



0.a. Hospital code number:

0.b. Medical Record Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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0.c. Date of discharge (for nonfatal case) or death:

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Month                  Day                  Year

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

Deceased ..... D

Alive ..... A

→

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

**SECTION I: SCREENING FOR DECOMPENSATION OR NEW ONSET**

- |   | <u>Yes</u>               | <u>No/Not Recorded</u>   |
|---|--------------------------|--------------------------|
| 1. Was there evidence of the following conditions?  |                          |                          |
| a. Increasing or new onset shortness of breath  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Increasing or new onset edema  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Increasing or new onset paroxysmal nocturnal dyspnea   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Increasing or new onset orthopnea  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Increasing or new onset hypoxia  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Was there evidence in the doctor's notes that the reason for this hospitalization was heart failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is this a cohort participant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.a. Does this cohort hospitalization have a 428 code?  | <input type="checkbox"/> | <input type="checkbox"/> |

If any one of Q1a-e =Y or Q2 =Y, skip →

If any response to items 1-3 is YES, go to item 4. If all are NO or not recorded, go to item 77. If item 3 is yes but cohort member does not meet any of the screening criteria (HFA1a-e or HFA2), and does not have a 428 code, go to item 77.

- |   | <u>Yes</u>               | <u>No/Not Recorded</u>   |
|---|--------------------------|--------------------------|
| 4. Did the patient have new onset or progressive symptoms/signs of heart failure: |                          |                          |
| a. At the time of admission to the hospital?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During this hospitalization?   | <input type="checkbox"/> | <input type="checkbox"/> |

If the response to both item 4a and 4b, is 'No/Not Recorded', skip items 5 and 5a.

5. Date of new onset or progression of symptoms/signs known (mm-dd-yyyy): --
- a. If exact date unknown, estimate weeks prior to this hospitalization:

6. Did the physician's note or discharge summary indicate any of the following specific types of heart failure? (check all that apply)
- |  | <u>Yes</u>               | <u>No/ Not Recorded</u>  |
|--|--------------------------|--------------------------|
| a. Ischemic cardiomyopathy                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Idiopathic/dilated cardiomyopathy           | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other specific cardiomyopathy/heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| j.1. If other cardiomyopathy, specify _____    |                          |                          |
| k. Unknown/Not recorded                        | <input type="checkbox"/> | <input type="checkbox"/> |

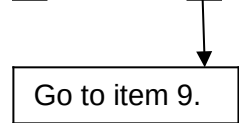
If No/Not Recorded, go to item 6k.

**SECTION II: HISTORY OF HEART FAILURE**

7. Prior to this hospitalization was there a history of any of the following:

	<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/Unk



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

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**SECTION III: MEDICAL HISTORY****9. General**

	<u>History of?</u>	
	<u>Yes</u>	<u>No/NR</u>

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

**10. Respiratory**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Asthma <sup>G</sup>                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Chronic bronchitis/COPD <sup>G</sup>    | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other chronic lung disease              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pulmonary embolus                       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Coughing, phlegm, wheezing <sup>G</sup> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sleep apnea                             | <input type="checkbox"/> | <input type="checkbox"/> |

**11. Cardiovascular**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Angina <sup>G</sup>                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arrhythmia                              |                          |                          |
| 1) Atrial fibrillation/atrial flutter      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Heart block or other bradycardia        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Ventricular fibrillation or tachycardia | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION III: MEDICAL HISTORY (continued)****11. Cardiovascular (continued)**

	<u>History of?</u>	
	<u>Yes</u>	<u>No/NR</u>
c. Infectious/bacterial endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
d. Cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>
e. Cardiac procedures		
1) CABG	<input type="checkbox"/>	<input type="checkbox"/>
2) PCI	<input type="checkbox"/>	<input type="checkbox"/>
3) Valve surgery	<input type="checkbox"/>	<input type="checkbox"/>
4) Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
5) Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
f. Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
g. Coronary heart disease (within year) <sup>G</sup>	<input type="checkbox"/>	<input type="checkbox"/>
h. Coronary heart disease (ever) <sup>G</sup>	<input type="checkbox"/>	<input type="checkbox"/>
i. Electrocardioversion/defibrillation	<input type="checkbox"/>	<input type="checkbox"/>
j. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
k. Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>
l. Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>
m. Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
n. Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>
o. Valvular heart disease	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, go to item 11.i.

**12. Gastrointestinal / Endocrine**

a. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
b. Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>
c. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>

**13. Renal**

a. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
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**SECTION III: MEDICAL HISTORY (continued)**

14. Neurology

History of?  
Yes No/NR

- a. Stroke/TIA
- b. Depression

15. Other significant medical condition: \_\_\_\_\_

16.r. Was Angina or Myocardial infarction listed as a precipitating factor (i.e. precipitated the onset of this event)?

Yes No/NR

**SECTION IV: PHYSICAL EXAM – VITAL SIGNS**

At hospital admission  
(or at onset of event)

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At hospital discharge  
(or last recorded)

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17. Blood pressure:

a.    / b.    mmHg      c.    / d.    mmHg

18. Heart rate: <sup>B, F, N</sup>

a.    bpm

19. Height:

a.         a.1.  cm/ in (c=cm, i=in)

20. Weight: <sup>F</sup>

a.    .       a.1.  lbs/ kg      b.    .       b.1.  lbs\ kg  
(l=lbs, k=kg)  (l=lbs, k=kg)

**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  
Yes      No/NR

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Lower extremity edema <sup>G, F, N</sup>           | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Jugular venous distension (JVD) <sup>B, F, N</sup> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hepatojugular reflux <sup>F</sup>                  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hepatomegaly <sup>F, N, B</sup>                    | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Leg fatigue on walking <sup>B</sup>                | <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  
Yes      No/NR

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Cough <sup>F</sup>                                | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dyspnea (Rest) <sup>B</sup>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dyspnea (Walking) <sup>B, F, N</sup>              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Dyspnea (Climbing or exertion) <sup>B, F, N</sup> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Stops for breath when walking <sup>N</sup>        | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stops for breath after 100 yards <sup>N</sup>     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Rhonchi <sup>G</sup>                              | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Paroxysmal nocturnal dyspnea <sup>B, F, G</sup>   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Orthopnea <sup>B</sup>                            | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Pulmonary basilar rales <sup>B, G, F, N</sup>     | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Rales (more than basilar) <sup>B, G, F, N</sup>   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Wheezing <sup>B</sup>                             | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes, enter yes for  
23c, 23d, 23e and 23f

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

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

Anytime during hospitalization

Yes                      No/NR

a. S3 (gallop)<sup>B, F</sup>

b. S4 (gallop)

c. Chest Pain<sup>G</sup>

**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?

- |  | <u>Yes</u>               | <u>No/Unknown</u>        |   |
|--|--------------------------|--------------------------|---|
| 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 <sup>G</sup> | <input type="checkbox"/> | <input type="checkbox"/> | c.1. On telemetry? Yes <input type="checkbox"/> No <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 <input type="checkbox"/> No <input type="checkbox"/> |

27. Was a chest X-ray performed during this hospitalization?: Yes  No/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?

- |  | <u>Yes</u>               | <u>No/Unknown</u>        |
|--|--------------------------|--------------------------|
| a. Alveolar infiltrates                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alveolar/pulmonary edema <sup>B, F, N</sup>             | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Interstitial pulmonary edema <sup>B, F, N</sup>         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cardiomegaly <sup>B, F</sup>                            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cephalization/upper zone redistribution <sup>B, N</sup> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Congestive heart failure                                | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Bilateral pleural effusion <sup>B, F, N</sup>           | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Unilateral pleural effusion <sup>F, N</sup>             | <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 $\geq 0.5$ <sup>B</sup>            | <input type="checkbox"/> | <input type="checkbox"/> |

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**SECTION VI: DIAGNOSTIC TESTS (continued)**

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

If the response to item 29 is YES, complete items 29a-29c3, and 29d1-29d14.;  
 If the response is No/NR skip items 29a-29c3, and 29d1-29d14

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=cm, 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"/> mmHg						
a. TR jet velocity: <input type="text"/> . <input type="text"/> m/s						
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:   .  liters/min

5. Cardiac index:   .  liters/min/m<sup>2</sup> 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:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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b. Left anterior descending artery and branches:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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c. Left circumflex/marginal artery:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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d. Right coronary artery and branches:

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

e. Intermediate ramus:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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  No/NR  Go to item 35.

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

b. Ejection fraction: LV:   %

c. RV:   %

35. Was a cardiac CT scan performed? Yes  No/NR  Go to item 36.

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

b. Ejection fraction: LV:   %

c. RV:   %

36. Was a stress test performed? Yes  No/NR  Go to item 37.

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

b. Normal  Abnormal  Equivocal  Not diagnostic

c. Ejection fraction: LV:   %

**SECTION VII: BIOCHEMICAL ANALYSES**

	a. <u>Worst*</u>	b. <u>Last</u>	c. <u>Upper Limit Normal</u>
37. Hemoglobin (g/dL)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	
38. Hematocrit (%)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	
39. BNP (pg/mL)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
40. ProBNP (pg/mL)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
41. Troponin T (ng/mL)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>
42. Troponin I (ng/mL)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
43. Sodium (mEq/L)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
44. Serum creatinine (mg/dL)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	
45. BUN (mg/dL)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	

\* Worst = highest value with exception of hemoglobin, hematocrit, and sodium. For these items worst is the lowest value ( <sup>L</sup> )

**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"/>

**SECTION IX: MEDICATIONS**

	<u>Prior to hospitalization or progression in hospital</u>		<u>At hospital discharge</u>	
	<u>Yes</u>	<u>No/NR</u>	<u>Yes</u>	<u>No/NR</u>
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 <sup>G</sup>	<input type="checkbox"/>	<input type="checkbox"/>	a. <input type="checkbox"/>	<input type="checkbox"/>
68. Diuretics <sup>G</sup>	<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"/>	a.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"/>
73. IV drugs during this hospitalization?				
a. IV inotropes:	Yes <input type="checkbox"/>	No/NR <input type="checkbox"/>		
b. IV diuretics:	Yes <input type="checkbox"/>	No/NR <input type="checkbox"/>		

**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): --