

**STASH SCREENING FORM (SSF1)**

CENTRE NAME .....  
PATIENT INITIALS.....  
STUDY TREATMENT NUMBER.....

**Please complete in block capitals and in black ink**

**DEMOGRAPHICS**

**Patient details (or attach addressograph)**  
Name  
  
Full Address  
  
Telephone Number  
  
Mobile number if known  
  
**Patient Hospital Number:**

**GP details**  
Name  
  
Full Address  
  
Telephone number

***THIS SHEET WILL BE DESTROYED ON COMPLETION OF THE 6 MONTH ASSESSMENT***

## STASH SCREENING FORM (SSF2)

CENTRE NAME .....

PATIENT INITIALS.....

STUDY TREATMENT NUMBER.....

**Please complete in block capitals and in black ink**

<b>Gender</b>	M <input type="checkbox"/>	F <input type="checkbox"/>
<b>Date of birth</b>	□ □ / □ □ □ □ / □ □	
<b>Race</b>	Caucasian/white <input type="checkbox"/>	
	Asian <input type="checkbox"/>	
	Black <input type="checkbox"/>	
	Hispanic <input type="checkbox"/>	
	Other <input type="checkbox"/>	

Pregnancy Test (if required)	Positive	<input type="checkbox"/>
	Negative	<input type="checkbox"/>
<b>Date of admission to Neurosurgical unit</b>		
□ □ / □ □ □ □ / □ □      eg 01 / JAN / 10		

	Yes	No
DNA informed consent given	<input type="checkbox"/>	<input type="checkbox"/>
Sample sent	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>Inclusion/Exclusion criteria</u></b>		
<b><u>(all need to be yes to recruit):</u></b>		
Please tick as appropriate	Yes	No
Patient age 18-65	<input type="checkbox"/>	<input type="checkbox"/>
Reasonable prospect of survival	<input type="checkbox"/>	<input type="checkbox"/>
Ictus to first dose <96hrs	<input type="checkbox"/>	<input type="checkbox"/>
Not pregnant	<input type="checkbox"/>	<input type="checkbox"/>
No known renal/hepatic impairment	<input type="checkbox"/>	<input type="checkbox"/>
No current statin therapy	<input type="checkbox"/>	<input type="checkbox"/>
Fully independent prior to bleed	<input type="checkbox"/>	<input type="checkbox"/>
No strong suspicion of drug abuse, alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Likely to be amenable to follow up	<input type="checkbox"/>	<input type="checkbox"/>
Not taking warfarin-type drugs	<input type="checkbox"/>	<input type="checkbox"/>
Not taking amiodarone, verapamil or potent CYP3A4 inhibitors (see SPC)	<input type="checkbox"/>	<input type="checkbox"/>
No known suspected additional disease which threatens life expectancy	<input type="checkbox"/>	<input type="checkbox"/>
Informed consent given	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm positively identified	<input type="checkbox"/>	<input type="checkbox"/>

## STASH SCREENING FORM (SSF3)

CENTRE NAME .....

PATIENT INITIALS.....

STUDY TREATMENT NUMBER.....

**Please complete in block capitals and in black ink**

**Date of onset of current ictus**

/    /

**Time if known**

:   [24 hr clock]

**Strong suspicion of previous ictus**

Yes  No

**WFNS Grade on admission to Neurosurgical unit**

Grade	GCS	Motor deficit	<input type="checkbox"/>
1	15	-	<input type="checkbox"/>
2	14-13	-	<input type="checkbox"/>
3	14-13	+	<input type="checkbox"/>
4	12-7	±	<input type="checkbox"/>
5	6-3	±	<input type="checkbox"/>

**Motor deficit on admission to Neurosurgical unit**

Yes  No

**Cranial nerve deficit on admission to unit**

Yes  No

**Ventilated**

Yes  No

**CT scan findings:**

**Fisher Grade**

**please tick**

Grade 1 normal scan

Grade 2 less than 1mm thickness of blood

Grade 3 more than 1mm thickness of blood

Grade 4 any, with ventricular or ICH blood

Intraparenchymal haemorrhage

Intraventricular haemorrhage

Subdural haematoma

Cerebral infarct

Hydrocephalus (needing EVD)

**Name of person completing form** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_