



# My Stroke Journey

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This section of the binder is made possible through support from



**Stroke Network**  
Southwestern Ontario





## About this Section

### Why is this Section Important?

A stroke is a sudden change in function. Learn more about your stroke and make notes about your stroke journey.

### How to Use this Section

This section provides information about stroke and a clear way to keep track of details about your journey. Use and adapt this section to fit your needs. Every healthcare journey is different.

#### About Stroke

Learn more about stroke and record how the stroke affects your function.

#### Risk Factors

There are risk factors that we can do something about and others that are out of our control. Talk to your health care team to learn more about your stroke risk factors. Record them and create goals for how you can reduce your risk of another stroke.

#### Tests and Procedures

Learn about common tests and procedures that occur after a stroke. Fill out the sections under tests and procedures to keep information about tests and procedures. Recording notes – how it was tolerated, issues with preparation or recovery, etc. – can help when you schedule or plan future tests and procedures.

#### Medications

Medications can be an important part of your care plan. A list of common medications and their purpose for preventing a future stroke is included.

#### Healthcare Appointments

Fill out the sections under healthcare appointments to keep information about upcoming and past appointments. Details about scheduled appointments, as well as previous information and notes can be valuable when planning appointments and/or tests.

In the days leading up to healthcare appointments, you often think of questions that you may want to ask. More often than not, these are forgotten when the appointment starts, unless they are written down in advance. There is an area to keep track of questions for each appointment. You are an advocate for yourself and/or the person you're caring for. These tools can help you in that role.

#### Patient Oriented Discharge Summary (PODS)

At the time of discharge, you will receive your "PODS". This document provides a summary of your admission and information you need as you return home. Add this document to your binder and share with your community providers.





## About Stroke

### What is a stroke?

A stroke is a sudden loss of brain function. It is caused by the blockage of blood flow to the brain or the rupture of blood vessels in the brain. The effects of the stroke depend on where the brain was injured and how much of the brain is damaged.

A stroke can be frightening for you and your family. You will have new experiences in the hospital and you may have questions. This binder will help answer some of your questions about your care and help you get to know your health care team.

For more detailed information please refer to ***Your Stroke Journey: A guide for people living with stroke*** a resource from Heart & Stroke.

Any member of the health care team will be pleased to answer your questions at any time - no question is too simple to ask.

### Changes since my stroke:

- ☐ Weakness to one side of body \_\_\_\_ Right side \_\_\_\_ Left side
- ☐ Weakness to both sides of body
- ☐ Difficulty speaking
- ☐ Difficulty understanding information
- ☐ Difficulty reading
- ☐ Difficulty with vision
- ☐ Difficulty writing
- ☐ Eating \_\_ and/or drinking \_\_\_\_
- ☐ Balance and walking problems
- ☐ Neglect: Poor attention to the Right side or Left side of your body and/or surroundings.
  - Ignoring or not recognizing objects, people or parts on your body on one side
- ☐ Difficulty with activities such as watching television, using the telephone, dressing yourself, meal preparation, or managing finances.
- ☐ Difficulty with thinking, concentrating, memory, safety, judgment or problem solving.
- ☐ Changes with your mood
- ☐ Feeling tired
- ☐ Other: \_\_\_\_\_

☒ ACTION: Place a checkmark next to the changes you notice.





# About Stroke

## About My Stroke

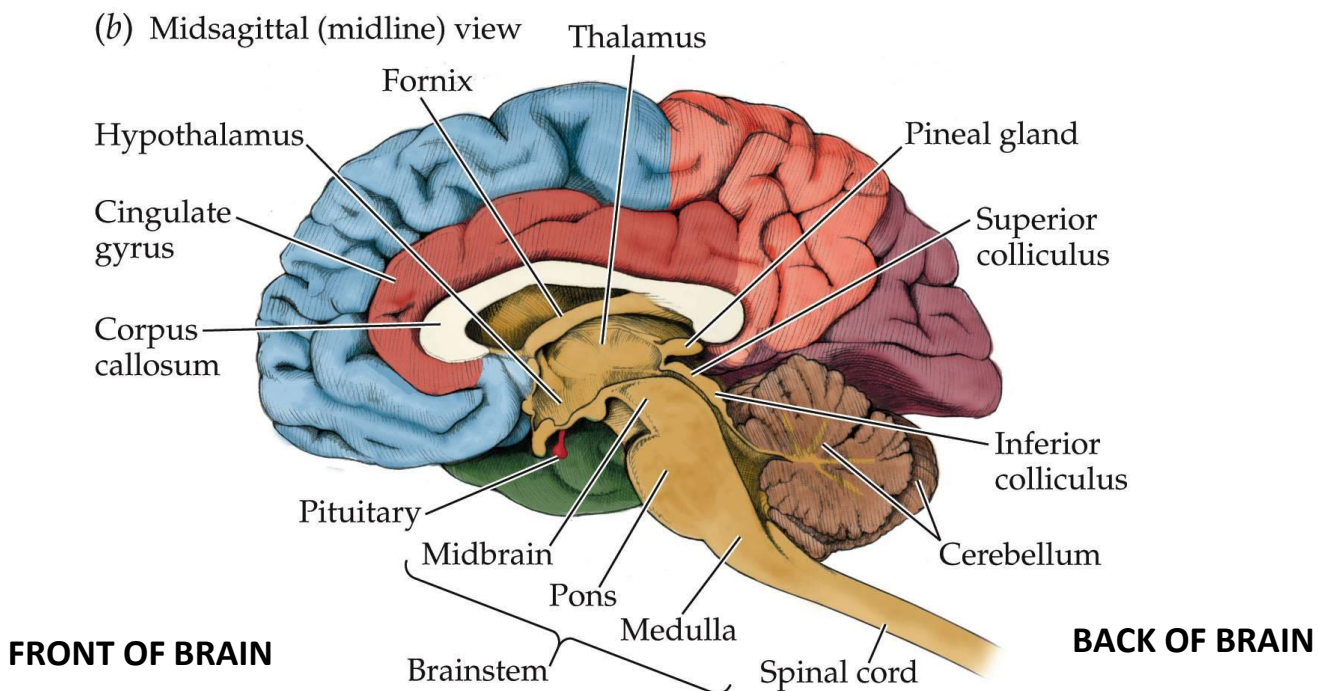
### My type of stroke

- ☐ Ischemic Stroke
- ☐ Hemorrhagic Stroke
- ☐ Transient Ischemic Attack (TIA)

☒ ACTION: Talk to your team and fill in the information about your stroke.

### The location of my stroke

- ☐ Cerebral Hemisphere
- ☐ Right side of my brain, also called the right hemisphere
- ☐ Left side of my brain, also called the left hemisphere
- ☐ Brainstem
- ☐ Cerebellum
- ☐ \_\_\_\_\_



*Biological Psychology 6e, Figure 2.12 (Part 2)*

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## About Stroke

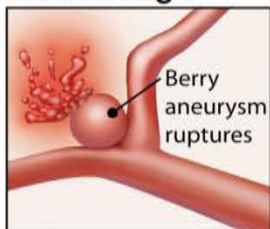
# Common Causes of Stroke

**HEMORRHAGIC STROKE 20%**

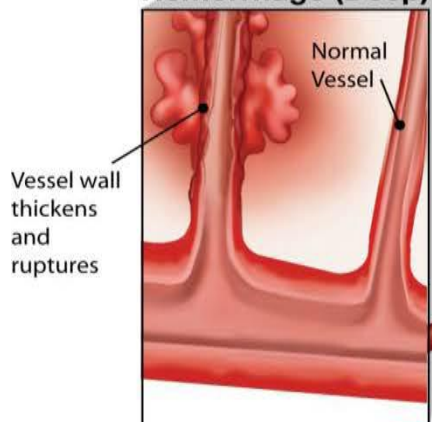
**ISCHEMIC STROKE 80%**

**Intracerebral Hemorrhage**  
(Multiple etiologies)

**Subarachnoid Hemorrhage**

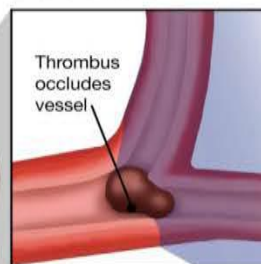


**Intracerebral Hemorrhage (Deep)**

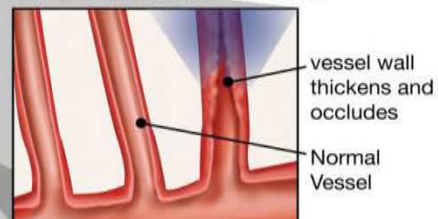


Modified From Hachinski & Norris  
Courtesy of Dr. Vladimir Hachinski

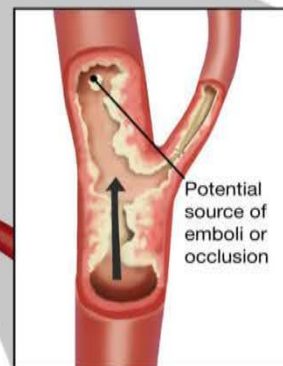
**Middle Cerebral Artery Embolism**



**Small Vessel Disease**

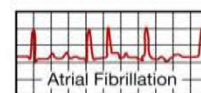


**Carotid Atherosclerosis**



**Cardioembolic**

Atrial Fibrillation



Electrocardiogram (ECG)

Heart Thrombus

Post Myocardial infarction





## Risk Factors

☒ **ACTION:** Talk to your health care team and place a checkmark next to your risk factors.

### Risk Factors You Can Do Something About

☐ **High blood pressure (hypertension)**

You cannot feel high blood pressure, so many people don't know they have it. When treated and controlled, the risk of stroke drops.

☐ **High blood cholesterol**

This is the fat in blood. High levels of cholesterol lead to the build-up of fat (plaque) on artery walls, narrowing the path for blood to flow and increasing stroke risk.

☐ **Atrial fibrillation/Irregular Heartbeat**

This condition could lead to blood clots forming in the heart which can break off, interrupt blood flow to the brain and cause a stroke.

☐ **Diabetes**

Especially if uncontrolled, high blood sugar levels damage the arteries and could lead to high blood pressure.

☐ **Being overweight**

As waist size increases so does stroke risk. Excess weight can lead to high blood pressure, high cholesterol and diabetes. Keep your waist size below 80 cm for women and below 94 cm for men.

☐ **Low activity levels**

This may result in an increased risk for high blood pressure, diabetes, weight gain and high stress levels.

☐ **Drinking too much alcohol**

Having more than two drinks per day (to a maximum of nine drinks a week for women/14 drinks a week for men) increases the risk of stroke.

☐ **Smoking**

Smoking and second hand smoke both lead to high blood pressure and plugged arteries, and increased risk of stroke.

☐ **Sleep Apnea**

Sleep apnea is a disorder that occurs when a person's breathing is interrupted during sleep. Signs of sleep apnea include pauses in breathing during sleep, and daytime fatigue despite adequate sleep time. It is also seen with high blood pressure, irregular heart rate, and heart failure.

☐ **Stress**

High stress levels can be linked to unhealthy lifestyle patterns (increased alcohol use, unhealthy diet, etc.) Stress can also lead to high blood pressure, obesity, anxiety and depression.

☐ **Poor Diet**

Diets high in fat, sugar, processed or salty foods increase the risk of high blood pressure, weight gain and diabetes.





## Risk Factors

### Risk Factors You Cannot Control

☒ ACTION: Place a checkmark next to your risk factors.

☐ **Age**

Stroke can occur at any age, but risk of stroke does increase with age. Most strokes (about 2/3) occur in people over age 65.

☐ **Sex and Gender**

Sex and gender are different, and both affect women's health. An increased risk of stroke is associated with estrogen, pregnancy and menopause.

☐ **Family History**

Risk of stroke increases if a family member (parent, child, and sibling) had a stroke before age 65.

☐ **Ethnicity**

Indigenous people as well as those of African, Chinese, Latin American, or South Asian descent often have greater rates of high blood pressure and diabetes than the general population. This puts them at greater risk of stroke.

☐ **History of Stroke or Transient Ischemic Attack (TIA)**

If you have had a stroke or TIA your risk of (another) stroke is increased.

### What You Can Do to Reduce Your Risk of Stroke

1. If you smoke, take steps to quit. Your health care team can assist with strategies/ medication to stop smoking.
2. Exercise for at least 30 minutes daily.
3. Eat a healthy diet that is low in salt and follows Canada's Food Guide.
4. Limit alcoholic drinks (1--2 per day and fewer than 9 per week).
5. Achieve and maintain a healthy weight.
6. Monitor your blood pressure and notify your physician if elevated.
7. Be tested to see if you have an unusual heartbeat (atrial fibrillation).
8. Know your cholesterol levels and work toward keeping them under control.
9. If you have diabetes, work with a health care provider to keep it under control.
10. Keep stress levels under control.
11. Take all of your medication as prescribed.
12. Know the warning signs of stroke/TIA. Get to hospital immediately if they occur.





# Risk Factors

☒ ACTION: Which risk factors do you want to change?

## My Stroke Prevention Goals

| My Risk Factor | What do I want to achieve? | How will I track my progress? | What support do I need? | Why does this matter to me? | When will I complete this goal? |
|----------------|----------------------------|-------------------------------|-------------------------|-----------------------------|---------------------------------|
|                |                            |                               |                         |                             |                                 |
|                |                            |                               |                         |                             |                                 |
|                |                            |                               |                         |                             |                                 |
|                |                            |                               |                         |                             |                                 |





## Tests and Procedures

### Diagnostic Tests

The physician may order certain tests in order to understand the current state of your health. This is a list of common tests. Your physician will determine which ones are recommended for you.

| Test                                   | Purpose of the Test                                                                                 | How the test is done                                                                                                                       |
|----------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Blood Tests                            | Done to learn if there is any abnormalities in your blood                                           | Blood is taken from your arm and studied in the lab.                                                                                       |
| Carotid Doppler                        | Helps with recognizing if there is plaque build-up narrowing your arteries and affecting blood flow | Uses ultrasound (non harmful sound waves) to listen to the flow of your blood through your arteries.                                       |
| ECG (electrocardiogram)                | Records the electrical activity of the heart.                                                       | Sticky pads are placed on your body that have sensors, which detect the electrical activity of your heart.                                 |
| Holter Monitor                         | Used to look at abnormal heart rhythms                                                              | It is a portable ECG (worn on the body) which monitors your heart rhythm for a longer period of time.                                      |
| Echocardiogram                         | Determines if there is a heart condition and detects if blood clots are forming in your heart       | Uses non harmful sound waves to create a picture of your heart.                                                                            |
| CT Scan (CAT, computerized tomography) | Done to identify conditions in the brain                                                            | You lay down in a scanner that takes a series of pictures of your brain using x-rays.                                                      |
| CTA (CT angiography)                   | Uses x-rays to visualize blood flow in the arteries. You will require an IV for this test.          | X-rays are passed from a rotating device through the area of interest. The computer makes a 3 dimensional picture of the area.             |
| MRI (magnetic resonance imaging)       | Used to detect bleeding or brain changes                                                            | Uses non-harmful magnetic field and radio waves to produce a 3 dimensional image of the brain. You are required to lay still in a scanner. |
| MBS (Modified Barium Swallow)          | To assess swallowing physiology and aspiration risk.                                                | X-Ray video while eating/drinking various foods/liquids combined with barium.                                                              |





## Tests and Procedures

| Procedure/Test                                 | Date and Time | Location                                                   |
|------------------------------------------------|---------------|------------------------------------------------------------|
|                                                | Date:         |                                                            |
| Who ordered the procedure/test?                | Time:         |                                                            |
|                                                |               |                                                            |
|                                                |               | <input type="checkbox"/> I asked about parking, cost & map |
| Notes about procedure prep, response, recovery |               | Questions to Ask                                           |
|                                                |               |                                                            |
| Follow up:                                     |               |                                                            |
|                                                |               |                                                            |

| Procedure/Test                                 | Date and Time | Location                                                   |
|------------------------------------------------|---------------|------------------------------------------------------------|
|                                                | Date:         |                                                            |
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|                                                |               |                                                            |
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| Notes about procedure prep, response, recovery |               | Questions to Ask                                           |
|                                                |               |                                                            |
| Follow up:                                     |               |                                                            |
|                                                |               |                                                            |

| Procedure/Test                                 | Date and Time | Location                                                   |
|------------------------------------------------|---------------|------------------------------------------------------------|
|                                                | Date:         |                                                            |
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|                                                |               |                                                            |
|                                                |               | <input type="checkbox"/> I asked about parking, cost & map |
| Notes about procedure prep, response, recovery |               | Questions to Ask                                           |
|                                                |               |                                                            |
| Follow up:                                     |               |                                                            |
|                                                |               |                                                            |





## Tests and Procedures

| Procedure/Test                                 | Date and Time | Location                                                   |
|------------------------------------------------|---------------|------------------------------------------------------------|
|                                                | Date:         |                                                            |
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|                                                |               |                                                            |
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|                                                |               |                                                            |
| Follow up:                                     |               |                                                            |
|                                                |               |                                                            |

| Procedure/Test                                 | Date and Time | Location                                                   |
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|                                                |               |                                                            |

| Procedure/Test                                 | Date and Time | Location                                                   |
|------------------------------------------------|---------------|------------------------------------------------------------|
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|                                                |               |                                                            |
|                                                |               | <input type="checkbox"/> I asked about parking, cost & map |
| Notes about procedure prep, response, recovery |               | Questions to Ask                                           |
|                                                |               |                                                            |
| Follow up:                                     |               |                                                            |
|                                                |               |                                                            |





## 5 Questions to Ask about your Medications

### Medications

Medications are used for many reasons. You will have your own medication plan to follow based on your condition. You may need medication to:

- help prevent blood clots
- lower your blood pressure
- lower cholesterol

☒ **ACTION:** Talk to your nurse if you have any of your medications with you.

It is important that you take your medications as prescribed. Never take anyone else's medications. Do not share your medications with other people.

### What do I need to know about my medications before leaving hospital?

- The correct name and dose of all your medications
- Why you are on these medications
- How to take your medications correctly and for how long
- The possible side effects of your medications
- When to speak to your pharmacist or doctor

You will be given a **Medication Discharge Prescription List**. This will be the most accurate list of your medications. If you have medications at home that are not on this list, please take them to your community pharmacist and discuss before taking them. Store your medications in a cool, dry place, away from children.

It is important to take your medications as prescribed by your doctor. Organizing your medications in a dosette or blister pack can help to keep you on track. Your community pharmacist can organize and package your medications in a blister pack to help you know which medications to take at the correct time. Using a blister pack helps you to track whether or not you need to take a dose or if you have already taken your dose for the day.

Your nurse, doctor and pharmacist will provide you with information about your medications. Your community pharmacist will review this information with you when you fill your prescription. Contact your community pharmacist if you have any questions regarding your medications.

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**Be sure to carry an up-to-date list of your medications and dosages with you at all times. Bring this list with you to all follow-up appointments.**

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## 5 Questions to Ask about your Medications

**Did you know??** Medication errors or mistakes are most likely to happen when moving throughout the healthcare system – such as being admitted or discharged from hospital<sup>1</sup>.

For this reason, organizations such as the **Institute for Safe Medication Practices in Canada**, **Patients for Patient Safety Canada**, the **Canadian Pharmacists Association**, and the **Canadian Association for Hospital Pharmacists** have worked together to develop 5 questions to help patients and caregivers start a conversation with their healthcare team about their medications<sup>2</sup>.

Use the questions below when talking with any member of your healthcare team about your medications. This includes doctors, nurses, and pharmacists.

### 1. Changes?

Have any medications been added, stopped or changed, and why?

### 2. Continue?

What medications do I need to keep taking, and why?

### 3. Proper Use?

How do I take my medications, and for how long?

### 4. Monitor?

How will I know if my medication is working, and what side effects do I watch for?

### 5. Follow-Up?

Do I need any tests and when do I book my next visits?

<sup>1</sup> Institute for Safe Medication Practices Canada. (2011, February 10). *Optimizing medication safety at care transitions – Creating a National Challenge*. Available from: [https://www.ismp-canada.org/download/MedRec/MedRec\\_National\\_summitreport\\_Feb\\_2011\\_EN.pdf](https://www.ismp-canada.org/download/MedRec/MedRec_National_summitreport_Feb_2011_EN.pdf)

<sup>2</sup> Institute for Safe Medication Practices Canada. (2016). *5 questions to ask about your medications when you see your doctor, nurse, or pharmacist*. Available from: <https://www.ismp-canada.org/medrec/5questions.htm>





# Medications

## Common Medications Used After Stroke

☒ ACTION: Which medications are you taking?

The charts below outline common medications used to reduce stroke risk. Most drugs have two names: a generic name and a trade name (or brand name). For example, Acetaminophen is a generic name for the drug Tylenol. Tylenol is the trade name.

If you have any questions, please ask your doctor, nurse or pharmacist. When you fill your prescriptions, the pharmacist will give you more written information.

| Mediations to help prevent blood clots                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Platelet Inhibitors:</b> <ul style="list-style-type: none"><li>▪ acetylsalicylic acid, ASA (<b>Aspirin®</b>, <b>Entrophen®</b>, <b>Novasen®</b>)</li><li>▪ acetylsalicylic acid, ASA+ dipyridamole (<b>Aggrenox®</b>)</li><li>▪ clopidogrel (<b>Plavix®</b>)</li></ul>                                                                                                                                                                        |
| <b>Anticoagulants:</b> <ul style="list-style-type: none"><li>▪ apixaban (<b>Eliquis®</b>)</li><li>▪ dabigatran (<b>Pradaxa®</b>)</li><li>▪ edoxaban (<b>lixiana®</b>)</li><li>▪ rivaroxaban (<b>Xarelto®</b>)</li><li>▪ warfarin (<b>Coumadin®</b>)</li></ul>                                                                                                                                                                                    |
| Mediations to help lower blood pressure                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Angiotensin-Converting Enzymes (ACE) Inhibitors:</b> <ul style="list-style-type: none"><li>▪ perindopril (<b>Coversyl®</b>)</li><li>▪ ramipril (<b>Altace®</b>)</li><li>▪ enalapril (<b>Vasotec®</b>)</li><li>▪ fosinopril (<b>Monopril®</b>)</li><li>▪ lisinopril (<b>Prinivil®</b>, <b>Zestril®</b>)</li><li>▪ trandolapril (<b>Mavik®</b>)</li></ul> <p><i>*These medications may cause light headedness when standing and a cough</i></p> |
| <b>Angiotensin Receptor Blockers (ARB):</b> <ul style="list-style-type: none"><li>▪ candesartan (<b>Atacand®</b>)</li><li>▪ irbesartan (<b>Avapro®</b>)</li><li>▪ losartan (<b>Cozaar®</b>)</li><li>▪ telmisarten (<b>Micardis®</b>)</li><li>▪ valsartan (<b>Diovan®</b>)</li></ul> <p><i>*These medications may cause light headedness when standing</i></p>                                                                                    |





## Medications

### Beta Blockers:

- atenolol (**Tenormin**®)
- bisoprolol (**Monocur**®)
- carvedilol (**Coreg**®)
- metoprolol (**Lopressor**®)

*\*These medications may cause light headedness when standing*

### Calcium Channel Blockers:

- amlodipine (**Norvasc**®)
- diltiazem (**Cardizem**®SR, **Cardizem**®CD, **Tiazac**®)
- nifedipine (**Adalat PA**, **Adalat XL**®)

*\*These drugs may cause stomach acid to come up from the stomach into the esophagus or swallowing tube. This condition is also known as GERD (gastroesophageal reflux disease).*

*\*These drugs may cause swelling in the legs.*

*\*These medications may cause light headedness when standing*

### Diuretics:

- furosemide (**Lasix**®)
- hydrochlorothiazide (**Apo Hydro**®/**Novo-Hydrazide**®)
- chlorthalidone (**Hygroton**®)
- indapamide (**Lozide**®)

*\*These medications may cause light headedness when standing*

### Medications to help lower cholesterol

#### Statins:

- atorvastatin (**Lipitor**®)
- fluvastatin (**Lescol**®)
- lovastatin (**Mevacor**®)
- pravastatin (**Pravachol**®)
- rosuvastatin (**Crestor**®)
- simvastatin (**Zocor**®)

#### Fibrates:

- bezafibrate (**Bezalip**®)
- fenofibrate (**Lipidil Micro**®)
- gemfibrozil (**Lopid**®)

#### Other:

- ezetimibe (**Ezetrol**®)
- nicotinic acid (**Niacin**®)





## Healthcare Appointment Tracking Sheet

| Appointment Date                                                                                      | Provider Name                      | Location                                                   |
|-------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------|
| Date:                                                                                                 |                                    |                                                            |
| Time:                                                                                                 |                                    | <input type="checkbox"/> I asked about parking, cost & map |
| Reason for Appointment                                                                                | Supporting Documents to Bring      | Notes for Appointment                                      |
|                                                                                                       |                                    |                                                            |
| Questions to Ask (i.e. what is my main problem today, what do I need to do next, why is it important) |                                    |                                                            |
|                                                                                                       |                                    |                                                            |
| Next Appointment Date                                                                                 |                                    | Follow up Instructions                                     |
| Date:                                                                                                 | <input type="checkbox"/> We book   |                                                            |
| Time:                                                                                                 | <input type="checkbox"/> They book |                                                            |

| Appointment Date                                                                                      | Provider Name                      | Location                                                   |
|-------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------|
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|                                                                                                       |                                    |                                                            |
| Next Appointment Date                                                                                 |                                    | Follow up Instructions                                     |
| Date:                                                                                                 | <input type="checkbox"/> We book   |                                                            |
| Time:                                                                                                 | <input type="checkbox"/> They book |                                                            |





## Healthcare Appointment Tracking Sheet

| Appointment Date                                                                                      | Provider Name                      | Location                                                   |
|-------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------|
| Date:                                                                                                 |                                    |                                                            |
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|                                                                                                       |                                    |                                                            |
| Next Appointment Date                                                                                 |                                    | Follow up Instructions                                     |
| Date:                                                                                                 | <input type="checkbox"/> We book   |                                                            |
| Time:                                                                                                 | <input type="checkbox"/> They book |                                                            |

| Appointment Date                                                                                      | Provider Name                      | Location                                                   |
|-------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------|
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|                                                                                                       |                                    |                                                            |
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| Date:                                                                                                 | <input type="checkbox"/> We book   |                                                            |
| Time:                                                                                                 | <input type="checkbox"/> They book |                                                            |

