reach to grasp

REACH TO GRASP

COMMUNICATION SHEET

REACH TO GRASP Patient ID: | | | | | |

Date and time	Name	Message	Action

reach to grasp

REACH TO GRASP

RECEIVING REFERRALS CHECKLIST

REACH TO GRASP Patient ID: ☐☐☐☐☐

REFERRER AND PATIENT DETAILS

Referrer Details

Name: _____

Position: _____

Organisation: _____

Phone number: _____ *Bleep:* _____

Patient Details

Name: _____

Date of birth __ __ /__ __ /__ __ __ __
d d m m y y y y

Patient Contact Details

Address: _____

_____

Home number: _____ *Keysafe number:* _____

Mobile number: _____

Clinical Details

Aphasic: *Yes* ☐ *No* ☐ *Date of stroke:* __ __ /__ __ /__ __ __ __
d d m m y y y y

HEALTH AND SAFETY (H&S)

Any H&S issues identified

Any H&S control measures implemented

Access (eg. steps, stairs, lift, etc):

VIOLENT PATIENT SCHEME (VPS)

Is patient known to VPS: *Yes* ☐ *No* ☐

If yes, what are the details and what control measures are in place: _____

_____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

FIRST PHONE CALL CHECKLIST

REACH TO GRASP Patient ID: ☐☐☐☐☐

FIRST PHONE CALL	***Please tick***
Introduce self and ask if person has any questions regarding project	☐
Arrange appointment – date and time	☐
Does participant have a preferred time? *am* ☐ *pm* ☐ No preference ☐	
Ask if participant has a table	☐
Ask if any animals can be secured	☐
Ask for visitors not to be present at appointment time to standardise assessment	☐
Advise participant about suitable clothing for assessment, ie. forearm will need to be bare	☐
Check contact details for patient and that they have our contact details	☐

GP DETAILS

Name: _____

Address: _____

_____

Phone number: _____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

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reach to grasp

REACH TO GRASP

RESEARCH ASSOCIATE CHECKLIST

REACH TO GRASP Patient ID: ☐☐☐☐☐

DOCUMENTATION OF TASKS	***Please tick***
Original signed patient consent form filed in patient's CRF folder	☐
Copy of the signed patient consent form sent to GP	☐
Copy of the signed patient consent form given to the patient	☐
Copy of the GP letter filed in patient's CRF folder	☐
Manual handling risk assessment: *high* ☐ *medium* ☐ low ☐	
Manual handling risk assessment form completed: *Yes* ☐ *Not applicable* ☐	

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

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reach to grasp

REACH TO GRASP

RESEARCH PHYSIOTHERAPIST CHECKLIST

REACH TO GRASP Patient ID: ☐☐☐☐☐

DOCUMENTATION OF TASKS	***Please tick***
Randomised	☐
Patient informed of randomisation result	☐
Is patient receiving, or due to receive, therapy input? *Yes* ☐ *No* ☐	

If yes, what services, named contact and contact details: _____

_____

_____

If applicable, have usual care therapists been contacted? ☐

'Recovery after Stroke' booklet sent ☐

7 week follow-up arranged ☐ Date and time __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) ___ ___ : ___ ___ (*24 hr clock*)

3 month follow-up arranged ☐ Date and time __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) ___ ___ : ___ ___ (*24 hr clock*)

6 month follow-up arranged ☐ Date and time __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) ___ ___ : ___ ___ (*24 hr clock*)

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
PAST HISTORY

A1

REACH TO GRASP Patient ID: ☐☐☐☐☐

DEMOGRAPHICS

Gender *Male* ☐ *Female* ☐

Date of birth __ __ /__ __ /__ __ __ __
d d m m y y y y

	Left	Right	Both
Side of deficit or weakness	☐	☐	☐
Handedness	☐	☐	☐

Living:
- *Living Alone* ☐
- *With family or friends* ☐

Residence (Tick one only)
- *Sheltered accommodation* ☐
- *Residential care* ☐
- *Nursing home* ☐

STROKE DETAILS

Date of stroke __ __ /__ __ /__ __ __ __
d d m m y y y y

Stroke type (Tick one only)
- *Infarct* ☐
- *Haemorrhage* ☐
- *Subarachnoid haemorrhage* ☐
- *Unknown* ☐

Thrombolysed *Yes* ☐ *No* ☐

Name of hospital admitted to _____

Stroke subtype (Tick one only)
- *Total anterior* ☐
- *Partial anterior* ☐
- *Lacunar* ☐
- *Posterior circulation* ☐
- *Unknown* ☐

NIHSS Score on admission ☐☐

Scan available *Yes* ☐ *No* ☐

HOSPITAL DISCHARGE

Acute trust length of stay (includes ESD)

Date admitted __ __ /__ __ /__ __ __ __
d d m m y y y y

Date discharged __ __ /__ __ /__ __ __ __
d d m m y y y y

Rehabilitation since discharge from hospital

Early Supported Discharge (ESD)	*Yes* ☐	*No* ☐
Outpatients	*Yes* ☐	*No* ☐
Community physio or OT for arm including DART or ICT	*Yes* ☐	*No* ☐
Botox Therapy	*Yes* ☐	*No* ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

CO- MORBIDITIES

A2

REACH TO GRASP Patient ID: ☐☐☐☐☐

CO-MORBIDITIES

Previous stroke or transient ischaemic attack	*Yes* ☐	*No* ☐
Ischaemic heart disease	*Yes* ☐	*No* ☐
Diabetes mellitus	*Yes* ☐	*No* ☐
Peripheral vascular disease	*Yes* ☐	*No* ☐
Hypertension	*Yes* ☐	*No* ☐
Hyperlipidaemia	*Yes* ☐	*No* ☐
Atrial fibrillation	*Yes* ☐	*No* ☐
Arthritis affecting upper limb	*Yes* ☐	*No* ☐
Depression	*Yes* ☐	*No* ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
COGNITIVE TESTS AND TABLE AND CHAIR DETAILS AT BASELINE

B0

REACH TO GRASP Patient ID: ☐☐☐☐☐

MOCA COGNITIVE TEST

	Score		
Alternating trail making	☐	Language	☐
Visuoconstructional skills (cube)	☐	Abstraction	☐
Visuoconstructional skills (clock)	☐	Delayed recall	☐
Memory	☐	Orientation	☐
Attention	☐	≤ 12 years in education	*Yes* ☐ *No* ☐

ADDITIONAL INFORMATION

*Date / time of **baseline** assessment:* __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) __ __ /__ __ (*h h m m*) Any AE's: *Yes* ☐ *No* ☐

Table height ☐☐☐ cms Chair height ☐☐☐ cms Arm rest on chair *Yes* ☐ *No* ☐

*Date / time of **7 week** assessment:* __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) __ __ /__ __ (*h h m m*) Any AE's: *Yes* ☐ *No* ☐

Other chair used? *Yes* ☐ *No* ☐ If yes: Chair height ☐☐☐ cms Arm rest on chair *Yes* ☐ *No* ☐

Why other chair used: _____

*Date / time of **3 month** assessment:* __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) __ __ /__ __ (*h h m m*) Any AE's: *Yes* ☐ *No* ☐

Other chair used? *Yes* ☐ *No* ☐ If yes: Chair height ☐☐☐ cms Arm rest on chair *Yes* ☐ *No* ☐

Why other chair used: _____

*Date / time of **6 month** assessment:* __ __ /__ __ /__ __ __ __ (*d d m m y y y y*) __ __ /__ __ (*h h m m*) Any AE's: *Yes* ☐ *No* ☐

Other chair used? *Yes* ☐ *No* ☐ If yes: Chair height ☐☐☐ cms Arm rest on chair *Yes* ☐ *No* ☐

Why other chair used: _____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B1

REACH TO GRASP Patient ID: ☐☐☐☐☐

VISUAL ANALOGUE SCALE — BASELINE

How would you rate any pain you have now? ☐☐ How would you rate any pain you have at other times? ☐☐

ACTION RESEARCH ARM TEST (ARAT) — BASELINE

Grasp *Score*

1. Pick up 10cm block ☐ If score =3, total =18 and go to grip
2. Pick up 2.5 block ☐ If score = 0, total = 0 and go to grip
3. Block, wood, 5cm cube ☐
4. Block, wood, 7.5cm ☐
5. Cricket ball, 7.5cm ☐
6. Stone 10 x 2.5 x 1cm ☐ Grasp Total ☐☐

Grip

1. Pour water from glass ☐ If score =3, total =12 and go to pinch
2. Tube 2.25cm ☐ If score = 0, total = 0 and go to pinch
3. Tube 1 x 16 cm ☐
4. Washer (3.5 cm) ☐ Grip Total ☐☐

Pinch

1. Ball bearing 3rd finger ☐ If score =3, total =18 and go to gross movement
2. Marble 1st finger ☐ If score = 0, total = 0 and go to gross movement
3. Ball bearing 2nd finger ☐
4. Ball bearing 1st finger ☐
5. Marble 3rd finger ☐
6. Marble 2nd finger ☐ Pinch Total ☐☐

Gross Movement

1. Place hand behind head ☐ If score =3, total = 9 and finish If score = 0, total = 0 and go to finish
2. Place hand top of head ☐ Gross movement Total ☐☐
3. Hand to mouth ☐ **ARAT Total** ☐☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B2

REACH TO GRASP Patient ID: ☐☐☐☐☐

WOLF MOTOR FUNCTION TEST — BASELINE

	TIME (secs)	QUALITY (0-5)
1.Forearm table	☐☐☐	☐
2.Forearm box	☐☐☐	☐
3.Ex. elbow	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
4.Ex.elbow/W	☐☐☐	☐
5. Hand table	☐☐☐	☐
6.Hand box	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
7.Weight box	☐☐ lbs	☐
8.Reach & R	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
9.Lift can	☐☐☐	☐
10.Lift pencil	☐☐☐	☐
11.Pick clip	☐☐☐	☐
12.Stack	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
13.Flip cards	☐☐☐	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
15.Turn key	☐☐☐	☐
16.Fold towel	☐☐☐	☐
17.Lift basket	☐☐☐	☐

Height of box used: 6 inches ☐ 8 inches ☐ 10 inches ☐

VISUAL ANALOGUE SCALE — BASELINE

How would you rate any pain you experienced during the assessment? ☐☐

MOTOR ACTIVITY LOG — BASELINE

	QoM	AoU
1. Light switch	☐	☐
2. Open draw.	☐	☐
3. Remove clo	☐	☐
4. Phone	☐	☐
5. Wipe surface	☐	☐
6. Out of car	☐	☐
7. Op. fridge	☐	☐

	QoM	AoU
8. Op. door	☐	☐
9. TV remote	☐	☐
10. W/hands	☐	☐
11. Turn taps	☐	☐
12. Dry hands	☐	☐
13. Socks on	☐	☐
14. Socks off	☐	☐

	QoM	AoU
15. Shoes on	☐	☐
16. Shoes off	☐	☐
17. Chair	☐	☐
18. Pull chair	☐	☐
19. Chair sit	☐	☐
20. Glass/cup	☐	☐
21. Teeth	☐	☐

	QoM	AoU
22. Key	☐	☐
23. Carry obj	☐	☐
24. Fork/sp	☐	☐
25. Comb	☐	☐
26. Pick cup	☐	☐
27. But. shirt	☐	☐
28. Eat sandw	☐	☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

OUTCOME MEASURES

B3

REACH TO GRASP Patient ID: ☐☐☐☐☐

STROKE IMPACT SCALE 3.0 — BASELINE

	a	b	c	d	e	f	g	h	i	j
Physical domain score	☐	☐	☐	☐	■	■	■	■	■	■
Memory & thinking score	☐	☐	☐	☐	☐	☐	☐	■	■	■
Emotion domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Communication score	☐	☐	☐	☐	☐	☐	☐	■	■	■
ADL/IADL domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mobility score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Hand function score	☐	☐	☐	☐	☐	■	■	■	■	■
Participation score	☐	☐	☐	☐	☐	☐	☐	☐	■	■

Stroke recovery
Recovery rating (0—100) ☐☐☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **B4**

MAL REFLECTION SHEET

REACH TO GRASP Patient ID: | | | | | |

BASELINE

7 WEEKS

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **B5**

MAL REFLECTION SHEET

REACH TO GRASP Patient ID: | | | | | |

3 MONTHS

6 MONTHS

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B1

REACH TO GRASP Patient ID: ☐☐☐☐☐

VISUAL ANALOGUE SCALE — 7 WEEKS

How would you rate any pain you have now? ☐☐ How would you rate any pain you have at other times? ☐☐

ACTION RESEARCH ARM TEST (ARAT) — 7 WEEKS

Grasp *Score*

1. Pick up 10cm block	☐☐	If score =3, total =18 and go to grip
2. Pick up 2.5 block	☐☐	If score = 0, total = 0 and go to grip
3. Block, wood, 5cm cube	☐☐	
4. Block, wood, 7.5cm	☐☐	
5. Cricket ball, 7.5cm	☐☐	
6. Stone 10 x 2.5 x 1cm	☐☐	Grasp Total ☐☐

Grip

1. Pour water from glass	☐☐	If score =3, total =12 and go to pinch
2. Tube 2.25cm	☐☐	If score = 0, total = 0 and go to pinch
3. Tube 1 x 16 cm	☐☐	
4. Washer (3.5 cm)	☐☐	Grip Total ☐☐

Pinch

1. Ball bearing 3rd finger	☐☐	If score =3, total =18 and go to gross movement
2. Marble 1st finger	☐☐	If score = 0, total = 0 and go to gross movement
3. Ball bearing 2nd finger	☐☐	
4. Ball bearing 1st finger	☐☐	
5. Marble 3rd finger	☐☐	
6. Marble 2nd finger	☐☐	Pinch Total ☐☐

Gross movement

1. Place hand behind head	☐☐	If score =3, total = 9 and finish — If score = 0, total = 0 and go to finish
2. Place hand top of head	☐☐	Gross movement Total ☐☐
3. Hand to mouth	☐☐	**ARAT Total** ☐☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B2

REACH TO GRASP Patient ID: ☐☐☐☐☐

WOLF MOTOR FUNCTION TEST — 7 WEEKS

	TIME (secs)	QUALITY (0-5)
1.Forearm table	☐☐☐	☐
2.Forearm box	☐☐☐	☐
3.Ex. elbow	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
4.Ex.elbow/W	☐☐☐	☐
5. Hand table	☐☐☐	☐
6.Hand box	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
7.Weight box	☐☐ lbs	☐
8.Reach & R	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
9.Lift can	☐☐☐	☐
10.Lift pencil	☐☐☐	☐
11.Pick clip	☐☐☐	☐
12.Stack	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
13.Flip cards	☐☐☐	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
15.Turn key	☐☐☐	☐
16.Fold towel	☐☐☐	☐
17.Lift basket	☐☐☐	☐

Height of box used: 6 inches ☐ 8 inches ☐ 10 inches ☐

VISUAL ANALOGUE SCALE — 7 WEEKS

How would you rate any pain you experienced during the assessment? ☐☐

MOTOR ACTIVITY LOG — 7 WEEKS

	QoM	AoU
1. Light switch	☐	☐
2. Open draw.	☐	☐
3. Remove clo	☐	☐
4. Phone	☐	☐
5. Wipe surface	☐	☐
6. Out of car	☐	☐
7. Op. fridge	☐	☐

	QoM	AoU
8. Op. door	☐	☐
9. TV remote	☐	☐
10. W/hands	☐	☐
11. Turn taps	☐	☐
12. Dry hands	☐	☐
13. Socks on	☐	☐
14. Socks off	☐	☐

	QoM	AoU
15. Shoes on	☐	☐
16. Shoes off	☐	☐
17. Chair	☐	☐
18. Pull chair	☐	☐
19. Chair sit	☐	☐
20. Glass/cup	☐	☐
21. Teeth	☐	☐

	QoM	AoU
22. Key	☐	☐
23. Carry obj	☐	☐
24. Fork/sp	☐	☐
25. Comb	☐	☐
26. Pick cup	☐	☐
27. But. shirt	☐	☐
28. Eat sandw	☐	☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

OUTCOME MEASURES

B3

REACH TO GRASP Patient ID: ☐☐☐☐☐

STROKE IMPACT SCALE 3.0 — 7 WEEKS

	a	b	c	d	e	f	g	h	i	j
Physical domain score	☐	☐	☐	☐	■	■	■	■	■	■
Memory & thinking score	☐	☐	☐	☐	☐	☐	☐	■	■	■
Emotion domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Communication score	☐	☐	☐	☐	☐	☐	☐	■	■	■
ADL/IADL domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mobility score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Hand function score	☐	☐	☐	☐	☐	■	■	■	■	■
Participation score	☐	☐	☐	☐	☐	☐	☐	☐	■	■

Stroke recovery
Recovery rating (0—100) ☐☐☐

Blinding — 7 WEEKS

I am blind to participant's treatment allocation ☐

I think I may have been unblinded (see note to file) ☐

I have definitely been unblinded (see note to file) ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B1

REACH TO GRASP Patient ID: ☐☐☐☐☐

VISUAL ANALOGUE SCALE — 3 MONTHS

How would you rate any pain you have now? ☐☐ How would you rate any pain you have at other times? ☐☐

ACTION RESEARCH ARM TEST (ARAT) — 3 MONTHS

Grasp *Score*

1. Pick up 10cm block	☐☐	If score =3, total =18 and go to grip
2. Pick up 2.5 block	☐☐	If score = 0, total = 0 and go to grip
3. Block, wood, 5cm cube	☐☐	
4. Block, wood, 7.5cm	☐☐	
5. Cricket ball, 7.5cm	☐☐	
6. Stone 10 x 2.5 x 1cm	☐☐	Grasp Total ☐☐

Grip

1. Pour water from glass	☐☐	If score =3, total =12 and go to pinch
2. Tube 2.25cm	☐☐	If score = 0, total = 0 and go to pinch
3. Tube 1 x 16 cm	☐☐	
4. Washer (3.5 cm)	☐☐	Grip Total ☐☐

Pinch

1. Ball bearing 3rd finger	☐☐	If score =3, total =18 and go to gross movement
2. Marble 1st finger	☐☐	If score = 0, total = 0 and go to gross movement
3. Ball bearing 2nd finger	☐☐	
4. Ball bearing 1st finger	☐☐	
5. Marble 3rd finger	☐☐	
6. Marble 2nd finger	☐☐	Pinch Total ☐☐

Gross movement

1. Place hand behind head	☐☐	If score =3, total = 9 and finish — If score = 0, total = 0 and go to finish
2. Place hand top of head	☐☐	Gross movement Total ☐☐
3. Hand to mouth	☐☐	**ARAT Total** ☐☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B2

REACH TO GRASP Patient ID: ☐☐☐☐☐

WOLF MOTOR FUNCTION TEST — 3 MONTHS

	TIME (secs)	QUALITY (0-5)
1.Forearm table	☐☐☐	☐
2.Forearm box	☐☐☐	☐
3.Ex. elbow	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
4.Ex.elbow/W	☐☐☐	☐
5. Hand table	☐☐☐	☐
6.Hand box	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
7.Weight box	☐☐ lbs	☐
8.Reach & R	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
9.Lift can	☐☐☐	☐
10.Lift pencil	☐☐☐	☐
11.Pick clip	☐☐☐	☐
12.Stack	☐☐☐	☐

	TIME (secs)	QUALITY (0-5)
13.Flip cards	☐☐☐	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
15.Turn key	☐☐☐	☐
16.Fold towel	☐☐☐	☐
17.Lift basket	☐☐☐	☐

Height of box used: 6 inches ☐ 8 inches ☐ 10 inches ☐

VISUAL ANALOGUE SCALE — 3 MONTHS

How would you rate any pain you experienced during the assessment? ☐☐

MOTOR ACTIVITY LOG — 3 MONTHS

	QoM	AoU
1. Light switch	☐	☐
2. Open draw.	☐	☐
3. Remove clo	☐	☐
4. Phone	☐	☐
5. Wipe surface	☐	☐
6. Out of car	☐	☐
7. Op. fridge	☐	☐

	QoM	AoU
8. Op. door	☐	☐
9. TV remote	☐	☐
10. W/hands	☐	☐
11. Turn taps	☐	☐
12. Dry hands	☐	☐
13. Socks on	☐	☐
14. Socks off	☐	☐

	QoM	AoU
15. Shoes on	☐	☐
16. Shoes off	☐	☐
17. Chair	☐	☐
18. Pull chair	☐	☐
19. Chair sit	☐	☐
20. Glass/cup	☐	☐
21. Teeth	☐	☐

	QoM	AoU
22. Key	☐	☐
23. Carry obj	☐	☐
24. Fork/sp	☐	☐
25. Comb	☐	☐
26. Pick cup	☐	☐
27. But. shirt	☐	☐
28. Eat sandw	☐	☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

OUTCOME MEASURES

B3

REACH TO GRASP Patient ID: ☐☐☐☐☐

STROKE IMPACT SCALE 3.0 — 3 MONTHS

	a	b	c	d	e	f	g	h	i	j
Physical domain score	☐	☐	☐	☐	■	■	■	■	■	■
Memory & thinking score	☐	☐	☐	☐	☐	☐	☐	■	■	■
Emotion domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Communication score	☐	☐	☐	☐	☐	☐	☐	■	■	■
ADL/IADL domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mobility score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Hand function score	☐	☐	☐	☐	☐	■	■	■	■	■
Participation score	☐	☐	☐	☐	☐	☐	☐	☐	■	■

Stroke recovery
Recovery rating (0—100) ☐☐☐

Blinding — 3 MONTHS

I am blind to participant's treatment allocation ☐

I think I may have been unblinded (see note to file) ☐

I have definitely been unblinded (see note to file) ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B1

REACH TO GRASP Patient ID: ☐☐☐☐☐

VISUAL ANALOGUE SCALE — 6 MONTHS

How would you rate any pain you have now? ☐☐ How would you rate any pain you have at other times? ☐☐

ACTION RESEARCH ARM TEST (ARAT) — 6 MONTHS

Grasp *Score*

1. Pick up 10cm block ☐☐ If score =3, total =18 and go to grip
2. Pick up 2.5 block ☐☐ If score = 0, total = 0 and go to grip
3. Block, wood, 5cm cube ☐☐
4. Block, wood, 7.5cm ☐☐
5. Cricket ball, 7.5cm ☐☐
6. Stone 10 x 2.5 x 1cm ☐☐

Grasp Total ☐☐

Grip

1. Pour water from glass ☐☐ If score =3, total =12 and go to pinch
2. Tube 2.25cm ☐☐ If score = 0, total = 0 and go to pinch
3. Tube 1 x 16 cm ☐☐
4. Washer (3.5 cm) ☐☐

Grip Total ☐☐

Pinch

1. Ball bearing 3rd finger ☐☐ If score =3, total =18 and go to gross movement
2. Marble 1st finger ☐☐ If score = 0, total = 0 and go to gross movement
3. Ball bearing 2nd finger ☐☐
4. Ball bearing 1st finger ☐☐
5. Marble 3rd finger ☐☐
6. Marble 2nd finger ☐☐

Pinch Total ☐☐

Gross movement

1. Place hand behind head ☐☐ If score =3, total = 9 and finish
2. Place hand top of head ☐☐
3. Hand to mouth ☐☐

If score = 0, total = 0 and go to finish

Gross movement Total ☐☐

ARAT Total ☐☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B2

REACH TO GRASP Patient ID: ☐☐☐☐☐

WOLF MOTOR FUNCTION TEST — 6 MONTHS

	TIME (secs)	QUALITY (0-5)
1.Forearm table	☐☐☐	☐
2.Forearm box	☐☐☐	☐
3.Ex. elbow	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
4.Ex.elbow/W	☐☐☐	☐
5. Hand table	☐☐☐	☐
6.Hand box	☐☐☐	☐
7.Weight box	☐☐ lbs	☐
8.Reach & R	☐☐☐	☐
Talc ☐ Duster ☐ Neither ☐		
9.Lift can	☐☐☐	☐
10.Lift pencil	☐☐☐	☐
11.Pick clip	☐☐☐	☐
12.Stack	☐☐☐	☐
13.Flip cards	☐☐☐	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
14.Grip stgth	☐☐ Kg	☐
15.Turn key	☐☐☐	☐
16.Fold towel	☐☐☐	☐
17.Lift basket	☐☐☐	☐

Height of box used: 6 inches ☐ 8 inches ☐ 10 inches ☐

VISUAL ANALOGUE SCALE — 6 MONTHS

How would you rate any pain you experienced during the assessment? ☐☐

MOTOR ACTIVITY LOG — 6 MONTHS

	QoM	AoU
1. Light switch	☐	☐
2. Open draw.	☐	☐
3. Remove clo	☐	☐
4. Phone	☐	☐
5. Wipe surface	☐	☐
6. Out of car	☐	☐
7. Op. fridge	☐	☐
8. Op. door	☐	☐
9. TV remote	☐	☐
10. W/hands	☐	☐
11. Turn taps	☐	☐
12. Dry hands	☐	☐
13. Socks on	☐	☐
14. Socks off	☐	☐
15. Shoes on	☐	☐
16. Shoes off	☐	☐
17. Chair	☐	☐
18. Pull chair	☐	☐
19. Chair sit	☐	☐
20. Glass/cup	☐	☐
21. Teeth	☐	☐
22. Key	☐	☐
23. Carry obj	☐	☐
24. Fork/sp	☐	☐
25. Comb	☐	☐
26. Pick cup	☐	☐
27. But. shirt	☐	☐
28. Eat sandw	☐	☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

OUTCOME MEASURES

B3

REACH TO GRASP Patient ID: ☐☐☐☐☐

STROKE IMPACT SCALE 3.0 — 6 MONTHS

	a	b	c	d	e	f	g	h	i	j
Physical domain score	☐	☐	☐	☐	■	■	■	■	■	■
Memory & thinking score	☐	☐	☐	☐	☐	☐	☐	■	■	■
Emotion domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Communication score	☐	☐	☐	☐	☐	☐	☐	■	■	■
ADL/IADL domain score	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mobility score	☐	☐	☐	☐	☐	☐	☐	☐	☐	■
Hand function score	☐	☐	☐	☐	☐	■	■	■	■	■
Participation score	☐	☐	☐	☐	☐	☐	☐	☐	■	■

Stroke recovery
Recovery rating (0—100) ☐☐☐

Blinding — 6 MONTHS

I am blind to participant's treatment allocation ☐

I think I may have been unblinded (see note to file) ☐

I have definitely been unblinded (see note to file) ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **B4**

OUTCOME MEASURES

REACH TO GRASP Patient ID: ☐☐☐☐☐

HEALTH AND SOCIAL QUESTIONNAIRE — 3 MONTHS

Q1. Attended A&E during the last 3 months *Yes* ☐ *No* ☐ If **NO**, go to Q2
If **YES,** how many times? ☐☐

Q2. Stayed in hospital overnight during last 3 months *Yes* ☐ *No* ☐ If **NO**, go to Q3
If **YES,** please complete below

Admission	Reason for admission	Ward/Dept (if known)	No.of nights
1st	_____	_____	☐☐
2nd	_____	_____	☐☐
3rd	_____	_____	☐☐

Q3. Attended hospital for an outpatient appt during last 3 months *Yes* ☐ *No* ☐ If **NO**, go to Q4
If **YES,** please complete below

Outpatient visits	No.of one to one sessions	No.of group sessions
Stroke consultant	☐☐	☐☐
Stroke nurse	☐☐	☐☐
Physiotherapist	☐☐	☐☐
Occupational therapist	☐☐	☐☐

Other *(Please specify)* _____

Q4. Visited GP/health centre or received healthcare at home during last 3 months *Yes* ☐ *No* ☐ If **NO**, go to Q5
If **YES,** please complete below

	GP/Health centre		**At home**	
	No.of one to one sessions	No.of group sessions	No.of one to one sessions	No.of group sessions
GP	☐☐	☐☐	☐☐	☐☐
Practice nurse	☐☐	☐☐	☐☐	☐☐
Physiotherapist	☐☐	☐☐	☐☐	☐☐
Occupational therapist	☐☐	☐☐	☐☐	☐☐

Other *(Please specify)* _____ _____

Q5. Received home help for personal care/ household tasks during last 3 months *Yes* ☐ *No* ☐ If **YES,** please specify: _____

Q6. Used equipment/aids to help day to day living during last 3 months *Yes* ☐ *No* ☐ If **YES,** please specify: _____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP
OUTCOME MEASURES

B4

REACH TO GRASP Patient ID: ☐☐☐☐☐

HEALTH AND SOCIAL QUESTIONNAIRE — 6 MONTHS

Q1. Attended A&E during the last 3 months — *Yes* ☐ *No* ☐
If **NO**, go to Q2
If **YES,** how many times? ☐☐

Q2. Stayed in hospital overnight during last 3 months — *Yes* ☐ *No* ☐
If **NO**, go to Q3
If **YES,** please complete below

Admission	Reason for admission	Ward/Dept (if known)	No.of nights
1st	_____	_____	☐☐
2nd	_____	_____	☐☐
3rd	_____	_____	☐☐

Q3. Attended hospital for an outpatient appt during last 3 months — *Yes* ☐ *No* ☐
If **NO**, go to Q4
If **YES,** please complete below

Outpatient visits	No.of one to one sessions	No.of group sessions
Stroke consultant	☐☐	☐☐
Stroke nurse	☐☐	☐☐
Physiotherapist	☐☐	☐☐
Occupational therapist	☐☐	☐☐
Other *(Please specify)*	_____	

Q4. Visited GP/health centre or received healthcare at home during last 3 months — *Yes* ☐ *No* ☐
If **NO**, go to Q5
If **YES,** please complete below

	GP/Health centre		**At home**	
	No.of one to one sessions	No.of group sessions	No.of one to one sessions	No.of group sessions
GP	☐☐	☐☐	☐☐	☐☐
Practice nurse	☐☐	☐☐	☐☐	☐☐
Physiotherapist	☐☐	☐☐	☐☐	☐☐
Occupational therapist	☐☐	☐☐	☐☐	☐☐
Other *(Please specify)*	_____		_____	

Q5. Received home help for personal care/ household tasks during last 3 months — *Yes* ☐ *No* ☐ If **YES,** please specify: _____

Q6. Used equipment/aids to help day to day living during last 3 months — *Yes* ☐ *No* ☐ If **YES,** please specify: _____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **B5**

OUTCOME MEASURES

REACH TO GRASP Patient ID: ☐☐☐☐☐

CARER STRAIN INDEX — 3 MONTHS

Patient's consent to ask carer *Yes* ☐ *No* ☐ Carer's consent *Yes* ☐ *No* ☐

Sleep is disturbed	*Yes* ☐	*No* ☐
It is inconvenient	*Yes* ☐	*No* ☐
It is a physical strain	*Yes* ☐	*No* ☐
It is confining	*Yes* ☐	*No* ☐
Family adjustments	*Yes* ☐	*No* ☐
Changes in personal plans	*Yes* ☐	*No* ☐
Other demands on time	*Yes* ☐	*No* ☐
Emotional adjustments	*Yes* ☐	*No* ☐
Behaviour is upsetting	*Yes* ☐	*No* ☐
Upsetting person has changed	*Yes* ☐	*No* ☐
Work adjustments	*Yes* ☐	*No* ☐
Financial strain	*Yes* ☐	*No* ☐
Completely overwhelmed	*Yes* ☐	*No* ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

OUTCOME MEASURES

REACH TO GRASP Patient ID: | | | | | |

CARER STRAIN INDEX — 6 MONTHS

Patient's consent to ask carer *Yes* ☐ *No* ☐ Carer's consent *Yes* ☐ *No* ☐

Sleep is disturbed	*Yes* ☐	*No* ☐
It is inconvenient	*Yes* ☐	*No* ☐
It is a physical strain	*Yes* ☐	*No* ☐
It is confining	*Yes* ☐	*No* ☐
Family adjustments	*Yes* ☐	*No* ☐
Changes in personal plans	*Yes* ☐	*No* ☐
Other demands on time	*Yes* ☐	*No* ☐
Emotional adjustments	*Yes* ☐	*No* ☐
Behaviour is upsetting	*Yes* ☐	*No* ☐
Upsetting person has changed	*Yes* ☐	*No* ☐
Work adjustments	*Yes* ☐	*No* ☐
Financial strain	*Yes* ☐	*No* ☐
Completely overwhelmed	*Yes* ☐	*No* ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

EXERCISES

REACH TO GRASP Patient ID: | | | | | |

THERAPY LOG **Visit number: ___ ___ of 14**

Visit duration: __ __ __ mins Treatment duration: __ __ __ mins

Subjective:

Consent: *Yes* ☐ *No* ☐

Objective:

Analysis:

Plan:

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) Date data entered *(dd/mm/yyyy)*

_____ __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **B6**

EXERCISES

REACH TO GRASP Patient ID: ☐☐☐☐☐

THERAPY LOG						**Visit number: ___ ___ of 14**
Comments & notes						
Variation	☐ *No* ☐ *Yes*	☐ *No* ☐ *Yes*	☐ *No* ☐ *Yes*	☐ *No* ☐ *Yes*	☐ *No* ☐ *Yes*	☐ *No* ☐ *Yes*
Exercise Description						
Time (mins)	||	||	||	||	||	||
Repetitions	|||	|||	|||	|||	|||	|||
Exercise	||||	||||	||||	||||	||||	||||

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

EXERCISE LOG

B7

REACH TO GRASP Patient ID: | | | | | |

EXERCISE LOG (PATIENTS)

Week beginning __ __ /__ __ /__ __ __ __
d d m m y y y y

Day	Duration (mins)	Exercise	Reps	Exercise	Reps	Exercise	Reps	Exercise	Reps
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___

Comments _____

_____

Week beginning __ __ /__ __ /__ __ __ __
d d m m y y y y

Day	Duration (mins)	Exercise	Reps	Exercise	Reps	Exercise	Reps	Exercise	Reps
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___
____	___	_____	___	_____	___	_____	___	_____	___

Comments _____

_____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

USUAL CARE LOG

B8

REACH TO GRASP Patient ID: | | | | | |

UPPER LIMB TREATMENT SESSION RECORDING FORM

Duration of upper limb treatment: .....

Aims of treatment	1. Postural control		2. Musculo-skeletal range of motion		3. Oedema management			
	4. Alignment		5. Manipulative ability of the hand		6. Sensory ability			
	7. Muscle activity paretic upper limb		8. Transport ability of the arm		9. Prevent / reduce pain			
	10. Muscle activity non-paretic upper limb		11. Incorporate arm into balance and mobility activity		12. Awareness of secondary complications			

Gross position of patient during upper limb treatment	1. Supine		2. Prone		3. Side-lying on unaffected side		4. Side-lying on affected side	
	5. 4-point kneeling		6. 2-point kneeling		7. Unsupported Sitting		8. Supported Sitting	
	9. Standing		10. Perch Sitting		11. Asymmetrical Sitting		12. Prone Sitting	

Setting:	1. Living Room		2. Kitchen		3. Bedroom		4. Bathroom	
	5. Stairs		6. Outside		7. Gym		8. Hydrotherapy/swimming pool	
Other (please state):								

Equipment Used: .....

1) Soft Tissue Mobilisation	
a. Stroking	
b. Effleurage	
c. Lymph drainage techniques	
d. Petrissage (kneading/wringing/picking-up/rolling)	
e. Specific compression (trigger points)	
f. Myofascial release	
g. Frictions	
2) Joint Mobilisation	
a. Accessory movements	
b. Passive movements	
c. Active movements	
3) Facility of muscle activity/movement	
a. Mental imagery	
b. Patient generated cueing	
c. Therapist generated cueing	
d. 'Hands on' to induce a desired motor response	
e. Active assisted	
f. Facilitated arm / hand activity from another body part	
g. Restricted use of non-paretic limb	
4) Positioning	
a. Side-lying hemiplegic side	
b. Side-lying non-hemiplegic side	
c. Supine lying	
d. Half lying	
e. Sitting in armchair	
f. Forwards lean sitting	
g. Sitting in wheelchair	

5) Specific sensory input	
a. Tactile stimulation	
b. Proprioceptive stimulation	
c. Electrical stimulation used passively for:	
6) *Splinting techniques*	
a. Shoulder support	
b. Elbow support	
c. Wrist / hand support	
d. Splinting material used	
7) Exercise to increase strength	
a. Resistance from the therapist	
b. Resistance from body weight	
c. Resistance from equipment	
d. Gravity neutral repetitive movement	
8) Balance and mobility incorporating upper limb activity	
a. In, or from, lying	
b. In, or from, kneeling	
c. In, or from, sitting	
d. In, or from, standing	
e. In walking	
9) Education for patient and / or carer	
a. To encourage self monitoring of upper limb	
b. Transfers training	
c. Limb handling and positioning skills	
d. Written / visual / photo exercise programme	
10) Other interventions / techniques	
a. Acupuncture	
b. Ultrasound	
c. Compression	
d. Other.....	

11) Upper Limb Functional Tasks	**Number of reps of tasks performed in session (no adjunct)**	**Reps with adjunct.....** (eg. FES, Saeboflex, virtual reality, metro-
a. Bilateral functional activities		
b. Unilateral reaching activities that are object directed		
c. Unilateral reaching activities that are spatially directed		
d. Dexterity exercises		

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

USUAL CARE LOG

REACH TO GRASP Patient ID: | | | | | |

INSTRUCTIONS FOR COMPLETING THE TREATMENT SCHEDULE RECORDING FORM

1. One form for each treatment session

Please complete one form for each treatment session given to patients included as subjects in the 'Pilot Study for a Randomised Controlled Trial of Home-based Reach-to-Grasp Training for People after Stroke'.

2. To complete the aims section

Please place a tick in the box that best describes the aims relevant to the particular treatment session being recorded. Unless stated otherwise, it is assumed that the aim is to 'improve/optimise' in each case.

3. To complete the gross position section

Place a tick in the box for every gross position used to deliver physiotherapy treatment during treatment sessions being recorded.

4. To complete the equipment section

Please write the name of any equipment used during the particular treatment session being recorded.

5. To complete the treatment activities section

Please place a tick in the boxes which best describe the treatment that was given to the patient during the particular treatment session being recorded.

6. Completed forms* to be given to *research team

ABBREVIATIONS FOR GLOSSARY OF TERMS USED IN RECORDING FORM

Effleurage:	A gliding manipulation performed with light centripetal pressure that deforms subcutaneous tissue down to the investing Layer of the deep fascia[a]
Facilitation:	The application of an appropriate mode and dose (frequency, duration and intensity) of sensory stimulus provided by the therapist to access a desired active response from the patient[b]
Friction:	A repetitive, specific, non-gliding technique that produces movement between the fibres of Connective tissue, increasing tissue extensibility and promoting ordered alignment of collagen within the tissues[a]
Lymph drainage techniques:	A non-gliding technique performed in the direction of lymphatic flow, using short, rhythmical strokes with minimal to light pressure, which deforms subcutaneous tissue without engaging muscle[a]
Mental imagery:	Mental rehearsal of a motor act that occurs in the absence of overt motor output
Myofascial release:	A technique that combines a non-gliding fascial traction with varying amounts of orthopaedic stretch to produce a moderate, sustained tensional force on the muscle and its associated fascia, which results in palpable visco-elastic lengthening and plastic deformation of the fascia[a]
Petrissage:	A group of related techniques that repetitively compress, shear and release muscle tissue with varying amounts of drag, lift and glide[a]
Physiotherapist:	Person with professional physiotherapy qualification
Specific compression:	A non-gliding technique that is applied with a specific contact surface to muscle, tendon or connective tissue; the compression and release is applied in a direction that is perpendicular to the target tissue, and The compression is often sustained[a]
Stroking:	Gliding over the patient's skin (unidirectionally) with minimal deformation of subcutaneous tissues[a]
Rehabilitation assistant:	Person assisting the physiotherapist but who is not a qualified physiotherapist

[a] Andrade C-K, Clifford P. Outcome-based massage. London: Lippincott Williams and Wilkins; 2001.
[b] Hunter SM, Crome P, Sim J, Donaldson C, Pomeroy VM. Development of treatment schedules for research: a structured review to identify methodologies used and a worked example of 'mobilisation and tactile stimulation' for stroke patients. Physiotherapy 2006;92:195–207.

reach to grasp

REACH TO GRASP **N1**

NOTE TO FILE

REACH TO GRASP Patient ID: ☐☐☐☐☐

Please use this form to record details of important events for formal documentation in the database.
Please also use this form to document breaches of GCP.

Does this note relate to a page in the CRFs? *Yes* ☐ *No* ☐ If **YES**, give page number (e.g. C1) ☐☐

Date and time of event (where applicable, or record NA):

__ __ /__ __ /__ __ __ __ ___ ___ : ___ ___

d d m m y y y y ***(24 hr clock)***

File note (include all relevant details of event)

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **D1**

EXPECTED ADVERSE EVENTS

REACH TO GRASP Patient ID: ☐☐☐☐☐

*The following events are all 'expected' and therefore do not require an SAE form to be completed. However, please tick 'YES' to **SAE** if the event fits any of the following criteria:*
i) caused hospital admission ii) Increased length of hospital admission, iii) life threatening, iv) persistent or significant disability iv) caused death

For any events that are not listed on the following forms and meet the above criteria, complete an SAE form (S1)

TARGETED TREATMENT-RELATED ADVERSE EVENTS			**If YES**, date started	**SAE** *YES*	*NO*
Shoulder and upper arm pain	*Yes* ☐	*No* ☐	__ __ /__ __ /__ __ __ __	☐	☐
Hand pain	*Yes* ☐	*No* ☐	__ __ /__ __ /__ __ __ __	☐	☐
Hand oedema	*Yes* ☐	*No* ☐	__ __ /__ __ /__ __ __ __	☐	☐
Falls	*Yes* ☐	*No* ☐	__ __ /__ __ /__ __ __ __	☐	☐
Equipment failure leading to injury requiring a hospital or GP visit	*Yes* ☐	*No* ☐	__ __ /__ __ /__ __ __ __	☐	☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

SAE MASTER FORM

S0

REACH TO GRASP Patient ID: ☐☐☐☐☐

An SAE report should be completed for any deaths of any events which are not listed on CRF D1
and fit into any of the following criteria:

i) caused hospital admission ii) Increased length of hospital admission, iii) life threatening, iv) persistent or significant disability iv) caused death

Complete one line in the table below and one initial report form (S1 and S2) for each event.
Follow-up reports should be completed every 5 days if necessary until the event is resolved or the patient had died.
Ensure the SAE reference number is completed correctly on all SAE forms, in accordance with the table below.

SAE ref	Brief description of event	Onset date	Date of initial report	Date of follow-up 1	Date of follow-up 2	Date of follow-up 3	Event resolved? (Tick)
1		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
2		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
3		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
4		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
5		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
6		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
7		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	
8		__/__/____	__/__/____	__/__/____	__/__/____	__/__/____	

Use the space below for details of any further follow-ups (use SAE reference):

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **S1**

SAE INITIAL REPORT FORM

SAE ref ___ (for CTEU use only)

SAE report page ___ of ___

REACH TO GRASP Patient ID: ☐☐☐☐☐

1. PARTICIPANT DETAILS

Patient initials ☐☐ *Sex* *Male* ☐ *Female* ☐ Date of Birth __ __ /__ __ /__ __ __ __
d d m m y y y y

2. BRIEF DESCRIPTION OF EVENT

3. REASON FOR REPORT EVENT AS SAE

	YES	NO		YES	NO
Resulted in death *Please provide copy of PM report or death certificate*	☐	☐	Required hospitalisation	☐	☐
Is / was life-threatening	☐	☐	Prolonged an ongoing hospitalisation	☐	☐
Resulted in persistent or significant disability / incapacity	☐	☐	Other (if **YES**, please specify below)	☐	☐

_____

4. DETAILS OF ONSET AND DURATION

Date and time of onset __ __ /__ __ /__ __ __ __ ___ ___ : ___ ___
d d m m y y y y (24 hr clock)

End date and time (if resolved) __ __ /__ __ /__ __ __ __ ___ ___ : ___ ___
d d m m y y y y (24 hr clock)

5. OUTCOME OF EVENT

Resolved, no sequelae ☐ *Resolved, with sequelae ** ☐ *Ongoing ** ☐ *Died * (give cause and PM details or Death Certificate)* ☐

*Give details

6. FURTHER DETAILS OF EVENT

Maximum intensity of event (up until time of initial report)

***Mild**: an event easily tolerated by patient, causing minimal discomfort, not interfering with everyday activities** ☐

***Moderate**: an event interfering with normal everyday activities** ☐

***Severe**: an event that prevents normal everyday activities** ☐

(* 'interfering with everyday activities' refers to activities that the patient was previously capable of doing at that stage in their recovery)

Full description of event, including body site, reported signs and symptoms and diagnosis where possible

7. DETAILS OF RESEARCH INTERVENTION

Patient treated according to allocation *Yes* ☐ *No* ☐

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **S2**

SAE INITIAL REPORT FORM

SAE ref ___ (for CTEU use only)

SAE report page ___ of ___

REACH TO GRASP Patient ID: | | | | | |

8. ACTION TAKEN AND FURTHER INFORMATION

Please describe action taken

Please record any other information relevant to assessment of case *(e.g. medical history, test results*)

9. WITHDRAWAL

Has the patient been withdrawn from allocated treatment *Yes* ☐ *No* ☐ *NA* ☐ If **YES** date treatment withdrawn __ __ /__ __ /__ __ __ __ *d d m m y y y y*

Has the patient been withdrawn from the study completely *Yes* ☐ *No* ☐ If **YES** date withdrawn __ __ /__ __ /__ __ __ __ *d d m m y y y y*

10. UNBLINDING *(Only to be used for blinded trials)*

Has the randomisation code been broken *Yes* ☐ *No* ☐

If **YES** please provide details of randomisation *Allocation 1* ☐ *Allocation 2* ☐ *Enter as many as required*

11. RELATEDNESS

In the opinion of the Chief Investigator, was the event related to the intervention

Not related ☐ *Unlikely to be related* ☐ *Possibly related* ☐ *Probably related* ☐ *Definitely related* ☐

12. DETAILS OF PRINCIPAL INVESTIGATOR, OR DELEGATED DOCTOR

The completed SAE form must be signed off by the **Chief Investigator** prior to faxing to the sponsor

I confirm that the contents of this form (pages S1 and S2) are accurate and complete

Name _____ Signature _____ Date __ __ /__ __ /__ __ __ __ *d d m m y y y y*

13. FURTHER INFORMATION only use if required

Where relevant, refer to question number to which the further information relates

If additional space is required, please use blank form S4

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP **S3**

SAE FOLLOW-UP REPORT FORM

SAE ref ___ (for CTEU use only)

SAE report page ___ of ___

REACH TO GRASP Patient ID: ☐☐☐☐☐

1. PARTICIPANT DETAILS

Patient initials ☐☐ Sex *Male* ☐ *Female* ☐ Date of Birth __ __ /__ __ /__ __ __ __
d d m m y y y y

2. SAE DETAILS

Date and time of onset __ __ /__ __ /__ __ __ __ ___ ___ : ___ ___
d d m m y y y y *(24 hr clock)*

3. FURTHER DETAILS OF EVENT

Maximum intensity of event (up until time of follow-up report)

***Mild**: an event easily tolerated by patient, causing minimal discomfort, not interfering with everyday activities** ☐

***Moderate**: an event interfering with normal everyday activities** ☐

***Severe**: an event that prevents normal everyday activities** ☐

(* 'interfering with everyday activities' refers to activities that the patient was previously capable of doing at that stage in

Full description of event, including body site, reported signs and symptoms and diagnosis where possible

Additional action taken and further information since initial report (e.g. medical history, test results etc)

4. OUTCOME OF EVENT

End date and time (if resolved) __ __ /__ __ /__ __ __ __ ___ ___ : ___ ___
d d m m y y y y *(24 hr clock)*

Resolved, no sequelae ☐ *Resolved, with sequelae** ☐ *Ongoing** ☐ *Died * (give cause and PM details or Death Certificate)* ☐

*Give details

If a long term SAE that is possibly/probably/definitely related to the intervention and a new follow-up schedule has been agreed with the Sponsor, give date of next follow-up __ __ /__ __ /__ __ __ __
d d m m y y y y

5. WITHDRAWAL

Has the patient been withdrawn from allocated treatment since initial report form *Yes* ☐ *No* ☐ *NA* ☐ If **YES** date treatment withdrawn __ __ /__ __ /__ __ __ __
d d m m y y y y

Has the patient been withdrawn from the study completely since initial report form *Yes* ☐ *No* ☐ If **YES** date withdrawn __ __ /__ __ /__ __ __ __
d d m m y y y y

6. UNBLINDING *(Only to be used for blinded trials)*

Has the randomisation code been broken since initial report *Yes* ☐ *No* ☐

If **YES** please provide details of randomisation *Allocation 1* ☐ *Allocation 2* ☐ *Enter as many as required*

7. DETAILS OF PRINCIPAL INVESTIGATOR, OR DELEGATED DOCTOR

The completed SAE form must be signed off by the **Chief Investigator** prior to faxing to the sponsor
I confirm that the contents of this form are accurate and complete

Name _____ Signature _____ Date __ __ /__ __ /__ __ __ __
d d m m y y y y

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____ Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

S4

SAE ADDITIONAL INFORMATION FORM

SAE ref ___ **(for CTEU use only)**

SAE report page ___ of ___

REACH TO GRASP Patient ID: | | | | | |

ADDITIONAL INFORMATION	
Section No	**Further Information**

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

reach to grasp

REACH TO GRASP

WITHDRAWAL FORM

W1

REACH TO GRASP Patient ID: ☐☐☐☐☐

Decision for withdrawal *Patient withdrawal* ☐ *Clinician withdrawal* ☐

Name of clinician if patient is discontinued _____

Date of withdrawal/discontinuation __ __ /__ __ /__ __ __ __
d d m m y y y y

Was withdrawal from the study *Before randomisation* ☐ *After randomisation but before intervention* ☐ *After intervention* ☐

Reason of withdrawal/discontinuation from trial if known _____

Is patient willing for data already collected to be used? *Yes* ☐ *No* ☐

If **YES:**

Is patient willing for data routinely collected about them by the NHS to be used in this study? *Yes* ☐ *No* ☐

Is the patient willing to participate in follow-up? *Yes* ☐ *No* ☐

*If the **patient withdraws / is withdrawn** from the study, a **photocopy** of the **completed withdrawal form** should be **stapled to the front of the copy of the Patient Consent Form in the patient's notes**.*

Additional information (only complete if relevant)

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

Name of person entering data* (capitals) _____

Date data entered *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*