

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
Afib/Aflutter:	Y/N
TIA/CVA:	Y/N
Diabetes Tx:	IDDM NIDDM 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	

Procedure Information:

Procedure Date/Time:	
Performed in Lab#:	
Indication for Procedure NSTEMI/ACS?	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

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

Stent Thrombosis	Y/N
Infection/Sepsis	Y/N
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

VT/VF Requiring Therapy	Y/N
New Atrial Fibrillation	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"/> Impella RP	
<input type="checkbox"/> Tandem Heart <input type="checkbox"/> Impella 2.5 <input type="checkbox"/> Impella5.0/LD	
<input type="checkbox"/> ECMO <input type="checkbox"/> Impella CP	
<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		
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
NSAID:	<input type="checkbox"/> Given	<input type="checkbox"/> Not Given

GLP-1:	<input type="checkbox"/> Given	<input type="checkbox"/> Not Given
SGLT2 Inhibitor:	<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 Inhibitor:	<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 _____	
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