Appendix S1

1) In which institution do you work?

2) Does your department manage patients with subarachnoid hemorrhage in the initial phase?
   - Yes
   - No

3) How many patients are admitted for SAH per year to your department?
   - Less than 50 patients per year
   - 50 to 100 patients per year
   - More than 100 patients per year

4) How many beds does your intensive care unit have?

5) Do patients on your ward in general receive physiotherapy?
   - Yes
   - No

6) What is the ratio of physiotherapists to patients in your department?
   - Not defined
   - < 5 patients per 1 physiotherapist
   - 5-10 patients per 1 physiotherapist
   - 11-15 patients per 1 physiotherapist
   - 16-20 patients per 1 physiotherapist
   - > 20 patients per 1 physiotherapist
   - Other :

7) In general, how many physiotherapy sessions per week do patients in your unit receive if they are deemed medically stable?
   - Twice a day
   - Once a day
   - Every second day
   - Twice a week
   - Once a week
   - Less than once a week
   - Other :

The term "mobilization" is to be understood here as: passive or active physiotherapy techniques, motor stimulation at the edge of the bed, positioning at the edge of the bed, standing up, transfer and positioning in the chair, walking, use of a cyclo-ergometer, etc.

8) Is there a mobilization protocol for patients admitted for SAH in your department? We are talking about a written document.
   - Yes
   - No

9) Is there a predefined period in your department during which all motor physiotherapy is forbidden for patients admitted for SAH?
   - Yes
   - No

In your department, how is the non-mobilization phase defined? Does it correspond to a post-hemorrhage delay (specify the duration) or is it conditioned by events (aneurysm awaiting securing, state of shock, etc.) or the presence of certain devices (ventricular bypass, intubation, etc.)? Is it specific to patients with high-grade SAH? Do not hesitate to provide all the details that you think are useful.

10) Describe as precisely as possible what defines this phase.

11) Is there a predefined period in your department during which only bed mobilization is allowed for patients admitted with SAH?
    - Yes
    - No

In your department, how is the in-bed mobilization phase defined? Does it correspond to a post-hemorrhage delay (specify the duration) or is it conditioned by events (aneurysm awaiting securing, state of shock, etc.) or the presence of certain devices (ventricular bypass, intubation, etc.)? Is it specific to patients with high-grade SAH? Do not hesitate to provide all the details that you think are useful.

12) Describe as precisely as possible what defines this phase.

13) In your department, when are the following mobilizations done? D0 is the day the aneurysm is secured.

	As soon as the clinical condition allows	D0	D1	D2	D3	D4	…	D15	>D15
Passive in bed mobilization									
In bed cycloergometer									
Active in bed mobilization									
Sitting in bed									
Edge of bed									
Standing									
Sitting in a chair									
Walking									

14) Is chair-sitting allowed on your ward within the first 5 days of securing the aneurysm?
    - Yes, only for low-grade patients (WFNS 1-3)
    - Yes, regardless of WFNS grade, depending on clinical status
    - No
    - Other :

15) Is there a defined maximum time limit for chair sitting?
    - No predetermined maximum duration
    - Less than 30 minutes

- 1 hour
- Two hours
- 3 hours
- Four hours
- Five hours
- Six hours
- One day
- Other :

16) Is the maximum frequency of sitting defined? Please specify.
    - No predetermined maximum frequency
    - Once a day
    - Twice a day
    - Every other day
    - Every third day
    - Once a week
    - Other :

17) In your department, what factors will delay or interrupt the prescription of any motor physiotherapy?
    - High WFNS Grades (4-5)
    - Intubated patient
    - Vasospasm under treatment
    - Suspected vasospasm
    - Intracranial hypertension
    - Administration of milrinone
    - Pain
    - External ventricular derivation
    - External lumbar derivation
    - Ventriculo-Peritoneal shunt
    - Patient who cannot tolerate clamping of the derivation during mobilizations
    - Catecholamines
    - Decompressive craniectomy
    - Decompressive craniectomy if no helmet is worn for mobilizations
    - Other :

18) What complications do you think might be associated with raising patients admitted for SAH?
    - No particular complications
    - Hemodynamic instability
    - Decreased cerebral perfusion
    - Development of vasospasm
    - Worsening of existing vasospasm
    - External ventricular or lumbar shunt abruption
    - Other :

19) Do you have any comments to make?