GWTG-CAD: Mission: Lifeline® Focus

PMT FORM SELECTION

Legend:

**BOLD** = Required

^ = MLL Data Element

Admin (Tab)

|^Patient ID: ____________________________|
|________/______|
|Gender: | Male | Female | Unknown |
|DOB: | | | |
|Patient Zip Code: |

^Arrival Date/Time: | |
|Admission Date: | |
|Not admitted, transferred out another acute care facility. |

Race:

□ American Indian or Alaska Native
□ Asian
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian

□ Black or African American
□ Native Hawaiian or Pacific Islander
□ White
□ Native Hawaiian
□ Guamanian or Chamorro
□ Other Pacific Islander
□ Samoan

Hispanic Ethnicity

<table>
<thead>
<tr>
<th>O Yes</th>
<th>O No/UTD</th>
</tr>
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</table>

If yes, □ Mexican, Mexican American, Chicoano/a □ Puerto Rican □ Cuban □ Another Hispanic, Latino or Spanish Origin

Cardiac Diagnosis:

□ Confirmed AMI – STEMI □ Confirmed AMI – STEMI/non-STEMI unspecified □ Confirmed AMI – non-STEMI/unspecified □ Coronary Artery Disease □ Unstable Angina □ Other

Pre-Hospital/Arrival

^Means of transport to first facility: □ Air □ Ambulance □ Walk-in

EMS Agency name/number:

Run/Sequence number:

EMS First Medical Contact:

^Non-EMS First Medical Contact:

Pre-Hospital Time Tracker

^EMS First Medical Contact: ___/___/______ __:___

^EMS Non-System Reason for Delay: □ Yes □ No

EMS Dispatch: ___/___/______ __:___

EMS Arrive on scene: ___/___/______ __:___

EMS depart scene: ___/___/______ __:___

EMS Non-System Reason for Delay:

Destination Pre-arrival alert or notification: ___/___/______ __:___

Method of 1st notification: □ ECG □ Phone □ Radio Transmission □ call

Transfers

^Transferred from other facility? □ Yes □ No

Transferring Facility:

Transfer Time Tracker

^Arrival at First hospital: ___/___/______ __:___

Transport requested: ___/___/______ __:___

Transport Arrived Date/Time: ___/___/______ __:___

Transfer out: ___/___/______ __:___

Mode of transport from outside facility

□ Air
□ Ambulance

Inter-facility transport EMS Agency name/number:

ECG

1st ECG Date/Time: ___/___/______ __:___

1st ECG obtained: □ Prior to hospital arrival
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<td>Relevant patient information and treatment details.</td>
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<tr>
<td><strong>Hospitalization</strong></td>
<td>Details about the patient's hospital stay and treatment.</td>
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**Reperfusion Candidate?**
- Yes
- No

**If no, primary reason:**
- No ST Elevation/LBBB
- MI diagnosis unclear
- Other

**Thrombolytics?**
- Yes
- No

**If yes, Dose Start Date/Time:**

**Documented non-system reason or delay- Lytics?**
- Yes
- No

**Primary PCI?**
- Yes
- No

**PCi Time Tracker**

**Cath Lab Activation:**

**Patient Arrival to Cath Lab:**

**Attending Arrival to Cath Lab:**

**Team Arrival to Cath Lab:**

**^1^st ECG Non-System Reason for Delay:**
- Yes
- No

**STEMI or STEMI Equivalent?**
- Yes
- No

**If yes, STEMI or STEMI equivalent first noted:**
- First ECG
- Subsequent ECG

**If subsequent ECG, Date/Time of positive ECG:**

**^Aspirin within 24 hours of arrival?**
- Yes
- No

**^Antithrombotic taken in 24hrs prior to arrival?**
- Yes
- No

**^Positive cardiac biomarkers in the first 24 hours?**
- Yes
- No

**^History of Smoking?**
- Yes
- No

**Reperfusion Contraindications**

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

- O Known bleeding diathesis
- O Ischemic stroke w/in 3 months except acute ischemic stroke w/in 3 hrs
- O Recent bleeding within 4 weeks
- O Any prior intracranial hemorrhage
- O Suspected aortic dissection
- O Recent surgery/trauma
- O Significant close head or facial trauma within previous 3 months
- O Active peptic ulcer
- O Pregnancy
- O Intracranial neoplasm, AV malformation, or aneurysm
- O Prior allergic reaction to thrombolytics
- O Severe uncontrolled hypertension
- O DNR at time of treatment decision
- O Traumatic CPR that precludes thrombolytics
- O Expected DTB < 90 minutes
- O No reason documented
- O Other

### Hospitalization

- ^LVF Assessment ______________%

  - Obtained: O This Admission
  - O W/in the last year
  - O > 1 year ago
  - O Planned After Discharge

- ^CABG During This Admission:
  - O Yes  O No

- ^LDL Cholesterol: __________mg/dl

### Discharge

- Discharge Date/Time: ___/___/______   ___: __

- ^Discharge Status:
  - 1 - Home
  - 2 - Hospice-Home
  - 3 - Hospice-Healthcare Facility
  - 4 - Acute Care Facility
  - 5 – Other Health Care Facility
  - 6 - Expired
  - 7 – Left Against Medical Advice/AMA
  - 8 – Not Documented or Unable to Determine (UTD)

- ^Comfort Measures Only
  - O Yes  O No

- ^Patient Referred to Cardiac Rehab?
  - O Yes  O No-Referral  O No-Medical Reason
  - O No-Pt Reason/Preference

- ^Smoking Cessation Counseling?
  - O Yes  O No

- ^ACEI at discharge
  - Prescribed: O Yes  O No
  - Contraindicated: O Yes  O No

- ^ARB at discharge
  - Prescribed: O Yes  O No
  - Contraindicated: O Yes  O No

- ^Aspirin at discharge
  - Prescribed: O Yes  O No
  - If yes, Dose: Frequency:
  - Contraindicated: O Yes  O No

- ^Clopidogrel at discharge
  - Prescribed: O Yes  O No
  - If yes, Dose: Frequency:
  - Contraindicated: O Yes  O No

- ^Prasugrel at discharge
  - Prescribed: O Yes  O No
  - If yes, Dose: Frequency:
  - Contraindicated: O Yes  O No
| ^Ticagrelor at discharge | Prescribed | □ Yes □ No | Frequency: 
|                        | If yes, Dose: |  |
| ^Ticlopidine at discharge | Prescribed | □ Yes □ No | Frequency: 
|                        | If yes, Dose: |  |
| ^Anticoagulation at discharge | Prescribed | □ Yes □ No | Class: Medication: Dose: Frequency: 
|                        | If yes, |  |
| ^Beta Blocker at discharge | Prescribed | □ Yes □ No |  |
|                        | Contraindicated | □ Yes □ No |  |
| ^Statin at discharge | Prescribed | □ Yes □ No |  |
|                        | Contraindicated | □ Yes □ No |  |
| Optional Field-1 |  |
| Optional Field-2 |  |
| Optional Field-3 |  |