

Carotid Stent Follow-Up

	30 Day Follow-Up	1 Year Follow-Up
Contact Date	____/____/____	____/____/____
Current Living Status	<input type="radio"/> Home <input type="radio"/> Nursing Home/Extended Care <input type="radio"/> Assisted Living <input type="radio"/> In Hospital <input type="radio"/> Not documented <input type="radio"/> Dead <input type="radio"/> Date of Death ____/____/____ <input type="radio"/> Cause of Death <input type="radio"/> Neurologic <input type="radio"/> Cardiac <input type="radio"/> Pulmonary <input type="radio"/> Vascular <input type="radio"/> Infection <input type="radio"/> Renal <input type="radio"/> Unknown	<input type="radio"/> Home <input type="radio"/> Nursing Home/Extended Care <input type="radio"/> Assisted Living <input type="radio"/> In Hospital <input type="radio"/> Not documented <input type="radio"/> Dead <input type="radio"/> Date of Death ____/____/____ <input type="radio"/> Cause of Death <input type="radio"/> Neurologic <input type="radio"/> Cardiac <input type="radio"/> Pulmonary <input type="radio"/> Vascular <input type="radio"/> Infection <input type="radio"/> Renal <input type="radio"/> Unknown
Additional Procedures Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> CAS <input type="radio"/> CEA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> CAS <input type="radio"/> CEA
Neurologic Deficit(s) Occurred Since Discharge Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="radio"/> Deficit occurred and resolved w/in 24 hours (i.e. TIA) <input type="radio"/> Deficit occurred and duration was greater than 24 hours, but completely resolved <input type="radio"/> Persistent deficit occurred, lasted greater than 24 hours, and did not completely resolve	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="radio"/> Deficit occurred and resolved w/in 24 hours (i.e. TIA) <input type="radio"/> Deficit occurred and duration was greater than 24 hours, but completely resolved <input type="radio"/> Persistent deficit occurred, lasted greater than 24 hours, and did not completely resolve
Territory of Neurologic Deficit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> Right Retinal <input type="radio"/> Left Retinal <input type="radio"/> Right Hemispheric <input type="radio"/> Left Hemispheric <input type="radio"/> Vertebrobasilar <input type="radio"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> Right Retinal <input type="radio"/> Left Retinal <input type="radio"/> Right Hemispheric <input type="radio"/> Left Hemispheric <input type="radio"/> Vertebrobasilar <input type="radio"/> Unknown
Carotid Duplex	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="radio"/> ≤50% <input type="radio"/> >50% <input type="radio"/> >60% <input type="radio"/> >70% <input type="radio"/> >80% <input type="radio"/> Occluded <input type="radio"/> Not Occluded	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="radio"/> ≤50% <input type="radio"/> >50% <input type="radio"/> >60% <input type="radio"/> >70% <input type="radio"/> >80% <input type="radio"/> Occluded <input type="radio"/> Not Occluded
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
Antiplatelets	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated
Statin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated
Beta Blocker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated
ACE Inhibitor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented <input type="checkbox"/> Contraindicated
Anticoagulant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
ARBs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
Other Cholesterol Lowering Agents	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
MI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented Date: ____/____/____