Six Month Post-Stroke Review

GM-SAT: the Greater Manchester Stroke Assessment Tool©

Name		**Date of review**	
D.O.B		**NHS number**	
Name of reviewer		**Designation**	
People present at the review (including relationship to the client)			

Does the client consent to receiving a six month review?	**Yes I No**
Does the client consent to information gathered at the review being shared with other people involved in their care?	**Yes I No**

Medication

Modified Rankin Scale (mRS)

Score at review:

0	**No symptoms.**
1	**No significant disability.** Able to carry out all usual activities, despite some symptoms.
2	**Slight disability.** Able to look after own affairs without assistance, but unable to carry out all previous activities.
3	**Moderate disability.** Requires some help, but able to walk unassisted.
4	**Moderate severe disability.** Unable to attend to own bodily needs without assistance and unable to walk unassisted.
5	**Severe disability.** Requires constant nursing care and attention, bedridden, incontinent.

Question * See Self Assessment Questionnaire	Notes
Medicine management Do you have problems getting your medicine? Do you have problems taking your medicine?	 Yes I No Yes I No
Medicine compliance Do you always take your medicine as prescribed? Do you get side effects from your medicine?	 Yes I No Yes I No
Blood pressure Is blood pressure above target? (140/90 or 130/80 for established CVD)	____ / ____ Yes I No
Anti-thrombotic therapy Do you have an irregular heart beat? *If yes*, is the patient anticoagulated i.e. warfarinised? *If no*, take pulse. Is pulse irregular?	 Yes I No Yes I No Yes I No
Cholesterol Do you take medicine to lower your cholesterol? *If no*, have you had your cholesterol checked since your stroke?	 Yes I No Yes I No
Diabetes Are you diabetic? *If yes*, is your blood sugar checked regularly?	 Yes I No Yes I No
Alcohol Do you drink alcohol? *If yes,* how much do you drink and how often?	 Yes I No Yes I No
Smoking Do you smoke? *If yes,* do you want to stop smoking?	 Yes I No Yes I No
Healthy eating Do you eat a balanced diet?	 Yes I No
Exercise Do you exercise regularly? Do you keep active?	 Yes I No
Vision* Do you have any new problems with your sight?	 Yes I No
Hearing* Do you have any new problems with your hearing?	 Yes I No
Communication* Do you have any new problems with your speech, reading or writing?	 Yes I No
Swallowing* Do you have any new problems swallowing?	 Yes I No
Nutrition* Have you recently lost weight without trying to?	 Yes I No MUST= .....
Weight management* Have you recently put on weight without trying to?	 Yes I No
Pain* Do you have any new pain that bothers you?	 Yes I No S-LANNS=.....

Continence* Do you have any new problems with incontinence?	Yes I No
Daily activities* Do you have any new problems with washing, getting dressed, cooking food, cleaning your home or other daily activities?	Yes I No
Mobility* Do you have any new problems getting around inside the home or outside?	Yes I No
Falls* Have you recently tripped or fallen?	Yes I No

Mood* Do you often feel sad or depressed?	Yes I No Score= .....
Anxiety* Do you often feel anxious or tense?	Yes I No
Emotionalism* Do you laugh or cry more since the stroke?	Yes I No
Personality changes* Have you or anyone else noticed any change in your behaviour or personality since your stroke?	Yes I No
Sexual health* Do you have any worries about sex or relationships after stroke?	Yes I No
Fatigue* Do you feel tired all the time or get tired very quickly since your stroke?	Yes I No
Sleep pattern* Do you have any new problems sleeping?	Yes I No
Memory, concentration and attention* Do you have any new problems remembering things or concentrating?	Yes I No
Driving Did you drive before your stroke? *If yes,* have you started driving again? Would you like to start driving again?	Yes I No Yes I No
Transport and travel* Do you have enough access to a car or public transport?	Yes I No
Activities and hobbies Do you take part in any leisure activities and hobbies? Are there any hobbies and activities you would like to do?	Yes I No Yes I No
Work Do you work? *If no,* would you like to work?	Yes I No Yes I No

Money and benefits*	
Do you need any information about benefits or money?	Yes I No
House and home*	
Do you have any new problems with where you live?	Yes I No
Carer needs	
Do you have a carer or someone who helps you?	Yes I No
If yes, is there anything they need help with?	Yes I No

Notes