



PhenX Measure: Functionality after Stroke (#820700)

PhenX Protocol: Recovery and Recurrence Questionnaire (RRQ) - Pediatrics (#820702)

Date of Interview/Examination (MM/DD/YYYY): _____

International Pediatric Stroke Study (IPSS) Recovery and Recurrence Questionnaire

Note: If child has died since discharge from hospital, please go directly to item 8 (skip items 1-7)

Q1. Has your child recovered completely from the stroke?

Yes

No - If no, please answer the following questions:

1A. **Does your child have any problems with strength, coordination, or sensation including vision or hearing, as a result of the stroke?** If yes, please choose which of the following are present in your child:

Developmental delay

Difficulty with speaking clearly (problem with pronouncing words)

Abnormal tone

Difficulty with drinking, chewing, or swallowing

Weakness on one side of the body

Loss of sensation on one side of the body

Weakness on one side of the face

Other sensory problems

Unsteadiness on one side of the body

Difficulty with vision

Difficulty with hearing

Other problems with strength or coordination; Describe: _____

Does the problem affect your child's day-to-day activities?

Yes

No

	<u>Right side face or body</u>	<u>Left side face or body</u>
Not Done	n/t	n/t
None	0	0
Mild but no impact on function	0.5	0.5
Moderate with some limitations with daily functions	1	1
Severe or Profound with missing function	2	2

1B. Does your child have difficulty expressing him/herself verbally? (Exclude dysarthrias or pronunciation problems)

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

1C. Does your child have difficulty understanding what is said to her/him?

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

1D. Does your child have difficulty with his/her thinking or behavior?

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

TOTAL PARENTAL PSOM SCORE: _____/10

Q2. Does your child need extra help with day-to-day activities compared with other children of the same age?

Yes

No

Q3. Since the first stroke, has your child had another Stroke or Transient Ischemic Attack (TIA) or blood clot in any other blood vessel (e.g. in the leg, lung, heart, other location) ?

Yes

No

Unknown

If yes, which *type*?

Unknown

Stroke in a brain artery (usual form of 'stroke')

Stroke in a brain vein ('sinus thrombosis')

TIA

Other blood clot: (State location of blood clot : _____)

If yes, *when* was the recurrence (if unknown, please estimate)? Year _____
Month _____ Day _____

Did your child have a *CT / MRI* at the time of the recurrence?

- Yes
- No
- Unknown

If yes,

a) which test was done?

- CT
- MRI
- Unknown

b) did the CT /MRI show a new stroke?

- Yes
- No
- Unknown

Describe the new clinical symptoms at the time of the recurrence:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Difficulty using hands |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Difficulty with vision |
| <input type="checkbox"/> Difficulty with drinking, chewing or swallowing | <input type="checkbox"/> Other, describe:
_____ |

Describe how long the symptoms lasted with the most recent attack:

- Less than 6hrs
- 6-24 hours
- More than 24 hours

If there was more than one episode, how many episodes occurred? _____

What stroke treatment was he/she on at the beginning of the episode?

None

Aspirin

Low molecular weight Heparin (Enoxaparin, Loxaprin, injections under the skin)

Coumadin (blood thinning pill) Other (describe): _____

Q4. Does your child suffer from headaches or seizures since being discharged after the stroke(s)?

Headache:

Yes

No

Seizures:

Yes

No

If yes, is he/she on a seizure medicine now?

Yes

No

Q5. Have there been any other major health problems or procedures resulting from the stroke(s) or the stroke(s) treatment?

Yes

No

If yes, describe:

Q6. What medications are being used right now for stroke treatment?

None

- Aspirin
- LMWH (blood thinner injected under the skin)
- Coumadin (blood thinner pill)
- Other (describe): _____

Q7. What rehabilitation treatments is your child receiving now?

- None
- Occupational Therapy
- Physical Therapy
- Speech therapy
- Special education services
- Other (describe): _____

Q8. If your child is deceased, please specify:

Date of death: Year _____ Month _____ Day _____

Cause of death:

Scoring:

The scores from questions 1A-1D are summed to give a total score, with higher scores indicating greater disability.