



Heart Failure Hospital Record Abstraction Form

FORM CODE:

H	F	A	
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Version A: 02-16-2007

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CONTACT

--	--

 NUMBER:

--	--

FORM SEQUENCE NUMBER:

--	--

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

INITIALS:

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General Instructions:

The Heart Failure hospital Record Abstraction Form is completed for heart failure-eligible Community Surveillance hospitalizations. See Surveillance Procedure manual for sampling rules. It should also be completed for all heart failure-eligible cohort hospitalizations. Refer to this form's question by question instructions for detailed information on each data item.

0. a. Hospital code number:

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0. b. Medical Record Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

0. c. Date of discharge (for nonfatal case) or death:

		-			-							
--	--	---	--	--	---	--	--	--	--	--	--	--

Month Day Year

0. d. What was the disposition of the patient on discharge?
DeceasedD
AliveA

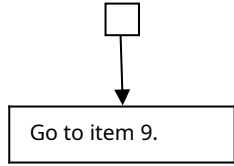
0. e. Was an autopsy performed?
Yes.....Y
No.....N

0. f. Was the patient either dead on arrival or did he/she die in the emergency room?
Yes.....Y
No.....N

- | | <u>Yes</u> | <u>No/Not Recorded</u> | <u>Unsure</u> |
|--|--------------------------|--------------------------|--------------------------|
| a. Diagnosis of heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Prior hospitalization for heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Treatment for heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. Was cardiac imaging performed prior to this hospitalization? Yes No nk

8. a. Lowest Ejection Fraction recorded:



8. a.1. Qualitative description:
- Normal..... N
 - Decreased mildly..... D
 - Decreased moderately.....M
 - Decreased severely..... S
 - None of the above.....O

8. b. Year of lowest ejection fraction (yyyy) :

- 8.c. Type of imaging:
- 1. MUGA
 - 2. ECHO
 - 3. Cath/LV gram
 - 4. CT
 - 5. MRI
 - 6. Other
 - 7. Unknown

SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS

9. General

History of?
Yes No/NR

- a. AIDS/HIV
- b. Excess alcohol use
- c. Illicit drug use
- d. Anemia
- e. Cancer (excluding skin cancer)
- f. Connective tissue disease
- g. Ex-smoker
- h. Current smoker
- i. Thyroid disease

Respiratory

- a. Asthma ^G
- b. Chronic bronchitis/COPD ^G
- c. Other chronic lung disease
- d. Pulmonary embolus
- e. Coughing, phlegm, wheezing ^G
- f. Sleep apnea

11. Cardiovascular

- a. Angina ^G
- b. Arrhythmia
 - 1) Atrial fibrillation/atrial flutter
 - 2) Heart block or other bradycardia
 - 3) Ventricular fibrillation or tachycardia

SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS (continued)

11. Cardiovascular (continued)

History of?
Yes No/NR

- c. Infectious/bacterial endocarditis
- d. cardiac arrest
- e. Cardiac procedures
 - a. CABG
 - b. PCI

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- c. Valve surgery
- d. Pacemaker
- e. Defibrillator
- f. Congenital heart disease
- g. Coronary heart disease (within year) ^G
- h. Coronary heart disease (ever) ^G
- i. Electrocardioversion/defibrillation
- j. Hypertension
- k. Myocardial infarction
- l. Pulmonary hypertension
- m. Peripheral vascular disease
- n. Rheumatic heart disease
- o. Valvular heart disease

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If Yes, go to item 11.i.

12. Gastrointestinal / Endocrine

- a. Diabetes
- b. Hyperlipidemia
- c. Liver disease

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

13. Renal

- a. Dialysis

<input type="checkbox"/>	<input type="checkbox"/>
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SECTION III: MEDICAL HISTORY AND PRECIPITATING FACTORS (continued)

14. Neurology

History of?
Yes No/NR

- a. Stroke/TIA
- b. Depression

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

15. Other significant medical condition: _____

16. Were any of the following medical problems listed as precipitating factors (i.e. precipitated the onset of this event)?

	<u>Yes</u>	<u>No/NR</u>
a. Postpartum state	<input type="checkbox"/>	<input type="checkbox"/>
b. Excess alcohol intake	<input type="checkbox"/>	<input type="checkbox"/>
c. Excess fluid intake/administration	<input type="checkbox"/>	<input type="checkbox"/>
d. Noncompliance with diet	<input type="checkbox"/>	<input type="checkbox"/>
e. Noncompliance with medication	<input type="checkbox"/>	<input type="checkbox"/>
f. Infection	<input type="checkbox"/>	<input type="checkbox"/>
g. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
h. Infectious/ bacterial endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
i. Pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>
j. Angina	<input type="checkbox"/>	<input type="checkbox"/>
k. Atrial fibrillation/flutter	<input type="checkbox"/>	<input type="checkbox"/>
l. Heart block	<input type="checkbox"/>	<input type="checkbox"/>
m. Ventricular fibrillation/flutter	<input type="checkbox"/>	<input type="checkbox"/>
n. Cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>
o. Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>
p. Valvular heart disease	<input type="checkbox"/>	<input type="checkbox"/>
q. Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>

SECTION IV: PHYSICAL EXAM - VITAL SIGNS

	At hospital admission (or at onset of event)	At hospital discharge (or last recorded)
17. Blood pressure:	a. <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>	c. / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
18. Heart rate: ^{B, F, N}	a. <input type="text"/> <input type="text"/> <input type="text"/> bpm	
19. Height:	a. <input type="text"/> <input type="text"/> <input type="text"/> a.1. <input type="text"/> m/ in (c=cm, i=in)	
20. Weight: ^F	a. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> l. <input type="text"/> kg b. <input type="text"/> <input type="text"/> <input type="text"/> lbs\ k <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> lbs\ k <input type="text"/> <input type="text"/>
	(l=lbs, k=kg)	(l=lbs, k=kg)
21. Respiration rate	a. <input type="text"/> <input type="text"/> <input type="text"/> /min	b. <input type="text"/> <input type="text"/> <input type="text"/> n

SECTION V: PHYSICAL EXAM AND SYMPTOMS - FINDINGS

22. Did the patient have any of the following GENERAL signs or symptoms?

	Anytime during hospitalization or at admission		At hospital discharge		
	Yes	No/NR	Yes	No/NR	
a. Lower extremity edema ^{G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	a.1.	<input type="checkbox"/>	<input type="checkbox"/>
b. Jugular venous distension (JVD) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	b.1.	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatojugular reflux ^F	<input type="checkbox"/>	<input type="checkbox"/>			
d. Hepatomegaly ^{F, N, B}	<input type="checkbox"/>	<input type="checkbox"/>			
e. Leg fatigue on walking ^B	<input type="checkbox"/>	<input type="checkbox"/>			

23. Did the patient have any of the following RESPIRATORY signs or symptoms?

	Anytime during hospitalization or at admission		At hospital discharge		
	Yes	No/NR	Yes	No/NR	
a. Cough ^F	<input type="checkbox"/>	<input type="checkbox"/>	a.1.	<input type="checkbox"/>	<input type="checkbox"/>
b. Dyspnea (Rest) ^B	<input type="checkbox"/>	<input type="checkbox"/>	b.1.	<input type="checkbox"/>	<input type="checkbox"/>
c. Dyspnea (Walking) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	c.1.	<input type="checkbox"/>	<input type="checkbox"/>
d. Dyspnea (Climbing or exertion) ^{B, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	d.1.	<input type="checkbox"/>	<input type="checkbox"/>
e. Stops for breath when walking ^N	<input type="checkbox"/>	<input type="checkbox"/>	e.1.	<input type="checkbox"/>	<input type="checkbox"/>
f. Stops for breath after 100 yards ^N	<input type="checkbox"/>	<input type="checkbox"/>			
g. Rhonchi ^G	<input type="checkbox"/>	<input type="checkbox"/>			
h. Paroxysmal nocturnal dyspnea ^{B, F, G}	<input type="checkbox"/>	<input type="checkbox"/>	h.1.	<input type="checkbox"/>	<input type="checkbox"/>
i. Orthopnea ^B	<input type="checkbox"/>	<input type="checkbox"/>	i.1.	<input type="checkbox"/>	<input type="checkbox"/>
j. Pulmonary basilar rales ^{B, G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	j.1.	<input type="checkbox"/>	<input type="checkbox"/>
k. Rales (more than basilar) ^{B, G, F, N}	<input type="checkbox"/>	<input type="checkbox"/>	k.1.	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing ^B	<input type="checkbox"/>	<input type="checkbox"/>	l.1.	<input type="checkbox"/>	<input type="checkbox"/>
m. Vital capacity (decreased 1/3) ^F	<input type="checkbox"/>	<input type="checkbox"/>			

If Yes, go to item 23g.

SECTION V: PHYSICAL EXAM AND SYMPTOMS - FINDINGS (continued)

24. Did the patient have any of the following CARDIOVASCULAR signs or symptoms?

	Anytime during hospitalization			At hospital discharge	
	Yes	No/NR		Yes	No/NR
a. S3 (gallop) ^{B,F}	<input type="checkbox"/>	<input type="checkbox"/>	a.1.	<input type="checkbox"/>	<input type="checkbox"/>
b. S4 (gallop)	<input type="checkbox"/>	<input type="checkbox"/>	b.1.	<input type="checkbox"/>	<input type="checkbox"/>
c. Chest Pain ^G	<input type="checkbox"/>	<input type="checkbox"/>	c.1.	<input type="checkbox"/>	<input type="checkbox"/>
d. NYHA class: I <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	recorded	<input type="checkbox"/>	

SECTION VI: DIAGNOSTIC TESTS

25. Was an electrocardiogram performed during this hospitalization?: Yes No/NR → Go to item 27.

26. Did the patient have any of the following ECG abnormalities at any time during this hospitalization?

Yes No/Unknown

- | | | | | |
|--|--------------------------|--------------------------|------------------------|--|
| a. MI (age undetermined) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| b. Ischemic changes or ST-T changes | <input type="checkbox"/> | <input type="checkbox"/> | | |
| c. Atrial fibrillation / atrial flutter ^G | <input type="checkbox"/> | <input type="checkbox"/> | d. On telemetry? Yes | No <input type="checkbox"/> <input type="checkbox"/> |
| d. Left ventricular hypertrophy | <input type="checkbox"/> | <input type="checkbox"/> | | |
| e. Left bundle branch block | <input type="checkbox"/> | <input type="checkbox"/> | | |
| f. Ventricular tachycardia | <input type="checkbox"/> | <input type="checkbox"/> | f.1. On telemetry? Yes | No <input type="checkbox"/> <input type="checkbox"/> |

27. Was a chest X-ray performed during this hospitalization?: Yes NR → Go to item 29.

28. Did the patient have any of the following signs on chest X-ray at any time during this hospitalization?

Yes No/Unknown

- | | | |
|--|--------------------------|--------------------------|
| a. Alveolar infiltrates | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alveolar/pulmonary edema ^{B, F, N} | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Interstitial pulmonary edema ^{B, F, N} | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cardiomegaly ^{B, F} | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cephalization/upper zone redistribution ^{B, N} | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Bilateral pleural effusion ^{B, F, N} | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Unilateral pleural effusion ^{F, N} | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Pulmonary vascular congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Kerley B lines | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cardiothoracic ratio ≥ 0.5 ^B | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION VI: DIAGNOSTIC TESTS (continued)

29. Was a transthoracic echocardiogram performed? Yes No NR Go to item 30 29.

First transthoracic echocardiogram performed after onset or progression of heart failure.

a. Date (mm-dd-yyyy): - -

b. Ejection fraction:

c. Wall thickness: septal: c.1. units (1 h, 2=mm)

c.2. posterior: c.3. units (1=cm, 2=mm)

d. Record the following if present on transthoracic echocardiogram:

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>None</u>	<u>Present</u>	<u>NR</u>
1. Left ventricular hypertrophy (LVH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired LV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Impaired RV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Aortic regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Aortic stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tricuspid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Mitral regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Mitral stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Estimated RVSP/PASP:	<input type="text"/> <input type="text"/> <input type="text"/>					
				a. TR jet velocity: . m <input type="text"/> <input type="text"/>		
10. Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Yes</u>	<u>No/Unknown/NR</u>				
11. Regional wall motion abnormality	<input type="checkbox"/>	<input type="checkbox"/>				
12. Dilated left ventricle	<input type="checkbox"/>	<input type="checkbox"/>				
13. Dilated right ventricle	<input type="checkbox"/>	<input type="checkbox"/>				
14. Diastolic dysfunction	<input type="checkbox"/>	<input type="checkbox"/>				

SECTION VI: DIAGNOSTIC TESTS (continued)

30. Was a transesophageal echocardiogram performed? Yes No/NR

→ Go to item 31.

First transesophageal echocardiogram performed after onset or progression of event.

a. Date (mm-dd-yyyy): - -

b. Ejection fraction:

c. Record the following if present on transesophageal echocardiogram:

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>None</u>	<u>Present</u>	<u>NR</u>
1. Impaired LV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired RV systolic function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No/Unknown/NR</u>
3. Regional wall motion abnormality	<input type="checkbox"/>	<input type="checkbox"/>
4. Dilated left ventricle	<input type="checkbox"/>	<input type="checkbox"/>
5. Dilated right ventricle	<input type="checkbox"/>	<input type="checkbox"/>

SECTION VI: DIAGNOSTIC TESTS (continued)

31 Was a right cardiac catheterization performed? Yes No/NR

→ Go to item 32.

a. Date (mm-dd-yyyy): - -

b. Record the following measurements from the catheterization report::

- 1. Right atrial pressure (mean): mmHg
- 2. Pulmonary arterial pressure: / mmHg
- 3. Pulmonary wedge pressure: mmHg
- 4. Cardiac output: l/min
- 5. Cardiac index: l/min/m² BSA

32 Was coronary angiography performed? Yes No/NR Go to item 33.

a. Date (mm-dd-yyyy): - -

b. Record the following:

1. Ejection fraction: %

2. Coronary stenosis:

0 1-24 25-49 50-74 75-94 95-99 100 NR
% % % % % % %

- a. Left main:
- b. Left anterior descending artery and branches:
- c. Left circumflex/marginal artery:
- d. Right coronary artery and branches:
- e. Intermediate ramus:

3. Were coronary bypass grafts present? Yes No/NR Go to item 32.b.4.

a. Number of occluded grafts:

4. Mitral regurgitation: mild moderate severe none present NR

SECTION VI: DIAGNOSTIC TESTS (continued)

33. Was a cardiac radionuclide ventriculogram performed? Yes No/NR Go to item 34.

- a. Date: - -
mm-dd-yyyy)
- b. Ejection fraction: LV: %
- c. RV:

34. Was a cardiac Magnetic Resonance Imaging (MRI) performed? Yes

/NR

Go to item 35.

a. Date: --
(mm-dd-yyyy)

b. Ejection fraction: LV:

c. RV:

35. Was a cardiac CT scan performed?

Yes

/NR

Go to item 36.

a. Date: --
(mm-dd-yyyy)

b. Ejection fraction: LV:

c. RV:

36. Was a stress test performed?

Yes

o/NR

Go to item 37.

a. Date: --

b. Normal Abnormal Equivocal Not diagnostic

c. Ejection fraction: LV:

SECTION VII: BIOCHEMICAL ANALYSES

a. Worst*

b. Last

c. Upper Limit Normal

37. Hemoglobin (g/dL)

38. Hematocrit (%)

39. BNP (pg/mL)

40. ProBNP (pg/mL)

41. Troponin T (ng/mL)

42. Troponin I (ng/mL)

43. Sodium (mEq/L)

44. Serum creatinine (mg/dL)

45. BUN (mg/dL)

Worst = highest value with exception of hemoglobin, hematocrit, and sodium. For these items worst is the lowest value (^L)

SECTION VIII: INTERVENTIONS

	<u>Yes</u>	<u>No/Unknown/NR</u>
46. Cardiac (electrophysiologic) ablation therapy	<input type="checkbox"/>	<input type="checkbox"/>
47. Implantable cardiac defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
48. Cardioversion	<input type="checkbox"/>	<input type="checkbox"/>
49. Pacemaker placement (non-biventricular)	<input type="checkbox"/>	<input type="checkbox"/>
50. Biventricular pacemaker (CRT)	<input type="checkbox"/>	<input type="checkbox"/>
51. Coronary Artery Bypass Graft	<input type="checkbox"/>	<input type="checkbox"/>
52. Percutaneous Coronary Intervention (PCI)/stent	<input type="checkbox"/>	<input type="checkbox"/>
53. Valve replacement/repair	<input type="checkbox"/>	<input type="checkbox"/>
54. Intra Aortic Balloon Pump (IABP)	<input type="checkbox"/>	<input type="checkbox"/>
55. Hemofiltration/dialysis	<input type="checkbox"/>	<input type="checkbox"/>
56. Listed/received transplant of heart	<input type="checkbox"/>	<input type="checkbox"/>
57. Left ventricular assist device	<input type="checkbox"/>	<input type="checkbox"/>
58. Was patient counseled regarding the following?		
a. Sodium/cholesterol reduction	<input type="checkbox"/>	<input type="checkbox"/>
b. Tobacco cessation <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>
c. Fluid restriction	<input type="checkbox"/>	<input type="checkbox"/>

SECTION IX: MEDICATIONS

	Prior to hospitalization or progression in hospital		At hospital discharge	
	Yes	No/NR	Yes	No/NR
59. ACE inhibitors	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
60. Angiotensin II receptor blockers	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
61. Antiarrhythmics				
a. Amiodarone	<input type="checkbox"/>	<input type="checkbox"/> a. 1.	<input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/> b. 1	<input type="checkbox"/>	<input type="checkbox"/>
62. Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
63. Anti-inflammatory	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
64. Antiplatelets				
a. Aspirin	<input type="checkbox"/>	<input type="checkbox"/> a.1.	<input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/>	b.1. <input type="checkbox"/>	<input type="checkbox"/>
65. Beta blockers	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
66. Calcium channel blockers	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
67. Digitalis ^G	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
68. Diuretics ^G	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>
69. Aldosterone Blocker	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
70. Lipid lowering agents				
a. Statins	<input type="checkbox"/>	<input type="checkbox"/> .1.	<input type="checkbox"/>	<input type="checkbox"/>
b. Other	<input type="checkbox"/>	<input type="checkbox"/> b.1.	<input type="checkbox"/>	<input type="checkbox"/>
71. Nitrates	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
72. Hydralazine	<input type="checkbox"/>	<input type="checkbox"/> a.	<input type="checkbox"/>	<input type="checkbox"/>

SECTION IX: MEDICATIONS (continued)

73. IV drugs during this hospitalization?

- a. IV inotropes: Yes No/NR
- b. IV diuretics: Yes No/NR
- c. IV vasodilators: Yes No/NR
- d. IV antiarrhythmics: Yes No/NR

SECTION X: COMPLICATIONS FOLLOWING EVENT

	<u>Yes</u>	<u>No/Unknown</u>
74. Cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>
75. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
76. Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>

SECTION XI: ADMINISTRATIVE

77. Time taken to abstract (mins):

78. Abstractor number:

79. Date abstract completed (mm-dd-yyyy): - -