Stroke Care Team

A group of healthcare professionals who will work with you to treat the different aspects of stroke care.

The stroke care team will work with you and your family members while you are in the hospital and when you go home. It can be helpful to write the names and contact details of your stroke team members.

Stroke Care Team Memeber	Name of your healthcare professional and contact details
Hospital:	
Doctor:	
Polyclinic/ General practitioner clinic:	
Nurses:	
Occupational therapist:	
Physiotherapist:	
Speech therapist:	
Pharmacist	
Dietitian:	
Medical social worker:	
Neuropsychologist:	
Others:	

Appointment Tracker

Appointment	Date / Time	Doctor's Name	Location	Clinic Contact

DISCHARGE CHECKLIST

To help you with recovery after stroke, it is important to speak to your healthcare team and your caregiver about what you can expect. Use the checklist below to help you and make sure your questions are answered.

1 What is my diagnosis?

- ◯ Ischaemic Stroke
- ◯ Haemorrhagic Stroke

2 What are my risk factors for stroke?
(you may tick more than one box)

- ◯ Hypertension
- ◯ High Cholesterol
- ◯ Diabetes
- ◯ Smoking
- ◯ Excessive Alcohol
- ◯ Atrial Fibrillation / Other Heart condition
- ◯ Others: _____

3 What can I do to prevent another stroke?

_____

_____

_____

4 What medications do I need to take? What are they for and how often do I need to take them? Can you help me complete the medication list below?

Name of medicine	What is it for?	How often?	Instruction

5 What are the plans for my rehabilitation?

6 What physical, emotional, behavior and communication challenges should I expect? How do I work to overcome the challenges?

7 Should I contact a stroke or caregiver support group in the community?

8 When, where and what are my medical follow-up checks?

9 Who should I contact if I have any queries about my hospital admission?

Additional notes:

POST STROKE CHECKLIST

Not sure what to update your doctor during your medical follow up for stroke? Here is a checklist developed by the Global Stroke Community Advisory Panel [2012], endorsed by the World Stroke Organization, adapted by the Heart and Stroke Foundation Canadian Stroke Best Practice Recommendations development team [2014].

SINCE YOUR STROKE OR LAST ASSESSMENT

1 Secondary Prevention

Have you received medical advice on health-related lifestyle changes or medications to prevent another stroke?

NO ◯	Refer patient to primary care providers for risk factor assessment and treatment if appropriate, or secondary stroke prevention services.
YES ◯	Continue to monitor progress

2 Activities of Daily Living (ADL)

Are you finding it more difficult to take care of yourself?

NO ◯	Continue to monitor progress
YES ◯	Do you have difficulty: ◯ dressing, washing, or bathing? ◯ preparing hot drinks or meals? ◯ getting outside? If Yes to any, consider referral to home care services; appropriate therapist; secondary stroke prevention services.

3 Mobility

Are you finding it more difficult to walk or move safely (i.e., from bed to chair)?

NO ◯	Continue to monitor progress	
YES ◯	Are you continuing to receive rehabilitation therapy?	◯ **NO** Consider referral to home care services; appropriate therapist; secondary stroke prevention services.
		◯ **YES** Update patient record; review at next assessment.

4 Spasticity

Do you have increasing stiffness in your arms, hand, or legs?

NO ◯	Continue to monitor progress	
YES ◯	Is this interfering with activities of daily living?	◯ **NO** Update patient record; review at next assessment.
		◯ **YES** Consider referral to rehabilitation service; secondary stroke prevention services; physician with experience in post-stroke spasticity (e.g., physiatrist, neurologist).

5 Pain

Do you have any new pain?

NO ◯	Continue to monitor progress
YES ◯	Ensure there is adequate evaluation by a healthcare provider with expertise in pain management.

6 Incontinence

Are you having more problems controlling your bladder or bowels?

NO ◯	Continue to monitor progress
YES ◯	Consider referral to healthcare provider with experience in incontinence; secondary stroke prevention services.

7 Communication

Are you finding it more difficult to communicate?

NO ◯	Continue to monitor progress
YES ◯	Consider referral to speech language pathologist; rehabilitation service; secondary stroke prevention services.

8 Mood

Do you feel more anxious or depressed?

NO ◯	Continue to monitor progress
YES ◯	Consider referral to healthcare provider (e.g., psychologist, neuropsychologist, psychiatrist) with experience in post-stroke mood changes; secondary stroke prevention services.

9 Cognition

Are you finding it more difficult to think, concentrate, or remember things?

NO ◯	Continue to monitor progress	
YES ◯	Is this interfering with your ability to participate in activities?	◯ **NO** Update patient record; review at next assessment.
		◯ **YES** Consider referral to healthcare provider with experience in post- stroke cognition changes; secondary stroke prevention services; rehabilitation service; memory clinic

10 Life After Stroke

Are you finding it more difficult to carry out leisure activities, hobbies, work, or engage in sexual activity?

NO ◯	Continue to monitor progress
YES ◯	Consider referral to stroke support organization support group; leisure, vocational, or recreational therapist.

11 Personal Relationships

Have your personal relationships (with family, friends, or others) become more difficult or strained?

NO ◯	Continue to monitor progress
YES ◯	◯ Schedule next primary care visit with patient and family member(s) to discuss difficulties.
	◯ Consider referral to stroke support organization; healthcare provider (e.g., psychologist, counsellor, therapist) with experience in family relationships and stroke.

12 Fatigue

Are you experiencing fatigue that is interfering with your ability to do your exercises or other activities?

NO ◯	Continue to monitor progress
YES ◯	◯ Discuss fatigue with Primary Care provider.
	◯ Consider referral to home care services for education and counselling.

13 Other Challenges

Do you have other challenges or concerns related to your stroke that are interfering with your recovery or causing you distress?

NO ◯	Continue to monitor progress
YES ◯	◯ Schedule next primary care visit with patient and family member(s) to discuss challenges and concerns.
	◯ Consider referral to healthcare provider; stroke support organization.

MY BLOOD PRESSURE DIARY

This is a sample template for you to record your blood pressure (BP). Keeping records of your BP is useful for you and your doctor in managing your hypertension. Do check with your doctor on the frequency of monitoring.

MY TARGET BP

Depending on your condition, you may have a different blood pressure target. Consult your doctor for your targeted blood pressure range.

Date	Time (AM)	Blood Pressure	Pulse	Time (PM)	Blood Pressure	Pulse
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		/			/	
		/			/	
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MY BLOOD TEST DIARY

This is a sample template for you to keep track of your blood test record. Keeping records of your blood test is useful for you in managing your risk factor.

Depending on your condition, you may have a different target range. Consult your doctor for your targeted blood test range.

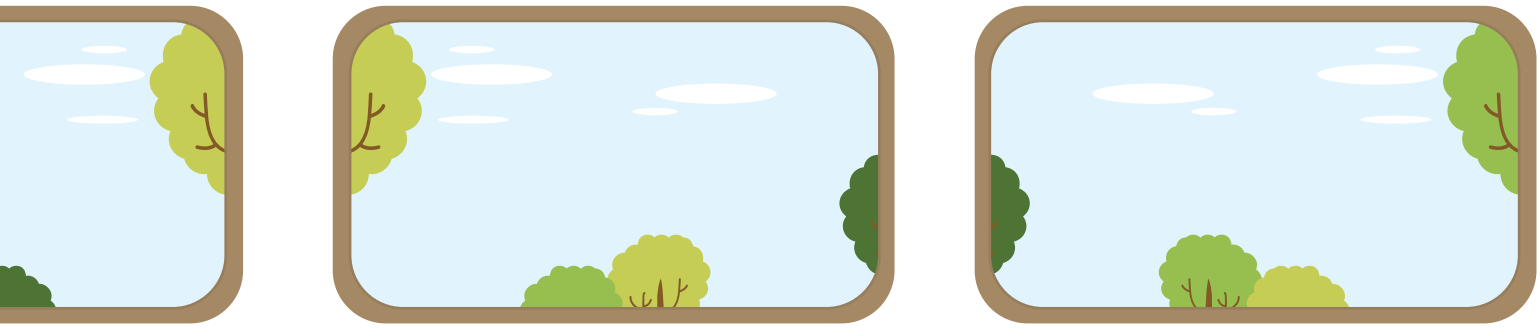
Test	Date _____	Date _____	Date _____	Date _____	Date _____
LDL MY TARGET					
Fasting Glucose MY TARGET					
HbA1c MY TARGET					
Comments					

MY BLOOD CLOTTING RATIO DIARY

This is a sample template for you to keep track of your INR results if you are on warfarin. Keeping records of your INR result is useful for your doctor and pharmacist in titrating the dosage of warfarin you should take.

MY TARGET	INR THERAPEUTIC TARGET
	2.0 - 3.0

Date	INR Value	Warfarin Dose (mg)	Comments



Stroke Services Improvement

www.healthhub.sg/strokehub

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