Case Review Form

Legend:
BOLD = Required (required when shown in eCRF)
Updates appear in yellow highlight

Demographics Tab

Vendor Name: ______________ **Vendor Software Version:** ______________

Patient ID: _________________________

Patient not admitted at this facility and transferred out to another acute care facility? O Yes O No

Demographics

Gender: O Male O Female OUnknown

Date of Birth: _____/_____/______

Patient Zip Code: _______________

Payment Source:	☐ Medicare ☐ Medicare-Private/HMO/PPO/Other ☐ Medicaid ☐ Medicaid – Private/HMO/PPO/Other ☐ Private/HMO/PPO/Other	☐ VA/CHAMPVA/Tricare ☐ Self-Pay/No Insurance ☐ Indian Health Services ☐ Other/Not Documented/UTD

Race and Ethnicity

Race:

☐ American Indian or Alaska Native
☐ Black or African American
☐ White
☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

☐ UTD

Hispanic Ethnicity	O Yes O No/UTD
If Yes,	☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Another Hispanic, Latino, or Spanish Origin

Admin Tab

Administrative

Attending Physician/Provider NPI: _________________________

Arrival Date/Time:	___/___/______ ___: ____	**Admission Date:**	___/___/______ ___: ____

Patient first evaluated:	O ED O Cath Lab O Other	Date/time of ED discharge/transfer out ___/___/______ ___: ____

ED Physician: _________________

Diagnosis

Cardiac Diagnosis:	O Confirmed AMI – STEMI O Confirmed AMI – non-STEMI	O Confirmed AMI – STEMI/non-STEMI unspecified O Unstable Angina	O Coronary Artery Disease O Other

Enrolled in Clinical Trial During Hospitalization	O Yes O No

If Yes, Type of Clinical Trials(s) (select all that apply)	☐ Precluding the use of aspirin in protocol ☐ Related to reperfusion therapy ☐ Involving new antiplatelet therapies ☐ Involving renin-angiotensin-aldosterone system inhibitor	☐ Related to lipid lowering therapy ☐ Related to AMI ☐ Related to STEMI

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Pre-Hospital/Arrival Tab

Pre-Hospital

Means of transport to first facility:	O Air O Ambulance O Walk-in	EMS Agency name/number: ______________________ Run/Sequence number: ______________________

Cardiac arrest prior to arrival? O Yes O No

If yes, was bystander CPR performed? O Yes O No

If yes, was therapeutic hypothermia initiated during this episode of care? O Yes O No

Pre-Hospital Time Tracker

EMS First Medical Contact:	___/___/______ ___: ____
Non-EMS First Medical Contact:	___/___/______ ___: ____
EMS Non-System Reason for Delay: ☐	
Date/time of Initial 911 Call for Help	___/___/______ ___: ____
EMS Dispatch:	___/___/______ ___: ____
EMS arrive on scene:	___/___/______ ___: ____
EMS depart scene:	___/___/______ ___: ____
Destination Pre-arrival alert or notification:	___/___/______ ___: ____
Method of 1st notification:	O ECG Transmission O Phone call O Radio O ND

Transfers

Transferred from other facility? O Yes O No | Transferring Facility:__________________________

Transfer Time Tracker

Arrival at First hospital:	___/___/______ ___: ____
Transport requested:	___/___/______ ___: ____
Transport Arrived Date/Time:	___/___/______ ___: ____
Transfer out:	___/___/______ ___: ____

Facility the patient was transferred to:____

Mode of transport O Air O Ambulance | Inter-facility transport EMS Agency name/number:_____________________

ECG

1st ECG Date/Time: ___/___/____ ___:___	**1st ECG obtained:** O Prior to Hospital Arrival O After First Hospital Arrival

1st ECG Non-System Reason for Delay: ☐

STEMI or STEMI Equivalent? O Yes O No	If yes, STEMI or STEMI equivalent first noted: O First ECG O Subsequent ECG

If subsequent ECG, Date/Time of positive ECG: ___/___/______ ___:___

If No, other ECG finding: O New or presumed new ST depression. O Transient ST elevation lasting < 20 minutes

Arrival

Symptom onset Date/Time: ___/___/______ ___: ____	Heart rate documented on first medical contact ________
Systolic blood pressure on first medical contact _________	Systolic blood pressure – ND ☐

Heart failure documented on first medical contact O Yes O No

Cardiogenic shock documented on first medical contact O Yes O No

Patient Current Medications	O Dabigatran O Rivaroxaban O Apixaban O Warfarin O None O ND	Initial Serum Creatinine ____________ mg/dL

Aspirin within 24 hours of arrival? O Yes O No O Contraindicated

Positive cardiac biomarkers in the first 24 hours? O Yes O No

Initial Troponin value __________ O ng/mL O ng/L O ug/L	Initial Troponin – ND ☐

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<table>
<tr><td colspan="2">Active bacterial or viral infection at admission or during hospitalization:</td><td colspan="2">☐ None/ND
☐ Bacterial Infection
☐ Emerging Infectious Disease
☐ MERS
☐ SARS-COV-1
☐ SARS-COV-2 (COVID-19)
☐ Other Emerging Infectious Disease</td><td>☐ Influenza
☐ Seasonal Cold
☐ Other Viral Infection</td></tr>
<tr><td>Patient Medical History:</td><td colspan="4">☐ Atrial Fibrillation ☐ Atrial Flutter ☐ Cancer ☐ Cerebrovascular Disease [parent] If yes, ☐ Stroke [child] If yes, ☐ TIA [child] ☐ Currently on Dialysis ☐ Diabetes Mellitus ☐ Dyslipidemia [parent] If yes, ☐ Familial Hypercholesterolemia [child] ☐ Emerging Infectious Disease [parent] ☐ MERS [child] ☐ SARS-COV-1 [child] ☐ SARS-COV-2 (COVID-19) [child] ☐ Heart Failure ☐ Hypertension ☐ Peripheral Artery Disease ☐ Prior CABG [parent], If Yes, Most Recent CABG Date __/__/____ [child]; ☐ Prior MI ☐ Prior PCI [parent], If Yes, Most Recent PCI Date __/__/____ [child]</td></tr>
<tr><td colspan="2">History of Smoking?</td><td colspan="3">O Yes O No</td></tr>
<tr><td colspan="3">History of vaping or e-cigarette use in the past 12 months?</td><td colspan="2">O Yes O No/ND</td></tr>
<tr><td colspan="2">Height ___________cm</td><td colspan="3">Weight ___________kg</td></tr>
<tr><td colspan="5">In-hospital Risk Adjusted Mortality Score ___________ (calculated)</td></tr>
</table>

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Hospitalization Tab		
Reperfusion		
Thrombolytics? O Yes O No	**If yes, Dose Start Date/Time**: ___/___/______ ___: ____	Documented non-system reason for delay- thrombolytics? O Yes O No If yes, reason (check all that apply) ☐ Cardiac Arrest ☐ Intubation ☐ Need for additional PPE for suspected/confirmed infectious disease ☐ Patient refusal

Reasons for not administering a thrombolytic		
	O Active peptic ulcer O Any prior intracranial hemorrhage O DNR at time of treatment decision O Expected DTB ≤ 90 minutes O Intracranial neoplasm, AV malformation, or aneurysm O Ischemic stroke w/in 3 months except acute ischemic stroke within 3hrs O Known bleeding diathesis O No Reason documented O Pregnancy	O Prior allergic reaction to thrombolytics O Recent bleeding within 4 weeks O Recent surgery/trauma O Severe uncontrolled hypertension O Significant close head or facial trauma within previous 3 months O Suspected aortic dissection O Transferred for PCI O Traumatic CPR that precludes thrombolytics O Other

PCI? O Yes O No

Physician interventionalist NPI ____________________

Reasons for not performing PCI			
	O Non-compressible vascular puncture(s) O Active bleeding on arrival or within 24 hours O Quality of life decision O Anatomy not suitable to primary PCI	O Spontaneous reperfusion (documented by cath only) O Patient/family refusal O DNR at time of treatment decision O Prior allergic reaction to IV contrast	O Other O Not performed O No reason documented O Thrombolytic Administered

PCI Time Tracker

Cath Lab Activation: ___/___/______ ___: ____	Patient Arrival to Cath Lab: ___/___/______ ___: ____
Attending Arrival to Cath Lab: ___/___/______ ___: ____	Team Arrival to Cath Lab: ___/___/______ ___: ____
First PCI Date/Time: ___/___/______ ___: ____	

PCI Indication			
	O Primary PCI for STEMI O PCI for STEMI (stable after successful full-dose lytic)	O PCI for STEMI (unstable, >12 hr from sx onset) O Rescue PCI for STEMI (after failed full-dose lytic)	O PCI for STEMI (stable, >12 hr from sx onset) O PCI for NSTEMI O Other

Non-system reason for delay- PCI?		
	☐ Difficult vascular access ☐ Cardiac arrest and/or need for intubation ☐ Patient delays in providing consent ☐ Difficulty crossing the culprit lesion	☐ Emergent placement of LV support device ☐ Need for additional PPE for suspected/confirmed infectious disease ☐ Other ☐ None

Hospitalization

LVF Assessment ______________%	Obtained:	O This Admission O W/in the last year	O > 1 year ago O Planned After Discharge

Was early diagnostic coronary angiography performed?	O Yes O No
Date and time of diagnostic angiography: **:** ___/___/______ ___: ____	

Reason for not performing early diagnostic Angiography	☐ Yes, medical reason ☐ Yes, patient reason	☐ Yes, system reason ☐ No reason documented

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CABG During This Admission:	O Yes O No	
LDL Cholesterol Value:	____________mg/dl	☐ LDL Not Documented
Risk-Stratification Score Documented?	O EDACS O GRACE O HEART O SYNTAX Score	O TIMI O Other O No Risk-Stratification Score Documented
Grace Risk Score ________	TIMI Risk Score	____________
Health Related Social Needs Assessment		
During this admission, was a standardized health related social needs form or assessment completed?	O Yes O No/ND	
If Yes, identify the areas of unmet social need (select all apply)	☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing ☐ Mental Health	☐ Personal Safety ☐ Substance Use ☐ Transportation Barriers ☐ Utilities ☐ None of the areas of unmet social needs listed were identified
Vaccinations and Testing		
Influenza Vaccination: [hfs_fluvacc]	o Influenza vaccine was given during this hospitalization during the current flu season o Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization o Documentation of patient's refusal of influenza vaccine o Allergy/sensitivity to influenza vaccine or if medically contraindicated o Vaccine not available o None of the above/Not documented/UTD	
Was patient tested for influenza during this hospitalization? [flutest]	o Yes o No/ND	
Influenza rapid Ag Result: Influenza PCR Result: If positive, Influenza Type	o Positive o Negative o Not Done o Positive o Negative o Not Done ☐ Type A ☐ Type B ☐ Unknown/UTD	
COVID-19 Vaccination [covidvacc]:	o COVID-19 vaccine was given during this hospitalization o COVID-19 vaccine was received prior to admission, not during this hospitalization o Documentation of patient's refusal of COVID-19 vaccine o Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated o Vaccine not available o None of the above/Not documented/UTD	
COVID-19 Vaccination Date: [covidvaccdate]		
Is there documentation that this patient was included in a COVID-19 vaccine trial?	o Yes o No/ND	

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Discharge Tab			
Discharge Information			
Discharge Date/Time: ___/___/______ ___: ____			
Discharge Disposition:	1 - Home	5 – Other Health Care Facility	
	2 - Hospice-Home	6 - Expired	
	3 - Hospice-Healthcare Facility	7 – Left Against Medical Advice/AMA	
	4 - Acute Care Facility	8 – Not Documented or Unable to Determine (UTD)	
Comfort Measures Only?	O Yes O No	If Yes, Date/Time ___/___/______ ___: ____	
Referrals/Counseling			
Patient Referred to Cardiac Rehab?	O Yes O No referral documented O No-Medical Reason O No-Patient Oriented Reason O No-Health Care System Reason		
Smoking Cessation Counseling? O Yes O No			
Discharge Medications			
ACEI at discharge	**Prescribed**	O Yes O No O NC	
ARB at discharge	**Prescribed**	O Yes O No O NC	
Aspirin at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	**Dose:**	Frequency:
Clopidogrel at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	Dose:	Frequency:
Prasugrel at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	Dose:	Frequency:
Ticagrelor at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	Dose:	Frequency:
Ticlopidine at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	Dose:	Frequency:
Anticoagulation at discharge	**Prescribed**	O Yes O No O NC	
	If yes,	**Class:** **Medication:**	Dose: Frequency:
Beta Blocker at discharge	**Prescribed**	O Yes O No O NC	
Statin at discharge	**Prescribed**	O Yes O No	
	If yes,	**Medication:**	
		Dose:	
		Statin Level of Intensity: O Low O Moderate O High	
Is there a non-system reason for not prescribing a high intensity statin medication? ☐ Yes, medical reason ☐ Yes, patient reason ☐ No			
PCSK9 Inhibitor	Prescribed	O Yes O No O NC	

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