Alberta Health Services

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Stroke Prevention Clinic
Patient Screening Checklist

The Stroke Prevention Clinic is often the last opportunity for healthcare providers to identify problems that may have been caused by your stroke. Part of routine screening for your health after a stroke also includes reviewing mood and emotional concerns. Please take a few minutes to answer the following questions.

Who will be completing this form?

- ☐ self
- ☐ family member/friend
- ☐ healthcare professional

Date *(yyyy-Mon-dd)*

Mobility / Sensation		
Since your stroke, do you have any weakness or paralysis that limits your ability to care for yourself or return to work?	☐ No	☐ Yes
Do you have any changes in sensation?	☐ No	☐ Yes
Do you have any pain? If so, where? _____	☐ No	☐ Yes
Have you received, or are you still receiving rehabilitation?	☐ No	☐ Yes
If yes, are you happy with your progress?	☐ No	☐ Yes
Speech		
Since your stroke, do you have:		
Trouble finding the right words?	☐ No	☐ Yes
Trouble understanding what people are saying?	☐ No	☐ Yes
Difficulty with reading or writing?	☐ No	☐ Yes
Swallowing difficulties or frequent coughing spells?	☐ No	☐ Yes
Cognition		
Since your stroke have you or others noticed that you have:		
Difficulty concentrating or solving problems?	☐ No	☐ Yes
Problems remembering things?	☐ No	☐ Yes
Trouble controlling your temper?	☐ No	☐ Yes
A decrease in your mental sharpness?	☐ No	☐ Yes
Changes in your **daily** ability to plan or organize?	☐ No	☐ Yes
Do you plan to return to work? If yes, what is your occupation? _____	☐ No	☐ Yes
If employed and working, have you noticed changes in your performance at work?	☐ No	☐ Yes

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During the past two weeks, have you had little interest or pleasure in doing things, **or** been feeling down, depressed or hopeless?

- ☐ No - this form is complete, please return to nurse.
- ☐ Yes - please complete the Patient Health Questionnaire below ▼

Patient Health Questionnaire (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems (Use "☑" to indicate your answer):	not at all (score = 0)	several days (score = 1)	more than half the days (score = 2)	nearly every day (score = 3)
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling/staying asleep, sleeping too much?				
4. Feeling tired or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down?				
7. Trouble concentrating on things, such as reading the newspaper or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or, the opposite; being so fidgety or restless that you have been moving around more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way?				
Total *(for office coding)*	0+	_____ +	_____ +	_____ +
Total Score *(for office coding)*	_____			

If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Patient Screening Checklist reviewed with patient by:

Healthcare Provider Name	Signature	Date
Patient/Family Member Name	Signature	Date

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This section to be completed by healthcare provider.

Date of Stroke *(yyyy-Mon-dd)*	Date of SPC appointment *(yyyy-Mon-dd)*

Depression Screening

Depression Screening Completed:	☐ Yes ☐ No, reason _____		
PHQ2 Score	☐ Negative ☐ Positive		
PHQ9 Score *(tally responses from page 1)*:	☐ Not Applicable Total: _____ /27		
Follow-up based on PHQ9 screen findings:	**Score less than 5:**	**Score between 5 and 9:**	**Score higher than 9:**
	☐ Monitor ☐ Other *(please specify)*	☐ Watchful waiting ☐ Other *(please specify)*	* Further assessment required *(choose one or more of the following)*: ☐ Managed by SPC Physician ☐ Referral to Family Physician ☐ Consult outpatient Psychiatry ☐ Other *(please specify)*

Screening Checklist – Patient Identified Concerns:

Action(s) Taken: