

Investigator Name:	Hospital:
Address:	
Phone No:	Fax No:
Email Address:	

1. General		
1.01	<input type="checkbox"/> Y <input type="checkbox"/> N	Are your staff familiar with the National Institutes of Health Stroke Scale (NIHSS)?
1.02	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you participating in an acute stroke trial at present?
1.03		If yes please specify:
1.04	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there a trial that is ongoing or planned at your hospital that would interfere with a trial of thrombolysis treatment for ischaemic stroke <4.5 hours of onset?
2. Management of patients with Ischaemic stroke		
2.01	_ _ _	Number of patients with acute stroke admitted to your hospital last year?
2.02	_ _ _	Number of patients with ischaemic stroke admitted to your hospital last month?
2.03	_ _ _   _ _ _   _ _ _	What proportion of patients arrive at your hospital according to the time from the onset of symptoms? % 0 – 3 hours % 3 – 4 hours % more than 4 hours
2.04	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you use rtPA for treatment of acute ischaemic stroke?
	_ _ _	If YES, please specify the number of patients treated in last year
2.05		How are patients with stroke-like symptoms assessed at your hospital?
	<input type="checkbox"/> Y <input type="checkbox"/> N	First assessed by an emergency department physician
	<input type="checkbox"/> Y <input type="checkbox"/> N	Admitted directly to a stroke unit
3. Blood Pressure management in ischaemic stroke patients		
3.01	_ _  %	Approximately, what proportion of your ischaemic stroke patients are hypertensive at presentation?
3.02	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have guidelines for the management of blood pressure in acute stroke?
3.03	_____mmHg	At what systolic blood pressure level would you commence blood pressure lowering therapy in a patient with ischaemic stroke?

3.04	_____ mmHg	What level of systolic blood pressure would you aim for in a hypertensive patient with ischaemic stroke?
3.05	_____ mmHg	What level of systolic blood pressure would you aim for <i>specifically</i> in a patient with ischaemic stroke who is to receive tPA?
3.06	_____ mmHg	What level of systolic blood pressure over the next 24 hours would you aim for in a patient with ischaemic stroke who has been given tPA?
3.07	<input type="checkbox"/> <input type="checkbox"/>	Would you be happy to randomise a patient to blood pressure lowering to a 150 mmHg systolic blood pressure target?
3.08	<input type="checkbox"/> <input type="checkbox"/>	Would you be happy to randomise a patient to blood pressure lowering to a 140 mmHg systolic blood pressure target?
3.09	<input type="checkbox"/> <input type="checkbox"/>	Do you use electronic devices to monitor blood pressure
3.10		If yes, please specify type is used (eg Omron): _____
<b>4. tPA dose in acute ischaemic stroke</b>		
4.01	<input type="checkbox"/> <input type="checkbox"/>	Do you ever offer low dose (0.6 mg/kg) tPA to patients?
4.02	<input type="checkbox"/> <input type="checkbox"/>	Would you be happy to randomise ischaemic stroke patients to 0.6 mg/kg dose tPA?
<b>5. Equipment - CT</b>		
5.01	_ _	On average, how long does it take from the time a stroke patient arrives at hospital to get a CT scan (minutes)?
5.02		Type of CT available: _____
5.03	<input type="checkbox"/> <input type="checkbox"/>	Is the CT equipment located in your own hospital?
		If No, specify location _____
5.04	<input type="checkbox"/> <input type="checkbox"/>	Is the CT equipment available 24 hours a day?
	_ _	If no, number of hours available
	<input type="checkbox"/> <input type="checkbox"/>	Are staff available to perform a CT 24 hours a day?
	_____	If Yes, what is the additional cost (US\$) of this scan?
5.05	<input type="checkbox"/> <input type="checkbox"/>	Are you able to undertake CT perfusion/diffusion?
	_____	If Yes, what is the additional cost (US\$) of this scan?
5.06	<input type="checkbox"/> <input type="checkbox"/>	Are you able to undertake rapid transcranial doppler (TCD) in acute ischaemic stroke patients who undergo thrombolysis?
	_____	If Yes, what is the additional cost (US\$) of this scan?

6. Ethics		
6.01	<input type="checkbox"/> <input type="checkbox"/>	Do you think that your Ethics Committee may have concerns about the conduct of this trial? Please specify why:
6.02	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	How long does it take you (from your experience) to get the necessary Ethic's Committee's approval? 1-2 months 3 months >3 months.
6.03	_ _	If greater than 3 months please specify
6.04	_ _	weeks How far in advance of the Ethics Committee meeting must the application be submitted
6.05		Please list the next 3 meeting dates for your Ethics Committee and the deadlines for submission:  Submission Date Meeting Date  1. 2. 3.
7. Staff		
7.01	<input type="checkbox"/> <input type="checkbox"/>	Please identify the other individuals who will assist you in the trial at your hospital?  Nurse/Study Coordinator: _____ Email Address: _____  Nurse/Study Coordinator: _____ Email Address: _____  Sub-Investigator: _____ Email Address: _____  Sub-Investigator: _____ Email Address: _____
8. Case Report Form		
8.01	<input type="checkbox"/> <input type="checkbox"/>	Have you worked on a study with electronic Case Report Forms before?
8.02	<input type="checkbox"/> <input type="checkbox"/>	Do you have direct access to the Internet in Emergency Department?
8.03	<input type="checkbox"/> <input type="checkbox"/>	Do you have direct access to the Internet on the stroke/neurology ward?

