**Suspected stroke following administration of COVID-19 vaccine\***

Local Identification Number: Adverse Event Reference Number:

Patient Initials: Patient Age: Patient Sex:

Ethnicity:

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| **Source of information** | | | |
| Name of the person reporting |  | Position (e.g. specialty and grade) |  |
| Hospital / Practice |  | Email address |  |

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| **Patient Background** | |
| Past Medical History: | |
| Regular and recent medications: | |
| Infectious illness in the last six weeks: | Yes/ No/ Unsure |
| Other vaccination received in the last six weeks: | Yes/ No/ Unsure |
| Previous adverse neurological reaction to a vaccine: | Yes/ No/ Unsure |
| History of neurological disease (previous or current): | Yes/ No/ Unsure |
| Immunosupression at the time of vaccination: | Yes/ No/ Unsure |
| If Yes to any above, please provide details: | |

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| **Patient’s Covid-19 Status** | |
| Previous diagnosis of Covid-19: | Yes, once/  Yes, more than once/ No/ Unsure |
| If Yes, date of onset: | Date: |
| If Yes, means of diagnosis: | PCR/ Antibody / Antigen/ Clinical |

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| **Vaccination Details** | |
| 1st vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| 2nd vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| Date of neurological symptoms onset | Date: |

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| **Case Definition** | |
| Rapidly developing disturbance of cerebral function | Yes/No/Unsure |
| PLUS Vascular origin | Yes/No/Unsure |
| PLUS Unknown Aetiology | Yes/No/Unsure |

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| **Clinical Features** | |
| Time from onset to peak symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Ischaemic/ Intracerebral haemorrhage/ Other- specify: | |
| For Ischaemic stroke, select:  Type: TACS/ PACS/POCS/ Lacunar/ Spinal  Suspected Aetiology: Large artery thrombosis/ Small penetrating artery thrombosis/ Cardiogenic & embolic/ Crytptogenic/ Other- specify: | |
| CNS location: Unifocal/ Multifocal | Right-sided/ Left-sided/ Bilateral |
| CNS location (select all that apply): frontal lobe/ temporal lobe/ parietal lobe/ occipital lobe/ basal ganglia/ thalamus/ cerebellum/ brainstem/spinal cord/ other- specify: | |
| Limb weakness with upper motor neuron signs: Yes/ No/ Unsure  Affected limbs (select): RUL/ LUL/ RLL/ LLL | |
| Abnormal tendon reflexes: Yes/No/Unsure  Affected reflexes (indicate R/L): | |
| Sensory disturbance: Paraesthesia/Hypoesthesia/ No/ Unsure  Modality affected: Light touch/ vibration/ proprioception/ pinprick/ temperature  Please describe distribution: | |
| Visual disturbance: Yes (select below)/ No/ Unsure  Reduced visual acuity/ RAPD/ Visual field defect- specify: \_\_\_\_\_/ Diplopia | |
| Unilateral facial weakness: Yes/No/Unsure  Dysphagia: Yes/ No/ Unsure  Dysphasia: Expressive/ Receptive/ Both/ No/ Unsure  Dysarthria: Yes/ No/ Unsure | |
| Cerebellar signs: Yes/ No/ Unsure  Nystagmus/ Ataxia/ Intention tremor/ / Other- specify: | |
| Other relevant symptoms and signs, including systemic features: | |
| Has the patient experienced a similar neurological event before? Yes/No/Unsure  If Yes, please provide details, including the date and suspected aetiology: | |

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| **Assessment and investigations to exclude other causes** (please indicate which of the following have been considered, and give details at the bottom) | |
| **Clinical assessment** | |
| History of cerebrovascular or small vessel disease  History of atherosclerotic disease elsewhere  Atrial fibrillation  Clinical suspicion of a cardio-embolic source  Hypercoaguable state (e.g. sickle cell diseae, pregnancy, coagulopathy) | Yes/ No/ Unsure  Yes/ No/ Unsure  Yes/ No/ Unsure  Yes/ No/ Unsure  Yes/ No/ Unsure |
| **Laboratory studies** | |
| HbA1c  Lipid profile  Urea and Electrolytes  Thrombophilia screen\*  ESR  Vasculitis screen\*  Homocysteine  HIV serology  Quantiferon-TB or alternative  Syphilis serology  COVID-19 serology or PCR | Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal |
| \*Please list tests comprising vasculitis and thrombophilia screen: | |
| CSF Biochemistry**:** CSF Protein: \_\_\_\_\_\_\_ Serum:CSF Glucose Ratio: \_\_\_\_\_\_\_\_\_  CSF RCC: \_\_\_\_\_\_\_\_\_ CSF WCC: \_\_\_\_\_\_\_\_ CSF differential: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ | |
| CSF Microscopy & culture  CSF Virolology\*\* | Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal |
| \*\*Please list the pathogens tested with the CSF panels: | |
| Any other relevant laboratory results: | |
| **Radiological studies** | |
| CT Brain  MRI Brain  CT-Angiogram/ MR-Angiogram  MRI Spine  Echocardiogram  Bubble Echocardiogram  US Doppler of the carotid arteries | Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal |
| **Extended cardiac rhythm recording** (min. 24h) | Normal/ Unknown/ Not Done/ Abnormal |
| **Genetic testing** | Normal/ Unknown/ Not Done/ Abnormal |
| **Details of any abnormal findings:** | |
| **Please describe if any of the findings could explain the aetiology of the event:** | |

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| **Treatment** (including dose and duration) |
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| **Patient outcome** |
| Date of last follow-up (if none, write none): |
| Maximum level of care required:  Outpatient/ Medical Inpatient/ High Dependency Unit/ Intensive Care Unit |
| Patient alive at last follow-up: Yes/ No  If No, was the stroke included on the death certificate: Yes/ No/ Unknown  If relevant, date of death: |
| Outcome at least follow up (circle): Complete resolution / Incomplete resolution / No improvement / Re-occurrence / Other sequalae  If relevant, time to complete resolution:\_\_\_\_\_\_\_\_\_\_ |
| Modified Ranking Scale: Before adverse event:\_\_\_\_\_\_\_ At the last follow-up: \_\_\_\_\_\_ |
| Details: |

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| **Subsequent COVID-19 Vaccinations** | |
| Has this patient received any further COVID-19 vaccines after the development of the neurological adverse event? | Yes/ No/ Unsure |
| If Yes: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| If Yes, Outcome: No adverse event/ Re-occurrence of the same adverse event/ Development of another neurological adverse event/ Worsening of previously unresolved neurological adverse event/ Other sequelae  Date the outcome was last known: | |
| Other details: | |