randomisation? Yes (complete Q6) ☐ No (complete Q7) ☐

6. DEATH DETAILS

Date of death (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

Most likely cause of death? _____

Was the cause of death confirmed on autopsy? Yes ☐ No ☐

7. DISCHARGE INFORMATION

Date of discharge (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

Discharged to **(tick one box only)**:

Own home ☐ Relative's/friend's home ☐

Care/nursing/residential home for long term placement ☐ Long term NHS care ☐

Intermediate care in community setting but not home ☐ Another hospital (for ongoing treatment/rehab) ☐

Other ☐ *please specify* _____

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8. CONTACT DETAILS OF PLACE TO WHICH PATIENT WAS DISCHARGED

Was this patient discharged to an address other than their home address at randomisation? Yes ☐ No ☐

House no/ hospital name: _____

Street name: _____

Town/City: _____ Postcode: _____

Tel No (home): _____ Tel No (work): _____ Tel No (mobile): _____

9. NEW CONTACTS (family or friends who may be contacted in addition to those given at randomisation)

	Name	Relationship to patient	Tel Number(s): (Home)	(Work)	(Mobile)
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

10. GENERAL PRACTITIONERS CONTACT DETAILS

Has this patient changed GP since the randomisation form was completed? Yes ☐ No ☐

GP name: _____ Practice name: _____

Street name: _____

Town/City: _____ Postcode: _____

Tel No: _____ Fax No (if available): _____