

Podcast: Patient Details**Fax: +44 (0)115 8230273**

ANY PROBLEMS CONTACT THE TRIAL OFFICE
on Telephone Number : + 44 (0) 115 8231671

CENTRE NUMBER :		FORM SUBMITTED BY :	
PATIENT'S INITIALS :	/ /	LOCAL SCREENING NUMBER :	
DATE OF INDEX STROKE :			

PATIENT INFORMATION

Surname :		First Name + Middle initials :	
Address:		Telephone No : (including country and area code)	
		Date of birth : (dd/mm/yyyy)	
Postcode:		Patient's NHS number : (if known, otherwise hospital number)	

GP DETAILS

Name :		Telephone No : (including country and area code)	
Address:			
Postcode:			

NEXT OF KIN

Next of Kin Name/relationship:		Telephone No : (including country and area code)	
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CLOSE RELATIVE/FRIEND

Close relative/friend's name::		Telephone No : (including country and area code)	
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CLRN name for each PCT linked to your hospital	
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LRN / SRN Region	
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Strategic Health Authority	
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Name and address of group practice (if applicable)	
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DATE OF COMPLETION AND SIGNATURE OF INVESTIGATOR :
