STROKE
PRE-REVIEW QUESTIONNAIRE

Please answer **all** questions appropriate to your stroke center. See Appendix on Page 4 for instructions or clarification, if needed. Do not use abbreviations. Use the "tab" key to move from question to question. **Please return with the application packet.** There are two ways to submit this questionnaire: (1) after you have completed the questionnaire save the form using your hospital's name and the date (e.g. hospital name-date) and then email the saved file to Karen.Digmon@adph.state.al.us or (2) return by mail to the address listed at the bottom of the page.

1. **Type of stroke visit** (check one):

   State designation-Initial visit ___

   Re-inspection visit ____ Date of last visit ____/____/____

   Has your facility been certified by TJC, DNV GL, or other accrediting body?

   Yes ___ No ___ If yes, provide copy of the certificate.

2. **Where is your facility's Regional Advisory Council (RAC) primary membership located?** (check one):

   ☐ North ☐ East ☐ BREMSS ☐ West ☐ Southeast ☐ Gulf

3. **Stroke Coordinator:** _____

4. **Stroke Numbers/DATA:**

Total number of stroke patients for prior year	
Number admitted to your facility	
Number transferred to higher level of stroke care	
Number of stroke deaths at your facility	
Total number of patients treated with tPA	
Total number of patients treated with MT, If N/A = 0	

   Data collection date range: ____/____/____ to ____/____/____

5. **Does your facility have stroke treatment protocols in place that define tPA administration?** (check one):

   Yes____ No____

Please submit a copy of your facility's stroke protocol with application packet.

6. **Members of the stroke team-certifications**
   (e.g. Surgeon Board Certification, EM Physicians EM Board Certification, or Neurologist.)

   Please submit a copy of each emergency physician(s), neurologist(s), and neurosurgeon(s) certification and certificates (refer to #6 on page 4).

7. **Does your hospital have a stroke transfer agreement with another facility?**
   (Written agreement is not required)

   Yes____ No____

   Please list facilities you have stroke transfer agreements with below:

   _____
   _____

8. **Please submit a copy of hospitals *Performance Improvement Policy***

9. **Continuing Education (Physicians/Staff) - Review Stroke Designation Criteria and submit information as indicated. (**Refer to #9 on page 4)

   Outreach programs - list below:

   List current stroke related educational programs here:

   _____
   _____
   _____
   _____

10. **Does hospital collaborate with existing regional, state, or national stroke prevention programs**?

    Yes____ No____

    (e.g. working with local American Heart and Stroke agencies to implement healthy lifestyle changes campaign.) **List the programs your facility collaborates with below:**

    _____
    _____
    _____

11. **List any current community stroke prevention activities**:

_____
_____
_____

12. **Comments**:

_____
_____
_____
_____
_____
_____
_____

_____

Print Name /Title Signature Date

_____

Facility Name

Return completed forms to:

Alabama Department of Public Health
Office of EMS
Attention: Karen Digmon
P.O. Box 303017
Montgomery, AL 36130-3017
Or
Email to: Karen.Digmon@adph.state.al.us
or
Email: Alice.Floyd@adph.state.al.us

Appendix: General Information and Instructions

1. Type of visit: initial on-site designation, check the first box. If this is a return site visit, check the second box and provide the date of the previous site visit. Indicate if certification as stroke center has been obtained. If yes provide a copy of certificate.

2. RAC Participation: indicate the appropriate RAC region your facility is a member.

3. Stroke Coordinator: list the stroke coordinator.

4. Stroke Numbers: provide number(s) for stroke patients only. Include the date range for data collection.

5. Stroke Treatment Protocol in place (defines tPA administration): check the appropriate answer. If yes, submit a copy of the protocol.

6. Stroke team member's certifications: submit a copy of each neurosurgeon, neurologist, and ED doctor certificates.

7. Transfer Arrangements: check the appropriate answer and, if answer is yes, list facilities.

8. Performance Improvement/Policy: submit a copy.

9. Continuing Education/Outreach: **Review Stroke Designation Criteria and submit continuing education information for Physicians and Staff as required.** For Outreach**,** list programs that apply.

10. List any organizations that your facility is collaborating with for stroke prevention activities.

11. List any community stroke prevention activities.

12. Comments: self-explanatory