GALA GENERAL ANAESTHESIA vs LOCAL ANAESTHESIA FOR CAROTID SURGERY
ONE MONTH POST-SURGERY FOLLOW-UP FORM

To the physician: Please complete this form for your patient at their follow-up appointment 30 DAYS after their carotid surgery

HOSPITAL CODE NUMBER ☐☐☐ |_____|

Hospital name if code not available

PATIENT DETAILS:

Family name: |_____|

First names: |_____| Hospital number |_____|

Date of birth: dd |_____| / mm |_____| / yyyy |_____|

DISCHARGE DETAILS

1. Has this patient been discharged from hospital? **YES** ☐ *(Please tick one box)*
   NO ☐

   If **YES** give Date of discharge *(dd/mm/yyyy)* |_____/_____/_____|

   OR

   If still in hospital, give Ward number or name: Ward |_____|

   If still in hospital, give the name of the doctor responsible for their care Dr |_____|

2. Did the patient require **re**-operation? **YES** ☐
   NO ☐

   *If **YES** please give the reason below:*

COMPLICATIONS

Between randomisation and today's appointment date (including the pre-, peri-, and post-operative periods) did this patient have any of the following? *(Please answer Yes or No for each question)*

		YES	NO		For any YES answers please give the date below:
3.	Stroke of any type (more than 24 hours)? *	☐	☐	→	3. |____/____/_____| (dd/mm/yyyy)
4.	Transient ischaemic attack (brain) (less than 24 hours)? *	☐	☐	→	4. |____/____/_____| (dd/mm/yyyy)
5.	Retinal infarction (more than 24 hours)? *	☐	☐	→	5. |____/____/_____| (dd/mm/yyyy)
6.	Amaurosis fugax (less than 24 hours)? *	☐	☐	→	6. |____/____/_____| (dd/mm/yyyy)
7.	Myocardial infarction? *	☐	☐	→	7. |____/____/_____| (dd/mm/yyyy)
8.	New or worsening angina?	☐	☐	→	8. |____/____/_____| (dd/mm/yyyy)
9.	New arrhythmia requiring treatment?	☐	☐	→	9. |____/____/_____| (dd/mm/yyyy)
10.	New or worsening heart failure?	☐	☐	→	10.|____/____/_____| (dd/mm/yyyy)
11.	Has this patient died? *	☐	☐	→	11.|____/____/_____| (dd/mm/yyyy)

If this patient has died please give cause of death below:

*** If you have answered Yes to any question above with an asterisk (*) please complete a MAJOR EVENT FORM and send it to the GALA Trial Office**

Please turn over/

Between the induction of anaesthesia and today's appointment date did the patient have any of the following?

	(Please answer Yes or No for each question)	**YES**	**NO**
12.	Deep vein thrombosis?		
13.	Pulmonary embolism?		
14.	Retention of urine?		
15.	Chest infection?		
16.	Wound haematoma?		
17.	Wound infection?		
18.	Headache ipsilateral to surgery?		
19.	Lower cranial nerve injury (weak face or tongue, hoarseness etc.)?		

*Q19 - If **YES** please describe below↘*

		YES	**NO**
20.	Any other medical or surgical complication?		

*Q20 - If **YES** please describe below↘*

NAME OF INDEPENDENT STROKE PHYSICIAN OR NEUROLOGIST COMPLETING THIS FORM: |_____|

TODAY'S APPOINTMENT DATE: (dd/mm/yyyy) |_____/_____/_____|

Please post or fax this form to:

GALA Trial Co-ordinator, Neurosciences Trials Unit, Bramwell Dott Building,
Western General Hospital, Edinburgh EH4 2XU.
Fax: +44 131 332 5150
(an envelope is provided)