Study Number: _____ Subject Initials: __ __ __ Date of Visit: ___ / ___ /____

Rating Form
Prestroke Rankin Focused Assessment (RFA)

Name of rater performing assessment: _____

Information for completing this form was obtained from (check all that apply):

[ ] Patient	[ ] Sister
[ ] Spouse	[ ] Brother
[ ] Son	[ ] Other relative, specify relationship: _____
[ ] Daughter	[ ] Friend
[ ] Father	[ ] Nurse
[ ] Mother	[ ] Home health aide
[ ] Physical therapist	[ ] Occupational therapist
[ ] Speech therapist	[ ] Physician
[ ] Medical record	
[ ] Other individual, specify role: _____	

Please mark (X) in the appropriate box. Please record responses to all questions (unless otherwise indicated in the text). Please answer questions based on the patient's status BEFORE the current stroke. Answers should reflect how all the medical/physical conditions the patient had before the current stroke affected their daily functioning before the current stroke. Please see instruction sheets for further information.

5	**BEDRIDDEN**	
5.1	**Is the person bedridden?** The patient is unable to walk even with another person's assistance. (if placed in a wheelchair, unable to self-propel effectively). May frequently be incontinent. Will usually require nearly constant care – someone needs to be available at nearly all times. Care may be provided by either a trained or untrained caregiver.	□ Yes □ No (5)

If yes, explain:

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4	**ASSISTANCE TO WALK**	
4.1	**Is another person's assistance essential for walking?** Requiring another person's assistance means needed another person to be always present when walking indoors around house or ward, to provide physical help, verbal instruction, or supervision. (Patients who use physical aids to walk, e.g. stick/cane, walking frame/walker, but do not require another person's help, are NOT rated as requiring assistance to walk). (For patients who use wheelchairs, patient needs another person's assistance to transfer into and out of chair, but can self-propel effectively without assistance.)	□ Yes □ No (4)

If yes, explain:

_____

_____

_____

3	**ASSISTANCE TO LOOK AFTER OWN AFFAIRS**	
	Assistance includes physical assistance, or verbal instruction, or supervision by another person. Central issue--Could the patient live alone for 1 week if he/she absolutely had to?	
3.1	**Is assistance ABSOLUTELY essential for preparing a simple meal?** (For example, able to prepare breakfast or a snack)	☐ Yes ☐ No (3)
3.2	**Is assistance ABSOLUTELY essential for basic household chores?** (For example, finding and putting away clothes, clearing up after a meal. Exclude chores that do not need to be done every day, such as using a vacuum cleaner.)	☐ Yes ☐ No (3)
3.3	**Is assistance ABSOLUTELY essential for looking after household expenses?**	☐ Yes ☐ No (3)
3.4	**Is assistance ABSOLUTELY essential for local travel?** (Patients may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.)	☐ Yes ☐ No (3)
3.5	**Is assistance ABSOLUTELY essential for local shopping?** (Local shopping: at least able to buy a single item)	☐ Yes ☐ No (3)

If yes to any of the above, explain:

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2. USUAL DUTIES AND ACTIVITIES. The next sets of questions are about how the patient usually spends his/her day.

2.1 Work

2.1	**Does a medical/physical condition substantially reduce the person's ability to work (or, for a student, study)?** e.g. change from full-time to part-time, change in level of responsibility, or unable to work at all. If patient is not working or is retired, is that because of a medical/physical condition?	☐ Yes ☐ No (2)

If yes, explain:

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2.2 Family responsibilities

2.2	**Does a medical/physical condition substantially reduce the person's ability to look after family at home?**	☐ Yes ☐ No (2)

If yes, explain:

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_____

2.3 Social & leisure activities

(Social and leisure activities include hobbies and interests. Includes activities outside the home or at home. Activities outside the home: going to the coffee shop, bar, restaurant, club, church, cinema, visiting friends, going for walks. Activities at home: involving "active" participation including knitting, sewing, painting, games, reading books, home improvements).

2.3	**Does a medical/physical condition substantially reduce the person's regular free-time activities by more than one half as often?**	☐ Yes ☐ No (2)

If yes, explain:

_____

_____

_____

_____

Study Number: __ __ __ - __ __ __ __ Initials: __ __ __ Date of Visit: ___ / ___ /____

1. SYMPTOMS AS A RESULT OF A PRIOR STROKE
(Can be any symptoms or problems reported by the patient).

1.1 SPONTANEOUSLY REPORTED SYMPTOMS

1.1	**Does the patient have any symptoms resulting from a prior stroke?**	□ Yes □ No (1)

If yes, record symptoms here:

_____

_____

1.2. SYMPTOM CHECKLIST

1.2.1	**Does the person have difficulty reading or writing as a result of a prior stroke?**	□ Yes □ No (1)
1.2.2	**Does the person have difficulty speaking or finding the right word as a result of a prior stroke?**	□ Yes □ No (1)
1.2.3	**Does the person have problems with balance or coordination as a result of a prior stroke?**	□ Yes □ No (1)
1.2.4	**Does the person have visual problems as a result of a prior stroke?**	□ Yes □ No (1)
1.2.5	**Does the person have numbness (face, arms, legs, hands, feet) as a result of a prior stroke?**	□ Yes □ No (1)
1.2.6	**Does the person have weakness or loss of movement (face, arms, legs, hands, feet) as a result of a prior stroke?**	□ Yes □ No (1)
1.2.7	**Does the person have difficulty with swallowing as a result of a prior stroke?**	□ Yes □ No (1)
1.2.8	**Does the person have any other symptoms related to a prior stroke?**	□ Yes □ No (1)

Details supporting any "Yes" checked boxes in Section 1:

_____

_____

_____

Rankin Grade = ☐