



BMC2 PCI 2021 WORKSHEET

Patient Information:

Date of Discharge:		NCDR Cath PCI Other ID:	
NCDR Cath PCI Pt ID:		Date of Birth:	

Insurance Coverage:

Insured: Y/N Commercial: Y/N <input type="radio"/> BCBSM <input type="radio"/> Other HMO Y/N <input type="radio"/> BCN <input type="radio"/> Other HMO	Government Provided: Y/N <input type="radio"/> Medicare Original Medicare Supplement Y/N <input type="radio"/> BCBSM <input type="radio"/> Other <input type="radio"/> Medicare Advantage (Part C) <input type="radio"/> BCBSM <input type="radio"/> BCN <input type="radio"/> Other	Government (cont.) <input type="radio"/> Blue Cross Complete of MI <input type="radio"/> Medicaid <input type="radio"/> County Coverage <input type="radio"/> Other Other Insurance: Y/N
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Patient History/Comorbidity:

Current/Recent GIB:	Y/N
Prior ICD:	Y/N
Afib/Aflutter:	Y/N
TIA/CVA	Y/N
Diabetes Tx: <input type="radio"/> IDDM <input type="radio"/> NIDDM <input type="radio"/> N/A	
Heart Team Eval:	Y/N
CTS+Additional Int. Consult	Y/N

Cardiac Arrest w/in 24 hrs: Y/N If yes: Hypothermia in cardiac arrest Date: Time: Location: <input type="radio"/> ER <input type="radio"/> Cath Lab <input type="radio"/> ICU <input type="radio"/> N/A	pH obtained Y/N First pH _____ pH at start _____
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Procedure Information:

Procedure Date/Time:	
Performed in Lab#: _____	
Indication for procedure NSTEMI/USA? Y/N	
If "Yes" select one of the following: NSTEMI/USA	
Presented to Cath lab from:	
<input type="radio"/> Home <input type="radio"/> Another Acute Care Facility	
<input type="radio"/> ED <input type="radio"/> Other area of this facility <input type="radio"/> Other	

Intra Procedure ACT: _____seconds <input type="checkbox"/> N/A
LVEDP: _____mmHg <input type="checkbox"/> N/A
IVUS/OCT post PCI: Y/N
COVID-19:
<input type="radio"/> Positive COVID +Result Date/Time: _____ <input type="checkbox"/> N/D
<input type="radio"/> Negative COVID -Result Date/Time: _____ <input type="checkbox"/> N/D
<input type="radio"/> Investigating COVID
<input type="radio"/> COVID not suspected
<input type="radio"/> Recovered COVID

Outcomes in Lab: None of the following outcomes in lab

Angina>30 Minutes:	Y/N
Acute Closure:	Y/N
No Reflow:	Y/N
Untreated Dissection:	Y/N

Side Branch Occlusion:	Y/N
Rescue IIb/IIIa:	Y/N
Distal Embolization:	Y/N

Outcomes Post Lab: None of the following outcomes post lab

Q wave MI:	Y/N
Stent Thrombosis	Y/N
Repeat Angio	Y/N

Infection/Sepsis	Y/N
VT/VF Req Tx :	Y/N
New Atrial Fibrillation:	Y/N

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Outcomes Post Lab (cont.)

Primary Access Site Vasc Comp: If "Yes", choose all that apply	
<input type="checkbox"/> Pseudoaneurysm	<input type="checkbox"/> Acute Thrombosis
<input type="checkbox"/> AV Fistula	<input type="checkbox"/> Surgical Repair
<input type="checkbox"/> Femoral Neuropathy	<input type="checkbox"/> Loss of Limb
<input type="checkbox"/> Retroperitoneal Hematoma	<input type="checkbox"/> Hematoma
Transfusion of Platelets:	Y/N
Transfusion of FFP:	Y/N

Secondary Access Site:	Y/N
Rationale for Secondary Site If "Yes", choose all that apply :	
<input type="checkbox"/> IABP	<input type="checkbox"/> Impella
<input type="checkbox"/> Tandem Heart	<input type="checkbox"/> Impella 2.5
<input type="checkbox"/> ECMO	<input type="checkbox"/> Impella CP
<input type="checkbox"/> Impella RP	<input type="checkbox"/> Impella5.0/LD
<input type="checkbox"/> Additional Procedure Access	
<input type="checkbox"/> Failed Access:	
<input type="checkbox"/> Femoral	<input type="checkbox"/> Brachial
<input type="checkbox"/> Radial	<input type="checkbox"/> Other
Secondary Access Site Vasc Comp:	Y/N
If "Yes", choose all that apply	
<input type="checkbox"/> Pseudoaneurysm	<input type="checkbox"/> Acute Thrombosis
<input type="checkbox"/> AV Fistula	<input type="checkbox"/> Surgical Repair
<input type="checkbox"/> Femoral Neuropathy	<input type="checkbox"/> Loss of Limb
<input type="checkbox"/> Retroperitoneal Hematoma	<input type="checkbox"/> Hematoma

Medications:

Aspirin w/in 24 hours:	<input type="checkbox"/> Given <input type="checkbox"/> Not Given		
IV Vasopressor(s):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> Pre <input type="checkbox"/> During <input type="checkbox"/> Post	Agent: <input type="checkbox"/> Dopamine <input type="checkbox"/> Norepinephrine <input type="checkbox"/> Phenylephrine <input type="checkbox"/> Other
IV Heparin post:	<input type="checkbox"/> Given <input type="checkbox"/> Not Given		
IV Nitroglycerin post:	<input type="checkbox"/> Given <input type="checkbox"/> Not Given		
Abciximab (Reopro):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> During <input type="checkbox"/> Post	
Bivalirudin (Angiomax):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> During <input type="checkbox"/> Post	
Cangrelor(Kengreal):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> During <input type="checkbox"/> Post	
Eptifibatide (Integrilin):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> During <input type="checkbox"/> Post	
Tirofiban (Aggrastat):	<input type="checkbox"/> Given <input type="checkbox"/> Not Given	<input type="checkbox"/> During <input type="checkbox"/> Post	

Hydration:

Oral: <input type="checkbox"/> Given <input type="checkbox"/> Not Given	6hr Pre: ml		6hr Post: ml
	<input type="checkbox"/> N/A		<input type="checkbox"/> N/A
Intravenous: <input type="checkbox"/> Given <input type="checkbox"/> Not Given	6hr Pre: ml	During: ml	6hr Post: ml
	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A

Medications at Admission:

Opioid <input type="checkbox"/> Given <input type="checkbox"/> Not Given
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NSAID <input type="checkbox"/> Given <input type="checkbox"/> Not Given

Medications at Discharge:

Aldosterone Antagonist:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
Opioid:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
NSAID:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
Icosapent Ethyl	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed

PPI:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
Entresto:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
SGLT2 Inhib.:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed
GLP-1.:	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not Prescribed

Discharge:

Lipid Panel Y/N Total _____ HDL _____ LDL _____ Triglycerides _____	COVID-19 Status Post PCI: <input type="checkbox"/> Positive COVID-19 +Result Date/Time: _____ <input type="checkbox"/> N/D <input type="checkbox"/> Negative COVID-19 -Result Date/Time: _____ <input type="checkbox"/> N/D <input type="checkbox"/> No COVID-19 Specimen <input type="checkbox"/> No COVID-19 Result <input type="checkbox"/> No Change in COVID Status
LVEF Assessment this admit: Y/N If "Yes": _____ %	
Smoking Cessation Counseling Y/N	
Cardiac Rehab Liaison Y/N	
LDL Goal Y/N	
P2Y12 Duration Y/N	