ARGATROBAN TIMELINE

*PLEASE REMEMBER TO USE STUDY SOURCE DOCUMENTS FOR BASELINE ASSESSMENTS

Updated 04/17/2013

BASELINE/Day 0:	**Initial**
Screening Inclusion/Exclusion Criteria - **Don't forget to make sure PTT is sent and processing in the lab.**	
TIME OUT W/ TEAM: ****Verify patient weight is correct** **	
Notify pharmacy for potential Argatroban pt and pt's weight in kg _____ **IDS Telephone #: 4-1557**	
History & Physical Exam	
ER Arrival time: Date:_____ Time:_____	
Stroke onset: Date:_____ Time: _____	
NIHSS pre-tPA bolus Time: _____, Score: _____ **Pre-mRS:**_____	
Baseline Tests: □ ECG □ CXR □ CT brain w/o contrast	
Baseline Labs: □Chemistry **(don't forget about bilirubin direct/indirect, AST/ALT)** □Hematology □ Serum HCG: if child-bearing age female **Baseline PTT** _____, **INR** _____	
CTA: TIMI Score:_____ **OR** **TCD**: TIBI Score: _____	
Informed Consent signed	
HAT score:_____ History of Diabetes mellitus or baseline blood glucose >200: No ☐ 0 points Yes ☐ 1 point NIHSS score: ≤14 ☐ 0 points 15-20 ☐ 1 point ≥21 ☐ 2 points Hypodensity on CT scan: No ☐ 0 points <1/3 of MCA territory ☐ 1 point ≥1/3 of MCA territory ☐ 2 point	
Randomization Website: https://cru.ccts.uth.tmc.edu/Stroke *****PRINT RANDOMIZATION PAGE***** • **Print a dose calculation form, if applicable** **KEEP 2HR NIHSS ASSESSOR BLINDED TO TREATMENT ARM**	
Vital signs ***Pre-tPA bolus***: Time:_____ BP:_____ HR:_____ Continue every 15 min. for 2 hrs; then every 30 min for 6 hrs; then every 1hr until 24hrs from tPA bolus.	
tPA bolus dose: _____ Time given: _____ (TIME ZERO) **Infusion dose: _____ Time given _____ Time completed _____**	
Call Rigo Delgado (For sub-study analysis) about study patient: 713-899-3206	
Administer Argatroban (*** **Must administered ASAP within 60 min from tPA bolus/before tPA complete**). **Bolus dose: _____ Time given: _____** **Infusion dose: _____ Time given: _____ Initial Rate**: _____ NA if tPA Alone Arm	
NIHSS: 2h post-tPA bolus (+ 30 min). (ALL STUDY ARMS) **COVER IV BAG/PUMP, AS ASSESSOR MUST BE BLINDED.**	

Signature_____Print Name _____ Date_____Time_____

Time _____, Score _____	
TCD/CTA: 2-3 hr post-tPA (ALL STUDY ARMS-if enrolled with TCD/CTA) **CTA:** TIMI Score**:**_____ **OR** **TCD**: TIBI Score: _____	
PTT for Argatroban Arms: Scheduled: pre-tPA, 2, 6,12, 24hrs, 48 hr (+ 30 min.) Unscheduled: 2-4 hr post dose change. (+ 30 min.) ***PTTs LINKED TO ARGATROBAN BOLUS TIME***	

Day 1 **Initial**

NIHSS: 24h (+ 4h) (ALL STUDY ARMS) **Time:_____ Score:_____**	
Labs: (ARGATROBAN ARMS ONLY) Scheduled: 2, 6, 12, 24hrs, (+ 30 min.) Unscheduled: 2-4 hr post dose change. (+ 30 min.)	

Signature_____Print Name _____ Date_____Time_____

Day 2 (48h post-tPA/end Argatroban) (+ 4h)) (ALL STUDY ARMS)
Scheduled Date: _____ Time: _____ **Initial**

Vital Signs (24-48 hrs): **Every 4 + 1 hr**	
Physical Exam	
Labs: □Chemistry □Hematology **Tests:** □ CT brain w/o contrast	
NIHSS: Time _____, Score _____	
Adverse event and concomitant medication assessments (within 24 h after the completion of the infusion or prior to hospital discharge).	
Discontinue Argatroban **D/C Time: _____**	

Signature_____Print Name _____ Date_____Time_____

Day 7 or Discharge (whichever comes first) (ALL STUDY ARMS) **Initial**

Physical Exam	
NIHSS : Time_____, Score _____	
mRS: Score _____	
Health Utilities Forms (standard gamble, VAS, EQ-5D)	
ACE, MoCA	

Day 90 (+ 10 days) (ALL STUDY ARMS) **Initial**

NIHSS : Time_____, Score _____	
mRS: Score _____	
ACE, MoCA	
Concomitant medications	
AE reporting	
Health Utilities Forms (standard gamble, VAS, EQ-5D)	

Scheduled PTT Lab draws (± 30 min):
With exception of baseline, please make sure to order <u>PTT ONLY</u> for the rest of the blood draws. NO PT & INR

	Initial
Baseline pre-tPA bolus	
2 Hours post-Argatroban bolus	
6 Hours	
12 Hours	
24 Hours	
48 Hours: End of Argatroban infusion/48 hrs Post tPA bolus	

*****Please repeat PTT 2-4 hours after any dosage changes *****
The unscheduled draw may be used as the scheduled draw if draw time is within 30 minutes of scheduled draw time

Please notify the ARTSS-2 TEAM of any adverse events or serious adverse events in this study.

<u>ARTSS-2 Coordinating Center Contact Information:</u>

PI: Andrew Barreto, MD	**(O) 713-500-7002**	**(C) 713-702-6721**
Project Manager: Loren Shen RN	**(O) 713-500-7084**	**(C) 832-515-7582**
Study Coordinator: Amber Jacobs	**(O) 713-500-7194**	**(C) 281-851-3717**
Study Coordinator: Hari Indupuru	**(O) 713-500-7537**	**(C) 617-417-5140**
Fax: 713-500-0628		

<u>Data Coordinating Center Contact Information</u> <u>(for randomization or website questions)</u>**<u>:</u>**

Li Xiaobao (Bob):	**(O) 713-500-7961**	**(C) 713-371-8093**
Rick Sline:	**(O) 713-500-7067**	**(C) 832-969-1248**

Patient # ☐☐☐-☐☐☐ **Initials** ☐☐☐

Vital Signs

From ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y) **To** ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

Record Vital Signs at: Pre-tPA Bolus, Q 15 min x 2 hours, Q 30 min x 6 hours, Q 1 hour x 16 hours. Then Q4 hours +/-1 hour from 24-48hr.

	TIME	HR	BP	Not done
Pre-bolus			/	☐
Q15min			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
Q30min			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐

	TIME	HR	BP	Not done
Q1hr			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
Q4hr			/	☐
			/	☐
			/	☐
			/	☐
			/	☐
			/	☐

Comment:

_____

_____

_____

Please add on the following laboratory tests for _____ (MRN: _____)

Direct bilirubin

Indirect bilirubin

(Investigators, please retain a copy of this sheet for the patient's research chart)

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

Baseline Physical Exam

Visit Type:	
Date : _____	**Time: _____**

	Normal	Abnormal	Not Done	Comments
General Appearance				
Head/Ears/Eyes/ Nose/Mouth/Throat				
Neck/Thyroid				
Respiratory				
Cardiovascular				
Gastrointestinal				
Musculoskeletal				
Genito-Urinary				
Skin				
Lymph Nodes				
Neurological* (Should NOT include current findings related to stroke deficit)				
Other, specify:				

_____

Name of person performing physical exam

_____

Signature of person performing physical exam

_____

Date

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

NIHSS

Assessment :	
☒ Baseline	□ 48 hours ± 4 hr post-TPA bolus
□ 2 ± 30 min post-TPA bolus	□ Day 7/Discharge
□ 24 hours ± 4 hr post-TPA bolus	□ Day 90

NIHSS

Date: _____

Time: _____

Status: _____

Total: _____

1a-LOC
0-alert 1-drowsy 2-stupor 3-comotose

1b-LOC questions
0-both 1-one 2-neither

1c-LOC commands
0-both 1-one 2-neither

2-Best Gaze
0-nl 1-partial 2-forced gaze

3-Visual Fields
0-nl 1-partial 2-complete 3-bilateral

4- Facial Paresis
0-nl 1-minor 2-partial 3-complete

5-8 MOTOR
____5-Left Arm
____6-Right Arm
____7-Left Leg
____8-Right Leg

0 = no drift
1 = drift
2 = some effort vs gravity
3 = no effort vs gravity
4 = no movement
x = untestable

9-Limb Ataxia
0-abs 1-1 limb 2-2 + limbs x-untestable

10-Sensory
0-nl 1-partial loss 2-denseloss

11-Best Language/Aphasia
0-nl 1-mild/mod 2-severe 3-mute

12-Dysarthia
0-nl 1-mild/mod 2-severe x-untestable

13-Neglect/Inattention
0-non 1-partial 2-complete

mRS: ☐ Pre-Morbid
☐ Day_____
☐ DC

_____

NAME: _____

SIGNATURE:_____

2 ± 30 min post-TPA bolus & Day 90 ONLY

Was the rater blinded to treatment arm? □ Yes □ No □ N/A

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

Modified Rankin Scale

Date : _____	**Time: _____**
☒ Baseline □ Day 7/Discharge □ Day 90	

Score	**Description**
0	No symptoms at all
1	No significant disability despite symptoms;
2	Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3	Moderate disability; requiring some help, but able to walk without assistanceable to carry out all usual duties and activities
4	Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5	Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6	Dead

_____

Name of rater

_____

Signature of rater

_____

Date

Patient Name: _____

MRN: _____ Patient ID: _ _ _ - _ _ _

ARTSS-2 Study Source Document

Medical History

History of Prior Stroke □ Yes □ No □ Unknown

Date of most recent prior stroke:_____

Number of prior strokes:_____

History of TIA □ Yes □ No □ Unknown

Date of most recent prior TIA: _____

Number of prior TIAs: _____

Current Stroke Symptoms:

Weakness	□ Yes	□ No	Sensory Chan	□ Yes	□ No	
Dysarthria	□ Yes	□ No	Visual Change	□ Yes	□ No	
Aphasia	□ Yes	□ No	Dizziness/Ver	□ Yes	□ No	□ Unknown

Please indicate if patient had any medical problems involving the following systems:

Cardiac

Myocardial Infarction	□ Yes	□ No	□ Unknown	Gastrointestinal	□ Yes	□ No	□ Unknown
CHF	□ Yes	□ No	□ Unknown	Genitourinary	□ Yes	□ No	□ Unknown
Atrial Fibrillation	□ Yes	□ No	□ Unknown	Pulmonary	□ Yes	□ No	□ Unknown
Hypertension	□ Yes	□ No	□ Unknown	Endocrine	□ Yes	□ No	□ Unknown
Previous CABG	□ Yes	□ No	□ Unknown	Cancer	□ Yes	□ No	□ Unknown
Hypercholesterolemia	□ Yes	□ No	□ Unknown	Diabetes	□ Yes	□ No	□ Unknown

Other , specify _____

Has patient ever had:			**If Yes, check on**	**Right**	**Left**	**Both**
Carotid Endarterectomy	□ Yes	□ No		□	□	□
Fem./ Pop. Bypass	□ Yes	□ No		□	□	□
Cigarette Smoking	□ Never	□ Former	□ Current	□ Unknown		
Alcohol Consumption	□ Never	□ Former	□ Current	□ Unknown		

Ethnicity:	□ Hispanic or Latino	□ Not Hispanic or Latino	□ Unknown	□ Not reported			
Race:	□American Indian or Alaskian	□ Black	□ White	□ Asian	□ Native Hawaiian or Pacific	□ Unknown	□ Other
Handedness	□ Right	□ Left	□ Both				

_____

Name of person completing form

_____ _____

Signature of person completing form **Date**

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

Baseline CT

Date : _____	**Time: _____**

Was an intracranial hemorrhage (ICH) Noted? □ Yes □ No

Is there acute hypoattenuation present or any other lesion that would preclude treatment? □ Yes □ No

If Yes to either, describe below:

_____
_____
_____

ASPECTS Score : 10 Points - _____ = _____ points

*Please check the box for each area with a hypodensity

Subcortical:

□Caudate head □ Lentiform nucleus
□ Internal Capsule

MCA Cortex:

□ Insular cortex □ M1 (low frontal)
□M2 (temporal) □ M3 (low parietal)
□ M4 (high frontal) □ M5 (lateral MCA territory)
□ M6 (high posterior parietal)

Comments: _____
_____
_____

_____
Name of person completing form

_____ _____
Signature of person completing form **Date**

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

CT-Angiogram

Date : _____	**Time: _____**
□ Baseline	□ 2-3 hours post TPA bolus

Vessel Occlusion Location (SELECT <u>ONLY ONE</u> SYMPTOMATIC VESSEL)

MCA

☐ M1 ☐ M2 (proximal)

☐ ICA (terminal)

PCA

☐ P1 ☐ P2 (proximal)

☐ Vertebro-basilar

☐ other: _____

TIMI Score

☐ 0—Abrupt cut-off of vessel, complete occlusion

☐ 1—Artery penetrated by contract, but no distal branch filling

☐ 2- Perfusion and incomplet or slow distal branch filling

☐ 3- Full perfusion with filling of all distal branches

_____

Name of person completing form

_____

Signature of person completing form

_____

Date

SUNY Downstate Medical Center
University Hospital of Brooklyn

Patient Name: _____
MRN:_____ Location: _____

Investigational Drug Study: ARTSS-2
Argatroban Intravenous Administration Orders

Checklist

☐ **Was Home Med List faxed to Pharmacy (Must be faxed to Pharmacy prior to dispensing of Study Drug)**

☐ Admit to: ☐ Stroke Unit/Neuro Step-down Unit ☐ MICU **Attending:**_____ **Diagnosis:** _____
Secondary diagnoses: _____ **Allergies:** _____ **Weight:** _____

☐ Patient/family informed of benefits and risks of Argatroban **Height:** _____

☐ **Symptom onset between 3 to 4.5 hours**

☐ Check if the informed consent has been signed by the patient or authorized representative and has been placed in the patient's medical record.

Contact Pharmacy at ext 2854/2856 at the time of alteplase administration to inform them that there is a potential ARTSS-2 patient who might be randomized to receive Argatroban. **Monday –Friday between 9:30 am – 5:30 pm please contact Research Pharmacy at ext 4340**.

Pharmacy Orders

Investigational Study – Argatroban Drip (ARTSS-II) Loading Dose	**Investigational Study – Argatroban Drip (ARTSS-II) Maintenance Dose (250mg argatroban in 250ml 0.9% NS)**
(Note: Argatroban must be initiated prior to the end of alteplase infusion given in ER; prepare STAT) **Prepare Argatroban 250 mg/250 ml NS**: Bolus dose: (_____kg) x (100 micrograms/kg) = _____mcg Infuse Loading dose from bag (drip) to be given over 5 minutes (please use pump to infuse loading dose) Remainder of drug in infusion bag is to be used for maintenance dose	Start Argatroban IV infusion at (check): ☐ Low Dose: 1 micrograms/kg/min ☐ High Dose: 3 micrograms/kg/min Titrate based on aPTT results per protocol up to a maximum of 10 micrograms/kg/min Goal is to achieve a target aPTT of 1.75 and 2.25 times of baseline for low dose and high dose group respectively

Nurse Instructions: Infusion bag of Argatroban 250mg/250ml of 0.9% NS must not hang for more than 24 hours

Initial bag hung on: Date _____Time _____

Discontinue Argatroban Infusion at the end of 48 hours .

Infusion not to exceed 48 hour period on Date _____Time _____

ICH Protocol

1. Discontinue alteplase and Argatroban
2. Type and Cross
3. Check fibrinogen level stat and every 6 hours
4. Give 10-20 units cryoprecipitate
5. Repeat cryoprecipitate (cryo) to bring fibrinogen > 100 mg/dl (1 unit cryo raises fibrinogen 5-10 mg/dl); May give fresh frozen plasma in case of no cryo (1 unit of cryo is made from 1 bag of FFP);
6. Give platelet concentrate if platelet count is low

Investigators and Sub-investigators: (only prescribers listed on FDA 1572 may prescribe study drug) ☐ Volodymyr Vulkanov

Please check off your name and sign and date below

☐ Steven Levine ☐ Richard Sinert ☐ Pia Chatterjee ☐ Diana Rojas-Soto ☐ Jennifer Martindale

☐ Ethan Brandler ☐ Lorenzo Paladino ☐ Helen Valsamis ☐ Benedict Tan ☐ Priyank Khandelwal

Prescriber signature: _____ Date/Time: _____ ☐ Adrian Marchidann

RN Name/Signature Date/Time:

Patient Name: ___________________________________
MRN:_________________ Patient ID: __ __ __-__ __ __

ARTSS-2 STUDY SOURCE DOCUMENT
aPTT Worksheet

Weight (kg): _____ __

<u>SCHEDULED PTT DRAWS</u>:
2 Hour TARGET TIME:____________
6 Hour TARGET TIME: ____________
12 Hour TARGET TIME: ___________
24 Hour TARGET TIME: ___________
48 Hour TARGET TIME: ___________

Target aPTT Range:_________
Baseline aPTT:________

Arg. Bolus Date:__________ Time: _______________
Infusion Start Date:__________ Time: _______________
Infusion Stop Date:__________ Time: _______________

Date (mm-dd-yyyy)	**Actual Draw Time** (0000-2359)	**Type for Draw** -**Scheduled**: 2hr, 6hr, 12hr, 24hr, 48hr -**Unscheduled**: PRN	**Comments** *provide reason for PRN draws	**aPTT Lab Result Time**	**aPTT** (sec)	**Argatroban Dose Adjustment**[¥] **Date & Time of Change**	**Amount of rate change µg/kg/min**	**New Infusion Rate** **µg/kg/min**	**cc/hour**	**Initials**
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			

◦aPTT will be checked at: baseline (prior to the rt-PA and Argatroban bolus dose); 2 hrs (±30 min); 6 hrs (± 30 min); 12 hrs (± 30 min); 24 hrs (± 30 min) and 48 hrs (± 30 min).
◦**<u>aPTT will be drawn every 2-4 hours after each dose change (unless the scheduled pTT is due within 30 minutes).</u>**
[¥]Use dose calculation guideline for adjustments.

Name: ____ **Signature:** ____ **Page ___ of ____**

Patient Name: ___________________________________

MRN:_________________ **Patient ID:** __ __ __-__ __ __

ARTSS-2 STUDY SOURCE DOCUMENT
aPTT Worksheet

Date (mm-dd-yyyy)	**Actual Draw Time** (0000-2359)	**Type for Draw** -**Scheduled**: 2hr, 6hr, 12hr, 24hr, 48hr -**Unscheduled**: PRN	**Comments** *provide reason for PRN draws	**aPTT Lab Result Time**	**aPTT** (sec)	**Argatroban Dose Adjustment**[¥]		**New Infusion Rate**		
						Date & Time of Change	**Amount of rate change µg/kg/min**	**µg/kg/min**	**cc/hour**	**Initials**
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by _____ µg/kg/min ↓ by _____ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			

◦aPTT will be checked at: baseline (prior to the rt-PA and Argatroban bolus dose); 2 hrs (±30 min); 6 hrs (± 30 min); 12 hrs (± 30 min); 24 hrs (± 30 min) and 48 hrs (± 30 min).

◦**aPTT will be drawn every 2-4 hours after each dose change (unless the scheduled pTT is due within 30 minutes).**

[¥]Use dose calculation guideline for adjustments.

Name: ____ **Signature:** ____ **Page** ___ **of** ____

Patient Name: ___________________________________

MRN:_________________ **Patient ID:** __ __ __-__ __ __

ARTSS-2 STUDY SOURCE DOCUMENT
aPTT Worksheet

Date (mm-dd-yyyy)	**Actual Draw Time** (0000-2359)	**Type for Draw** -**Scheduled**: 2hr, 6hr, 12hr, 24hr, 48hr -**Unscheduled**: PRN	**Comments** *provide reason for PRN draws	**aPTT Lab Result Time**	**aPTT** (sec)	**Argatroban Dose Adjustment**[¥]		**New Infusion Rate**		
						Date & Time of Change	**Amount of rate change µg/kg/min**	**µg/kg/min**	**cc/hour**	**Initials**
							↑ by ______ µg/kg/min ↓ by ______ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by ______ µg/kg/min ↓ by ______ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by ______ µg/kg/min ↓ by ______ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by ______ µg/kg/min ↓ by ______ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			
							↑ by ______ µg/kg/min ↓ by ______ µg/kg/min □ infusion held □ infusion stopped □ infusion restarted □ No change			

◦aPTT will be checked at: baseline (prior to the rt-PA and Argatroban bolus dose); 2 hrs (±30 min); 6 hrs (± 30 min); 12 hrs (± 30 min); 24 hrs (± 30 min) and 48 hrs (± 30 min).

◦**aPTT will be drawn every 2-4 hours after each dose change (unless the scheduled pTT is due within 30 minutes).**

[¥]Use dose calculation guideline for adjustments.

Name: ____ **Signature:** ____ **Page** ___ **of** ____

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

NIHSS

Assessment :	
□ Baseline	□ 48 hours ± 4 hr post-TPA bolus
☒ 2 ± 30 min post-TPA bolus	□ Day 7/Discharge
□ 24 hours ± 4 hr post-TPA bolus	□ Day 90

NIHSS

Date: _____

Time: _____

Status: _____

Total: _____

1a-LOC
0-alert 1-drowsy 2-stupor 3-comotose

1b-LOC questions
0-both 1-one 2-neither

1c-LOC commands
0-both 1-one 2-neither

2-Best Gaze
0-nl 1-partial 2-forced gaze

3-Visual Fields
0-nl 1-partial 2-complete 3-bilateral

4- Facial Paresis
0-nl 1-minor 2-partial 3-complete

5-8 MOTOR
____5-Left Arm
____6-Right Arm
____7-Left Leg
____8-Right Leg

0 = no drift
1 = drift
2 = some effort vs gravity
3 = no effort vs gravity
4 = no movement
x = untestable

9-Limb Ataxia
0-abs 1-1 limb 2-2 + limbs x-untestable

10-Sensory
0-nl 1-partial loss 2-deep loss

11-Best Language/Aphasia
0-nl 1-mild/mod 2-severe 3-mute

12-Dysarthia
0-nl 1-mild/mod 2-severe x-untestable

13-Neglect/Inattention
0-non 1-partial 2-complete

mRS: ☐ Pre-Morbid ☐ Day_____ ☐ DC

_____

NAME: _____

SIGNATURE:_____

2 ± 30 min post-TPA bolus & Day 90 ONLY

Was the rater blinded to treatment arm? □ Yes □ No □ N/A

Patient Name: _____
MRN:_____ Patient ID: __ __ __-__ __ __

ARTSS-2 Study Source Document

CT-Angiogram

Date : _____	**Time: _____**
□ Baseline	☒ 2-3 hours post TPA bolus

Vessel Occlusion Location (SELECT <u>ONLY ONE</u> SYMPTOMATIC VESSEL)

MCA

☐ M1 ☐ M2 (proximal)

☐ ICA (terminal)

PCA

☐ P1 ☐ P2 (proximal)

☐ Vertebro-basilar

☐ other: _____

TIMI Score

☐ 0—Abrupt cut-off of vessel, complete occlusion

☐ 1—Artery penetrated by contract, but no distal branch filling

☐ 2- Perfusion and incomplet or slow distal branch filling

☐ 3- Full perfusion with filling of all distal branches

_____

Name of person completing form

_____

Signature of person completing form

_____

Date