Supplementary File 1

# Demographics

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Record ID

Initials of interviewer

Given names of the patient (First and surname)

Hospital ID

Sex Male

Female



Age in years at the time of stroke

Marital status Ever married

Never married



Tribe

Level of education None

Primary Secondary College and above



Occupation Employed

Not employed



Place of residency

Residency Urban

Semi urban Rural



Referral status Referred

Self-referred



Mode of hospital arrival Emergency medical services eg Ambulance Own means

Other eg inter-hospital transfers



Health insurance coverage Yes

No



Type of insurance

Contact mobile number 1

Contact mobile number 2

Contact mobile number 3

Previous comorbidities

Hypertension Diabetes mellitus

Current Smoker (within the last 12 months) Alcohol intake (within the last 12 months) Previous stroke

Previous TIA Heart failure

Acute coronary syndrome Ischemic heart disease Atrial fibrillation

Obesity Dyslipidemia HIV infection

Sickle cell disease Other

None

Ex-smoker

Previous alcohol consumer Rheumatic Heart Disease

Other comorbidities

(Specify)

If has hypertensive Regularly taking medications

Not on regular medications Not known



If has diabetic Regularly taking medications

Not on regular medications Not known



If has HIV infected Regularly on ARV

Not on regular ARV Not known



Other previous drugs used

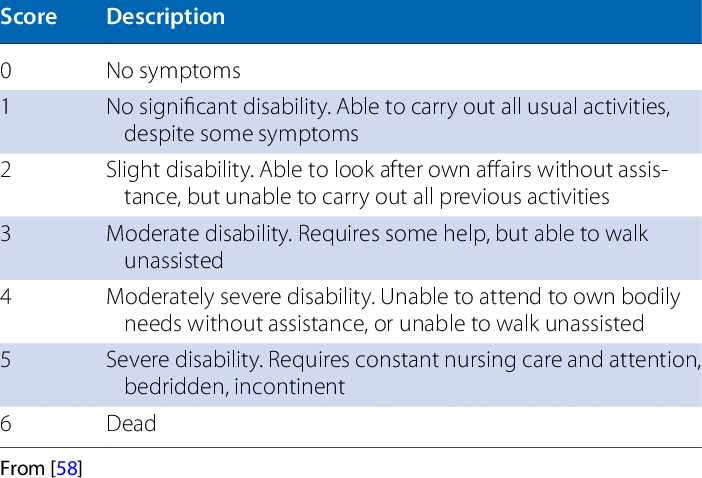
Anti-platelet eg aspirin

Anti-coagulant eg warfarin, rivaroxiban Statins

Other

Not known

Illicit drug use as cannabis, cocaine, amphetamines

Pre-morbid modified Rankin scale

Provide premorbid modified Rankin Scale score obtained

# Baseline Information on Arrival

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Ward admitted General medical ward



Intensive care unit Stroke unit Neurosurgical ward Obstetrics

Other ward

Presenting complaints

Hemiparesis

Loss of consciousness Seizures

Aphasia

Difficulty in breathing Fever

Headache Nausea Vomiting Vision loss Confusion Ataxia Dysarthria

(Select multiple options)

Any other additional complaints

Time of symptom onset

(If the patient woke up with symptoms, enter the time when the patient was last symptom-free. Time of onset is given in hours and minutes)

If the time of onset is unknown or it is only possible Within 3 hours



to determine the hour of onset Within 4.5 hours Within 6 hours

within 24 hours

After 24 hours Not known

Date of symptom onset

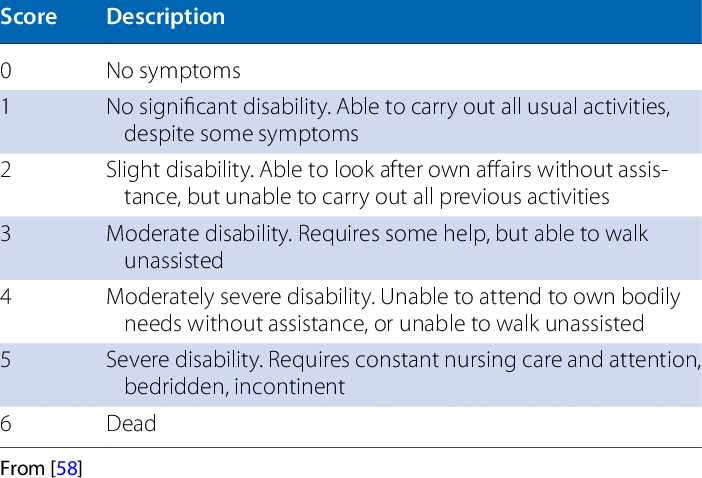
Time of admission from symptom onset in HOURS

(If a patient came in after 24 hours, take the number of days \* 24 hours)

Date of admission

NIHSS on arrival

NIHSS score on arrival at the ED/Ward

modified Rankin Scale on arrival at the ED or ward

Provide arrival modified Rankin Scale score

Arrival Glasgow coma scale score

Systolic Blood Pressure on arrival at the ED

(In mmHg)

Diastolic Blood pressure on arrival at ED

(mmHg)

Pulse rate/Heart rate on arrival at the ED

(beats/min)

Temperature on arrival at the ED

(degrees Celsius )

Swallow screen performed Yes documented in the medical records

No not performed or documentation missing from the medical records



 Not examined owning to patients reduced level of consciousness

Nasal gastric tube placed Yes



No, including those who do not need it

Blood glucose on arrival

(in mmol/l, if not done record 'not done')

Glycated hemoglobin

(If not done record 'not done')

Low density Lipoproteins

(mmol/l, If not done record 'not done')

Total cholesterol

(mg/dl, If not done record 'not done')

HIV testing Reactive

Non reactive



Not done because the patient is known to have HIV Not done for other reasons

Total white cell count

(If not done record 'not done')

Hemoglobin

(If not done record 'not done')

Platelet count

(If not done record 'not done')

Sodium levels

(If not done record 'not done')

Potassium

(If not done record 'not done')

Creatinine

(If not done record 'not done')

Urea

Prothrombin time (PT)

(If not done record 'not done')

Partial Thromboplastin Time (PTT)

(If not done record 'not done')

International Normalized Ratio (INR)

(If not done record 'not done')

Sickling test Positive

Negative



Electrocardiographic findings

Sinus

Atrial fibrillation STEMI

LVH (Cornell criteria S-v3+R-aVL >28m, >20f) ECG not done

Echocardiography findings

LVH

Left atrial enlargement Left atrial thrombus Vegetations

Mitral stenosis

Ejection fraction < 45% Dilated cardiomyopathy Normal

Not done

Carotid duplex findings

(Summarize the findings. If not done record 'not done')

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# Hyperacute And Acute Management 0-48 Hours

Time from symptom onset to first brain imaging in HOURS

(If first imaging completed after 24 hours, take no. of days \* 24hours)

Date of first brain image obtained

Type of first brain imaging performed CT brain

CT angiography MRI brain



MRI angiography

First brain imaging findings ischemic

Hemorrhagic Normal



Ischemic with hemorrhagic transformation

CT/MRI angiography performed in connection with the Yes first CT/MRI No

Not known



Ischemic stroke subtype (TOAST criteria) Large vessel Cardio embolic Small vessel

Ischemic stroke of other determined etiology Ischemic stroke of unknown etiology



Received IV thrombolysis/tPA on arrival Yes

(alteplase/tenecteplase) No



(For ischemic strokes only)

Door to needle time (i.e time from arrival in the ED to administering IV tPA)

(indicate date and time in hours and minutes)

Time from Symptom onset to administering IV tPA

(Indicate the date and time in hours and minutes )

NIHSS at 24 hours

NIHSS score obtained at 24 hours

Performed Mechanical thrombectomy Yes No

(For ischemic strokes only)



Symptom onset to groin/arterial puncture for MT patients

(Indicate the date and time in hours and minutes)

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Arrival from ED to groin/arterial puncture for MT patients

Location of hemorrhage

Intracerebral Sub arachnoid Intraventricular

Further description of site of hemorrhage

Cerebrum, central/deep Cerebrum lobar/superficial

Cerebrum unspecified if deep or superficial Brain stem (midbrain, pons, medullae) Cerebellum

Several different sites Other

Unknown

Hematoma size

Any surgical interventions provided

External ventricular drain

Other neurosurgical interventions No intervention

(For hemorrhagic strokes)

Time of symptom onset to second brain imaging in HOURS

(If second imaging done after 24 hours, take no. of days \* 24hours)

Date of second brain imaging

Type of second brain imaging CT brain

CT angiography MRI Brain



MRI angiography

Findings of the second brain imaging

(Summarise findings)

Developed medical complications

Aspiration pneumonia Deep venous thrombosis Urinary tract infection Pulmonary embolism Sepsis

Bed sores Intubation Kidney injury Hyponatremia

Other complications No complications

Other complications specify

# Post-Acute Management From 72 Hours

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Medical treatment received during the index stroke

Anti-hypertensives Statins

Anti-platelet Anti coagulation Anti biotics

Anti-diabetics (insulin or oral) Anti convulsants

The patient was assessed by a speech therapist or Yes



other dysphagia specialist with regard to swallowing No; No need

function No; patient has need but no speech therapist or

other dysphagia specialist available

 Not known or patient declines evaluation

The patient was assessed by a speech therapist Yes

regarding speech function No; No need



No; patient has need but no speech therapist available

no, but ordered for after discharge no



not known or patient declines evaluation

Patient received in-patient Physiotherapy after Yes, ≤24hrs

arrival in the ward Yes >24 hrs but ≤48hrs



Yes, >48hrs No

Not known

Any Deep venous thrombosis prophylaxis received while Yes

in the ward (medical/physical) No, did not need it



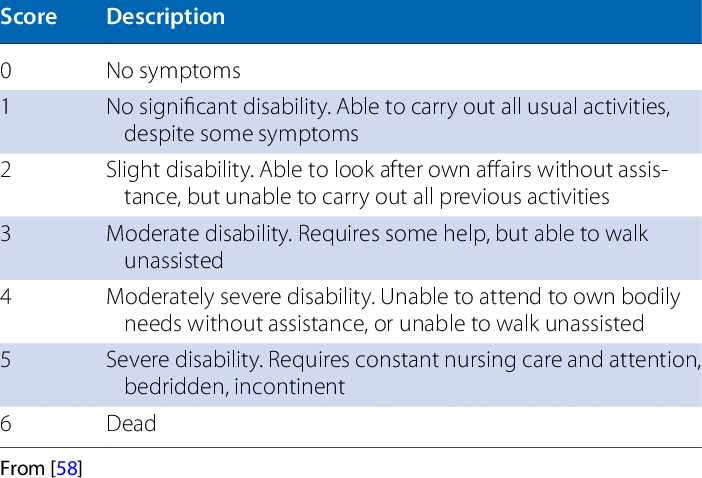
No, not given or no documentation Not known

Discharge NIHSS

Discharge NIHSS score obtained

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Discharge modified Rankin Scale



Provide discharge modified Rankin Scale score obtained

Date of death or discharge

Documented cause of in-hospital mortality

Discharge systolic blood pressure

Discharge diastolic blood pressure

Discharge medications

Anti-hypertensives Anti-diabetics

Anti-platelets Statins

Anti-coagulants Anti-convulsant Anti-biotics

Social support at discharge Discharged to live with a family member Discharged to live with friends or neighbors Discharged to live alone



Since your stroke or last assessment, has your  Yes (If YES, consider referral to a psychologist relationship with your family become more difficult or or clinician for further evaluation)

stressed?  No

(Relationship with family