



CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS

**Rehabilitation, Recovery and Community Participation
Following Stroke
Part One: Stroke Rehabilitation Planning for Optimal Care
Delivery
7th Edition, 2025**

Box 7: Checklist of Core Transition Summary Information

*Salbach N, Yao J (Writing Group Chairs)
Nelson M, Shi J (Section Leads)
on behalf of the Canadian Stroke Best Practice Recommendations
Stroke Rehabilitation and Recovery Writing Group*

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Box 7: Checklist of Core Transition Summary Information

Transition Summary to next care setting and primary care provider should include:

- Stroke diagnosis, stroke etiology, and date of stroke
- Stroke risk factors
- Past medical history
- Medications on discharge
- Summary of hospital course including secondary complications, comorbid illnesses, relevant investigations (e.g., labs and diagnostic imaging) and any follow up appointments planned/pending
- Summary of stroke impairments, treatments/therapies and education received
- Level of function on transition for ADLs, functional mobility, functional communication and instrumental activities of daily living (iADLs) including any supervision or assistance required
- Secondary prevention strategies (and referrals to clinics)
- Mental health and emotional support needs and access to services
- Social and family history
- Identification of urgent care needs and priority issues
- Advance care plan status
- Community resources and home care services arranged as required
- Crisis placement recommendations if required
- Ongoing and long-term goals
- Recommended future management plan, including rehabilitation therapies, home program, community resources, activities and programs, and outstanding medical consultations
- Equipment and resources prescribed, including what has been provided, and what is pending
- Return to driving recommendations/plan if applicable
- Return to vocation (e.g. paid or volunteer employment, or education) recommendations/plan if applicable
- Specific identification of primary care provider follow-up responsibilities
- Means for direct communication between most responsible physician and the primary care provider when needed