**DASH trial**
**Desmopressin for reversal of Antiplatelet drugs in Stroke due to Haemorrhage**

ISRCTN 67038373

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# Discharge or death in hospital form v1.1

**For participants with a long stay in hospital, this form is to be completed by day 90**

| Section A: Discharge/death details | | | |
|---|---|---|---|
| A1 | Date of data collection *(dd-mmm-yyyy)* | D _____ / M _____ / Y _____ | |
| A2 | Date of discharge or death *(dd-mmm-yyyy)* | D _____ / M _____ / Y _____ | |
| A3a | Discharge disposition | ☐ Home - independent<br>☐ Warden-aided flat<br>☐ Residential home<br>☐ Home - needing care<br>☐ Carer's home<br>☐ Respite care<br>☐ Care home<br>☐ Nursing home<br>☐ Rehabilitation hospital<br>☐ In hospital with readmission<br>☐ Still in hospital after admission<br>☐ Transfer to another hospital - neurosurgery<br>☐ Transfer to another hospital - ICU/ITU<br>☐ Transfer to another hospital - repatriation<br>☐ Died<br>☐ Other | ☐ Not known |
| A3b | If 'Transfer to another hospital', 'Died' or 'Other', please give details<br><br>For 'Transfer to another hospital', please state which hospital<br><br>For death, provide details about cause of death, where the participant died and contact details of place (if different from local investigators' hospital) | | ☐ Not applicable<br>☐ Not known |

| | | | |
|---|---|---|---|
| A4a | Did the participant have any hyponatraemia (low sodium) events after randomisation? | ☐ Yes<br>☐ No | ☐ Not known |
| A4b | If yes, what was the lowest sodium? | _____ mmol/L | ☐ Not applicable<br>☐ Not done<br>☐ Not known |
| A4c | If yes, date of sodium reading *(dd-mmm-yyyy)* | D ____ / M _____ / Y _____ | ☐ Not applicable<br>☐ Not known |
| A5 | Did the participant have any hypervolaemia (fluid overload) events after randomisation? | ☐ Yes<br>☐ No | ☐ Not known |
| A6 | Did the participant develop seizures after randomisation? | ☐ Yes<br>☐ No | ☐ Not known |
| A7 | Did the participant have any Serious Adverse Events?<br><br>**If 'yes', please complete a Serious Adverse Events form** | ☐ Yes<br>☐ No | ☐ Not known |
| | | | |
| A8a | What was the final diagnosis? | ☐ Intracerebral haemorrhage with no known underlying cause<br>☐ Intracerebral haemorrhage with underlying cause<br>☐ Ischaemic stroke with haemorrhagic transformation<br>☐ Ischaemic stroke without haemorrhagic transformation<br>☐ Non-stroke/other | ☐ Not known |
| A8b | If there was an underlying cause of ICH, what was it? | ☐ Amyloid angiopathy<br>☐ AVM<br>☐ Tumour<br>☐ Aneurysm<br>☐ Venous infarct<br>☐ Coagulopathy<br>☐ Hypertension<br>☐ Other | ☐ Not applicable<br>☐ Not known |
| A8c | If non-stroke or 'other' underlying cause, what was the cause? | | ☐ Not applicable |

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|---|---|---|---|---|---|---|---|
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| **Hospital number** | **C** | **Trial number** | | **Sex** | | **Investigator** | |
| **Date of collection** | d /m /y | **Initials** | | **Date of birth** | d /m /y | **Signature** | |

| Section B: Participant care | | | |
|---|---|---|---|
| B1a | Was neurosurgery performed? | ☐ Yes<br>☐ No | ☐ Not known |
| B1b | If yes, date of surgery | D ____ / M _____ / Y _____ | ☐ Not applicable<br>☐ Not known |
| B1c | If yes, type of surgery<br>*Please tick all that apply* | ☐ Craniotomy ☐ Haematoma drainage<br>☐ Endovascular coiling ☐ EVD insertion | ☐ Not applicable<br>☐ Not known |
| | | | |
| B2a | Transfer to intensive care unit? | ☐ Yes<br>☐ No | ☐ Not known |
| B2b | If yes, date of transfer | D ____ / M _____ / Y _____ | ☐ Not applicable<br>☐ Not known |
| | | | |
| B3a | Invasive ventilation? | ☐ Yes<br>☐ No | ☐ Not known |
| B3b | If yes, date of invasive ventilation | D ____ / M _____ / Y _____ | ☐ Not applicable<br>☐ Not known |
| | | | |
| B4a | Was a Do Not Attempt Resuscitation order put in place? | ☐ Yes<br>☐ No | ☐ Not known |
| B4b | If yes, date order was put in place? | D ____ / M _____ / Y _____ | ☐ Not applicable<br>☐ Not known |

| Section C: COVID-19 | | | |
|---|---|---|---|
| C1 | Is there definite or possible diagnosis of active COVID-19 based on:<br>• positive swab/antigen test,<br>• symptoms (cough, fever, lost taste/smell, fatigue), and/or<br>• chest X-ray/CT scan? | ☐ Definite (2 or 3 of these)<br>☐ Possible (one of these)<br>☐ Unlikely (none of these) | ☐ Not known |
| C2 | If the participant was diagnosed with COVID-19, which intervention(s) did they require?<br>*Please tick all that apply* | ☐ Oxygen<br>☐ ICU admission<br>☐ Mechanical ventilation<br>☐ Dexamethasone<br>☐ Remdesivir<br>☐ None of these | ☐ Not applicable<br>☐ Not known |

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|---|---|---|---|---|---|---|---|
| Hospital number | C | Trial number | | Sex | | Investigator | |
| Date of collection | d /m /y | Initials | | Date of birth | d /m /y | Signature | |

| | |
|---|---|
| Are any values missing due to tests not done (or measures not taken), or because data are unknown and every effort has been made to find the data – i.e. 'Not done' / 'Not known'? | ○ Yes ○ No |
| Comments<br><br>If any values are missing, please provide a full explanation | |

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