POST-STROKE CHECKLIST (PSC):
IMPROVING LIFE AFTER STROKE

This Post-Stroke Checklist (PSC) has been developed to help healthcare professionals identify post-stroke problems amenable to treatment and/or referral. The PSC is a brief and easy-to-use tool, intended for completion with the patient and the help of a caregiver, if necessary. PSC administration provides a standardized approach for the identification of long-term problems in stroke survivors and facilitates appropriate referral for treatment.

INSTRUCTIONS FOR USE:

Please ask the patient each numbered question and indicate the answer in the "response" section. In general, if the response is NO, update the patient record and review at next assessment. If the response is YES, follow-up with the appropriate action. Please note that the actions described in this version are for guidance and the 'If Yes' and 'If No' text boxes (highlighted in yellow) can and should be edited for local implementation.

1. SECONDARY PREVENTION

Since your stroke or last assessment, have you received any advice on health related life style changes or medications for preventing another stroke?	☐ NO	If **NO**, refer to a Primary Care Physician or Stroke Neurologist for risk factor assessment and treatment if appropriate	
	☐ YES	Observe Progress	

2. ACTIVITIES OF DAILY LIVING (ADL)

Since your stroke or last assessment, are you finding it <u>more</u> difficult to take care of yourself?	☐ NO	Observe Progress	
	☐ YES	Do you have difficulty dressing, washing and/or bathing? Do you have difficulty preparing hot drinks and/or meals? Do you have difficulty getting outside?	If **YES** to any, refer to Primary Care Physician, Rehabilitation Physician or an appropriate therapist (i.e. OT or PT) for further assessment

3. MOBILITY

Since your stroke or last assessment, are you finding it <u>more</u> difficult to walk or move safely from bed to chair?	☐ NO	Observe Progress	
	☐ YES	Are you continuing to receive rehabilitation therapy?	If **YES**, update patient record and review at next assessment
			If **NO**, refer to Primary Care Physician, Rehabilitation Physician or an appropriate therapist (i.e. OT or PT) for further assessment

4. SPASTICITY

Since your stroke or last assessment, do you have <u>increasing</u> stiffness in your arms, hands, and/or legs?	☐ NO	Observe Progress	
	☐ YES	Is this interfering with activities of daily living, sleep or causing pain?	If **YES**, refer to a physician with an interest in post-stroke spasticity (i.e. Rehabilitation Physician or Stroke Neurologist) for further assessment
			If **NO**, update patient record and review at next assessment

5. PAIN

Since your stroke or last assessment, do you have any new pain?	☐ NO	Observe Progress
	☐ YES	If **YES**, refer to a physician with an interest in post-stroke pain for further assessment and diagnosis

6. INCONTINENCE

Since your stroke or last assessment, are you having more of a problem controlling your bladder or bowels?	☐ NO	Observe Progress
	☐ YES	If **YES**, refer to Healthcare Provider with an interest in incontinence

7. COMMUNICATION

Since your stroke or last assessment, are you finding it more difficult to communicate with others?	☐ NO	Observe Progress
	☐ YES	If **YES**, refer to specialist Speech and Language Pathologist for further assessment

8. MOOD

Since your stroke or last assessment, do you feel more anxious or depressed?	☐ NO	Observe Progress
	☐ YES	If **YES**, refer to a Physician or Psychologist with an interest in post-stroke mood changes for further assessment

9. COGNITION

Since your stroke or last assessment, are you finding it more difficult to think, concentrate, or remember things?	☐ NO	Observe Progress	
	☐ YES	Does this interfere with activity or participation?	If **YES**, refer to a Physician or Psychologist with an interest in post-stroke cognition for further assessment
			If **NO**, update patient record and review at next assessment

10. LIFE AFTER STROKE

Since your stroke or last assessment, are you finding things important to you more difficult to carry out (e.g. leisure activities, hobbies, work)	☐ NO	Observe Progress
	☐ YES	If **YES**, refer to a local stroke support group or a stroke association (i.e. The American Stroke Association or National Stroke Association)

11. RELATIONSHIP WITH FAMILY

Since your stroke or last assessment, has your relationship with your family become more difficult or stressed?	☐ NO	Observe Progress
	☐ YES	If **YES**, schedule next Primary Care visit with patient and family member. If family member is present refer to a local stroke support group

Adapted from: Philp I, et al. Development of a Poststroke Checklist to Standardize Follow-up Care for Stroke Survivors. *Journal of Stroke and Cerebrovascular Diseases.* December 2012.
Endorsed by the World Stroke Organization to support improved stroke survivor follow-up and care