

Patient Event Form

Cervical Artery Dissection in Stroke Study

Centre name	Investigator
Patient identification number	Patient's initials.....

Event in the study artery territory		
Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
Type of event:		
Amaurosis fugax <input type="checkbox"/>	TIA <input type="checkbox"/>	Stroke <input type="checkbox"/>
CT/MRI/MRA performed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Date of imaging <input type="text"/> / <input type="text"/> / <input type="text"/>
If yes, please send the report and imaging copy		
Synopsis:		
.....		
.....		
.....		

Event in another territory			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Which territory			Left carotid <input type="checkbox"/>	Right carotid <input type="checkbox"/>
			Vertebrobasilar <input type="checkbox"/>	
Date of event <input type="text"/> / <input type="text"/> / <input type="text"/>				
Type of event:				
Amaurosis fugax <input type="checkbox"/>		TIA <input type="checkbox"/>		Stroke <input type="checkbox"/>
CT/MRI/MRA performed		Yes <input type="checkbox"/>		No <input type="checkbox"/>
			Date of imaging <input type="text"/> / <input type="text"/> / <input type="text"/>	
If yes, please send the report and imaging copy				
Synopsis:				
.....				
.....				
.....				

***Please send copies of imaging films/reports to CADISS central office:**
 Centre of Clinical Neuroscience, St George's, University of London, Cranmer Terrace, London, SW17 0RE
 Fax: 020 8725 2950