BMC2 PCI 2025 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 ○ BCBSM ○ Other HMO Y | N ○ BCN ○ Other HMO	Government Provided: Y | N ○ Medicare Original Medicare Supplement Y | N ○ BCBSM ○ Other ○ Medicare Advantage (Part C) ○ BCBSM ○ BCN ○ Other	Government (cont.) ○ Blue Cross Complete of MI ○ Medicaid ○ County Coverage ○ Other Other Insurance: Y | N

Patient History/Comorbidity:

Afib/Aflutter: Y | N TIA/CVA: Y | N Diabetes Tx: ○ IDDM ○ NIDDM ○ N/A	Cardiac Arrest w/in 24 hrs: Y | N **If "Yes":** TTM in cardiac arrest: Y | N If "Y", Select Protocol Type: ☐ Normothermia ☐ Hypothermia ☐ Not Available	Cardiogenic shock and/or arrest: Y | N **If "Yes":** Lactate: _____mmol/l pH: _____

Medications at Admission:

Bempedoic acid: Y | N	Colchicine: Y | N	GLP-1: Y | N	SGLT2 Inhibitor: Y | N

Medications at Discharge:

Aldosterone Antagonist: Y | N Bempedoic acid: Y | N	Colchicine: Y | N Entresto: Y | N	GLP-1: Y | N Icosapent Ethyl: Y | N	PPI: Y | N SGLT2 Inhibitor: Y | N

Discharge:

Lipid Panel: Y | N Total_____HDL_____LDL____Triglycerides_____ LVEF this admission: Y | N If "Yes": _____% P2Y12 Duration: Y | N Cardiac Rehab Liaison: Y | N N/A LDL Goal: Y | N	Smoking Cessation Counseling: Y | N If "Yes": ☐ Physician delivered advice ☐ Pt. refused ☐ Nicotine Replacement Therapy ☐ Pt. refused ☐ Referral to smoking counseling services ☐ Pt. refused ☐ Local counseling service ☐ Michigan Quitline ☐ Other counseling service

Procedure Information:

Procedure Date/Time: Performed in Lab#: Indication for Procedure NSTE- ACS? Y | N If "Yes", select one of the following: NSTEMI/USA Presented to Cath lab from: ○ Home ○ Other acute care facility ○ ASC/FSOF ○ Other area of this facility ○ ED ○ Other CT or Angiogram w/in 24 hrs: Y | N If "Yes": Contrast Amount: _____mL ☐ N/A Intra Procedure ACT: _____seconds ☐ N/A	Non-Wire Base Physio Assess: Y | N LVEDP: _____ mmHg ☐ N/A IVUS/OCT post PCI: Y | N If "Yes", enter lesion number: Lesion # ___MSA_____mm^2 ☐ N/A DRLA_____mm^2 ☐ N/A Lesion # ___MSA_____mm^2 ☐ N/A DRLA ____mm^2 ☐ N/A Lesion # ___MSA_____mm^2 ☐ N/A DRLA_____mm^2 ☐ N/A Lesion # ___MSA_____mm^2 ☐ N/A DRLA_____mm^2 ☐ N/A	Secondary Access Site: Y | N If "Yes", Rationale for Secondary Site: ***choose all that apply***: ☐ IABP ☐ Tandem Heart ☐ ECMO ☐ Impella(non-specific) ☐ Impella CP ☐ Impella RP ☐ Impella ECP ☐ Additional Procedure Access ☐ Failed Access: ☐ Femoral ☐ Brachial ☐ Radial ☐ Other

Procedure Information Cont.:

Outcomes in lab: ☐ None of the following in lab

Chronic Total Occlusion (CTO): Y | N If "Yes", please enter the following: J-CTO Score: ☐ Not Documented Select all approaches utilized or attempted to cross CTO lesion: ☐ Antegrade wiring ☐ Antegrade dissection/re-entry ☐ Retrograde ☐ Not Documented Re-entry device used? ☐ Yes, attempted successful ☐ Yes, attempted unsuccessful ☐ No Perforation requiring treatment? Y | N	Acute Closure: Y | N No Reflow: Y | N Untreated Dissection: Y | N Side Branch Occlusion: Y | N Distal Embolization: Y | N

Outcomes Post lab: ☐ None of the following post lab

Stent Thrombosis: Y | N VT/VF Req. Therapy: Y | N New Atrial Fibrillation: Y | N	Primary Access Site Vasc Comp: Y | N If "Yes", choose all that apply: ☐ Pseudoaneurysm ☐ Acute Thrombosis ☐ AV Fistula ☐ Surgical Repair ☐ Femoral Neuropathy ☐ Loss of Limb ☐ Retroperitoneal Hematoma ☐ Hematoma	Secondary Access Site Vasc Comp: Y | N If "Yes", choose all that apply: ☐ Pseudoaneurysm ☐ Acute Thrombosis ☐ AV Fistula ☐ Surgical Repair ☐ Femoral Neuropathy ☐ Loss of Limb ☐ Retroperitoneal Hematoma ☐ Hematoma

Medications:

Aspirin w/in 24 hours:	☐ Given ☐ Not Given	☐ Contraindicated
Bivalirudin (Angiomax):	☐ Given ☐ Not Given	☐ During ☐ Post
Cangrelor (Kengreal):	☐ Given ☐ Not Given	☐ During ☐ Post
Eptifibatide (Integrilin):	☐ Given ☐ Not Given	☐ During ☐ Post
IV Vasopressor(s):	☐ Given ☐ Not Given	☐ Pre ☐ During ☐ Post Agent: ☐ Dopamine ☐ Epinephrine ☐ Norepinephrine ☐ Phenylephrine ☐ Other
Tirofiban (Aggrastat):	☐ Given ☐ Not Given	☐ During ☐ Post

Hydration:

Oral: ☐ Given ☐ Not Given	6hr Pre: ____mL ☐ N/A		6hr Post: ____mL ☐ N/A
Intravenous: ☐ Given ☐ Not Given	6hr Pre: ____mL ☐ N/A	During: ____mL ☐ N/A	6hr Post: ____mL ☐ N/A