

Study Number: _____ Subject Initials: ___ ___ Date of Visit: ___ / ___ / ___

Rating Form

Rankin Focused Assessment - Ambulation (RFA-A)

Name of rater performing assessment: _____

Information for completing this form was obtained from (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Brother |
| <input type="checkbox"/> Son | <input type="checkbox"/> Other relative, specify relationship: _____ |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Home health aide |
| <input type="checkbox"/> Physical therapist | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Speech therapist | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Medical record | |
| <input type="checkbox"/> Other individual, specify role: _____ | |

Please mark (X) in the appropriate box. Please record responses to all questions (unless otherwise indicated in the text). Please see instruction sheets for further information.

5 BEDRIDDEN	
5.1 Is the person bedridden? The patient is unable to walk even with another person's assistance. May frequently be incontinent. May require constant care	<input type="checkbox"/> Yes <input type="checkbox"/> No (5)

If yes, explain:

4 ASSISTANCE TO WALK	
4.1 Is another person's assistance essential for walking? Requiring another person's assistance means needing another person to be always present when walking, including indoors around house or ward, to provide physical help, verbal instruction, or supervision. (Patients who use physical aids to walk, e.g. stick/cane, walking frame/walker, but do not require another person's help, are NOT rated as requiring assistance to walk).	<input type="checkbox"/> Yes <input type="checkbox"/> No (4)

If yes, explain:

3 ASSISTANCE TO LOOK AFTER OWN AFFAIRS	
Assistance includes physical assistance, or verbal instruction, or supervision by another person. Central issue--Could the patient live alone for 1 week if he/she absolutely had to?	
3.1 Is assistance ABSOLUTELY essential for preparing a simple meal? (For example, able to prepare breakfast or a snack)	<input type="checkbox"/> Yes <input type="checkbox"/> No (3)
3.2 Is assistance ABSOLUTELY essential for basic household chores? (For example, finding and putting away clothes, clearing up after a meal. Exclude chores that do not need to be done every day, such as using a vacuum cleaner.)	<input type="checkbox"/> Yes <input type="checkbox"/> No (3)
3.3 Is assistance ABSOLUTELY essential for looking after household expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No (3)
3.4 Is assistance ABSOLUTELY essential for local travel? (Patients may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver.)	<input type="checkbox"/> Yes <input type="checkbox"/> No (3)
3.5 Is assistance ABSOLUTELY essential for local shopping? (Local shopping: at least able to buy a single item)	<input type="checkbox"/> Yes <input type="checkbox"/> No (3)

If yes to any of the above, explain:

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2. USUAL DUTIES AND ACTIVITIES. The next sets of questions are about how the patient usually spends his/her day.

2.1 Work

2.1	Has the new stroke substantially reduced (compared to prestroke status) the person's ability to work (or, for a student, study)? e.g. change from full-time to part-time, change in level of responsibility, or unable to work at all.	<input type="checkbox"/> Yes <input type="checkbox"/> No (2)
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If yes, explain:

2.2 Family responsibilities

2.2	Has the new stroke substantially reduced (compared to prestroke status) the person's ability to look after family at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No (2)
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If yes, explain:

2.3 Social & leisure activities

(Social and leisure activities include hobbies and interests. Includes activities outside the home or at home. Activities outside the home: going to the coffee shop, bar, restaurant, club, church, cinema, visiting friends, going for walks. Activities at home: involving "active" participation including knitting, sewing, painting, games, reading books, home improvements).

2.3	Has the new stroke reduced (compared to prestroke status) the person's regular free-time activities by more than one half as often?	<input type="checkbox"/> Yes <input type="checkbox"/> No (2)
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If yes, explain:

2.4 Other physical/medical condition

2.4	Are the patient's work, family, and/or social/leisure activities substantially reduced by a physical/medical condition other than the stroke that led to trial enrollment?	<input type="checkbox"/> Yes <input type="checkbox"/> No (2)
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Provide explanation if 1) answer is yes, but prestroke assessment section 2 answers were all no, or 2) answer is no, but any prestroke assessment 2 section answer was yes:

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1. SYMPTOMS AS A RESULT OF THE STROKE

(Can be any symptoms or problems reported by the patient).

1.1 SPONTANEOUSLY REPORTED SYMPTOMS

1.1 Does the patient have any symptoms resulting from the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
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If yes, record symptoms here:

1.2. SYMPTOM CHECKLIST

1.2.1 Does the person have difficulty reading or writing as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.2 Does the person have difficulty speaking or finding the right word as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.3 Does the person have problems with balance or coordination as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.4 Does the person have visual problems as a result of stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.5 Does the person have numbness (face, arms, legs, hands, feet) as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.6 Does the person have weakness or loss of movement (face, arms, legs, hands, feet) as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.7 Does the person have difficulty with swallowing as a result of the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)
1.2.8 Does the person have any other symptoms related to the new stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No (1)

Details supporting any “Yes” checked boxes in Section 1:

Rankin Grade =

Is this Rankin Grade score lower (better) than the prestroke Rankin Grade? Yes No

If yes, explain why:
