

# POST-STROKE CHECKLIST (PSC): IMPROVING LIFE AFTER STROKE



This Post-Stroke Checklist (PSC) has been developed to help healthcare professionals identify post-stroke problems amenable to treatment and/or referral. The PSC is a brief and easy-to-use tool, intended for completion with the patient and the help of a caregiver, if necessary. PSC administration provides a standardized approach for the identification of long-term problems in stroke survivors and facilitates appropriate referral for treatment.

## INSTRUCTIONS FOR USE:

Please ask the patient each numbered question and indicate the answer in the “response” section. In general, if the response is NO, update the patient record and review at next assessment. If the response is YES, follow-up with the appropriate action. Please note that the actions described in this version are for guidance and the ‘If Yes’ and ‘If No’ text boxes (highlighted in yellow) can and should be edited for local implementation.

1. SECONDARY PREVENTION			
Since your stroke or last assessment, have you received any advice on health related life style changes or medications for preventing another stroke?	<input type="checkbox"/> NO →		
	<input type="checkbox"/> YES →	Observe Progress	
2. ACTIVITIES OF DAILY LIVING (ADL)			
Since your stroke or last assessment, are you finding it <b>more</b> difficult to take care of yourself?	<input type="checkbox"/> NO →	Observe Progress	
	<input type="checkbox"/> YES →	Do you have difficulty dressing, washing and/or bathing? Do you have difficulty preparing hot drinks and/or meals? Do you have difficulty getting outside?	
3. MOBILITY			
Since your stroke or last assessment, are you finding it <b>more</b> difficult to walk or move safely from bed to chair?	<input type="checkbox"/> NO →	Observe Progress	
	<input type="checkbox"/> YES →	Are you continuing to receive rehabilitation therapy?	
4. SPASTICITY			
Since your stroke or last assessment, do you have <b>increasing</b> stiffness in your arms, hands, and/or legs?	<input type="checkbox"/> NO →	Observe Progress	
	<input type="checkbox"/> YES →	Is this interfering with activities of daily living, sleep or causing pain?	

## 5. PAIN

Since your stroke or last assessment, do you have any **new** pain?

**NO** →

Observe Progress

**YES** →

## 6. INCONTINENCE

Since your stroke or last assessment, are you having **more** of a problem controlling your bladder or bowels?

**NO** →

Observe Progress

**YES** →

## 7. COMMUNICATION

Since your stroke or last assessment, are you finding it **more** difficult to communicate with others?

**NO** →

Observe Progress

**YES** →

## 8. MOOD

Since your stroke or last assessment, do you feel **more** anxious or depressed?

**NO** →

Observe Progress

**YES** →

## 9. COGNITION

Since your stroke or last assessment, are you finding it **more** difficult to think, concentrate, or remember things?

**NO** →

Observe Progress

**YES** →

Does this interfere with activity or participation?

## 10. LIFE AFTER STROKE

Since your stroke or last assessment, are you finding things important to you **more** difficult to carry out (e.g. leisure activities, hobbies, work)?

**NO** →

Observe Progress

**YES** →

## 11. RELATIONSHIP WITH FAMILY

Since your stroke or last assessment, has your relationship with your family become **more** difficult or stressed?

**NO** →

Observe Progress

**YES** →