

Patient ID:		Legend: Elements in bold are required	
DEMOGRAPHICS		Demographics Tab	
Sex	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Unknown
Patient Gender Identity	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="radio"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="radio"/> Genderqueer, neither exclusively male nor female <input type="radio"/> Additional gender category or other. _____ <input type="radio"/> Did not disclose.		
Patient-Identified Sexual Orientation	<input type="radio"/> Straight or heterosexual <input type="radio"/> Lesbian or gay <input type="radio"/> Bisexual <input type="radio"/> Queer, pansexual, and/or questioning <input type="radio"/> Something else; please specify: _____ <input type="radio"/> Don't know <input type="radio"/> Declined to answer		
Date of Birth	___/___/___ (MM/DD/YYYY)		
Patient Postal Code	_____ - _____	<input type="checkbox"/> Homeless	
Payment Source	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare – Private/HMO/PPO/Other <input type="checkbox"/> Medicaid – Private/HMO/PPO/Other	<input type="checkbox"/> Private/HMO/PPO/Other <input type="checkbox"/> VA/CHAMPVA/Tricare <input type="checkbox"/> Self-pay/No Insurance <input type="checkbox"/> Other/Not Documented/UTD	
RACE AND ETHNICITY		Demographics Tab	
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> UTD	
Hispanic Ethnicity	<input type="radio"/> Yes	<input type="radio"/> No/UTD	
If yes,	<input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino, or Spanish Origin	
ARRIVAL AND ADMISSION INFORMATION		Admission Tab	
Arrival Date/Time	___/___/___ :__ (MM/DD/YYYY HH:MM)		
Point of Origin for Admission	<input type="radio"/> Home <input type="radio"/> Transfer from a Hospital (Different Facility) <input type="radio"/> Clinic <input type="radio"/> Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	<input type="radio"/> Transfer from another Health Care Facility <input type="radio"/> Non-Healthcare Facility Point of Origin <input type="radio"/> Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program <input type="radio"/> Information not available	
Initial point of hospital arrival	<input type="radio"/> Emergency Department <input type="radio"/> Direct to inpatient unit – ICU <input type="radio"/> Direct to inpatient unit – Non-ICU	<input type="radio"/> Cath Lab/Operating Room <input type="radio"/> Other	
MEDICAL HISTORY		Admission Tab	

Medical History (Select all that apply):	
<input type="checkbox"/> None <input type="checkbox"/> Atherosclerotic vascular disease (choose all that apply) <input type="checkbox"/> Cerebrovascular disease (including previous TIA/CVA) <input type="checkbox"/> Coronary Artery Disease (CAD) <input type="checkbox"/> Peripheral Arterial Disease <input type="checkbox"/> Prior CABG <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Atrial fibrillation or flutter <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Chronic hemodialysis <input type="checkbox"/> Chronic pulmonary disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Smoking/Vaping <input type="checkbox"/> Cigarette use <input type="checkbox"/> e-cigarette use <input type="checkbox"/> Vaping <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypertension <input type="checkbox"/> Unknown	<input type="checkbox"/> Heart Failure (HF) <input type="checkbox"/> Reduced EF <input type="checkbox"/> Ischemic Cardiomyopathy <input type="checkbox"/> Nonischemic Cardiomyopathy <input type="checkbox"/> History of heart transplantation <input type="checkbox"/> Presence of durable left ventricular assist device (LVAD) <input type="checkbox"/> Presence of Implantable cardioverter-defibrillator (ICD) <input type="checkbox"/> Presence of biventricular pacemaker (CRT) <input type="checkbox"/> Preserved EF <input type="checkbox"/> Cardiac amyloidosis <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Hypertrophic cardiomyopathy <input type="checkbox"/> Isolated right ventricular failure <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Valvular heart disease <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other infectious respiratory pathogen

MEDICATIONS AT HOSPITAL ADMISSION	<i>Admission Tab</i>
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Medications Used Prior to Admission: [Select all that apply]

<input type="checkbox"/> No meds prior to admission <input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Angiotensin Receptor Neprilysin Inhibitor (ARNI) <input type="checkbox"/> Anticoagulation Therapy <input type="checkbox"/> Direct oral anticoagulant <input type="checkbox"/> Warfarin <input type="checkbox"/> Other <input type="checkbox"/> Anti-hyperglycemic medications: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral	<input type="checkbox"/> Antiplatelet Medication: <input type="checkbox"/> Aspirin <input type="checkbox"/> P2Y12 Inhibitors <input type="checkbox"/> Other Antiplatelet <input type="checkbox"/> Beta-Blocker <input type="checkbox"/> Loop Diuretic <input type="checkbox"/> Mineralocorticoid Receptor Antagonist (MRA) <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> GLP-1 agonist <input type="checkbox"/> Unknown/Unable to Determine
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EXAMS/LABS AT ADMISSION	<i>Admission Tab</i>
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Date/Time of vital signs		___/___/___ :__	<input type="checkbox"/> Not Documented
Initial Vital signs	Height	_____ <input type="radio"/> inches <input type="radio"/> cm	<input type="checkbox"/> Not Documented
	Weight	_____ <input type="radio"/> Lbs. <input type="radio"/> Kgs.	<input type="checkbox"/> Not Documented
	BMI	_____ (Automatically Calculated)	
	BSA	_____ (Automatically Calculated)	
	Heart Rate	_____ bpm	<input type="checkbox"/> Not Documented
	BP	___ / ___ mmHg (systolic/diastolic)	<input type="checkbox"/> Not Documented
	Temperature	_____ <input type="radio"/> C <input type="radio"/> F	<input type="checkbox"/> Not Documented
Admission Labs	Lactate	_____ (mmol/L)	<input type="checkbox"/> Unavailable
	Hgb	_____ <input type="radio"/> g/dL <input type="radio"/> g/L	<input type="checkbox"/> Unavailable
	NT-proBNP	_____ <input type="radio"/> pg/mL <input type="radio"/> ng/L	<input type="checkbox"/> Unavailable
	BNP	_____ <input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L	<input type="checkbox"/> Unavailable
	SCr	_____ <input type="radio"/> mg/dL <input type="radio"/> µmol/L	<input type="checkbox"/> Unavailable

ALT	_____	<input type="radio"/> IU/L	<input type="checkbox"/> Unavailable
Platelet Count	_____ (mm ³)		<input type="checkbox"/> Unavailable
Troponin	_____	<input type="radio"/> T <input type="radio"/> I	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="checkbox"/> Unavailable
Random Blood Glucose	_____ (mg/dL)		<input type="checkbox"/> Unavailable

SHOCK ONSET *Shock Onset Tab*

Cardiogenic shock present on hospital arrival?	<input type="radio"/> Yes	<input type="radio"/> No
Cardiac arrest prior to shock onset?	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Unknown/Not Documented
Most favorable neurological status after the arrest and <u>prior to hospital discharge</u>	<input type="radio"/> Conscious without severe disability <input type="radio"/> Conscious with severe disability <input type="radio"/> Comatose <input type="radio"/> Unable to assess due to sedation <input type="radio"/> Unknown/Not Documented	
Onset of shock (Date/Time):	___/___/___ :__	<input type="radio"/> Unknown
Was a multidisciplinary shock team involved in patient management?	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not documented
If multidisciplinary shock team was involved, select the timeframe	<input type="radio"/> Within 3hrs of shock onset <input type="radio"/> Within 6hrs of shock onset <input type="radio"/> Within 24hrs of shock onset	<input type="radio"/> >24hrs of shock onset <input type="radio"/> Unknown/not documented
SCAI Shock Stage at Onset (first 6hrs)	<input type="radio"/> Stage B <input type="radio"/> Stage C <input type="radio"/> Stage D	<input type="radio"/> Stage E <input type="radio"/> ND/Unable to Determine
SCAI Shock Stage Serial assessment (Assessed at 6h-12h)	<input type="radio"/> Stage B <input type="radio"/> Stage C <input type="radio"/> Stage D	<input type="radio"/> Stage E <input type="radio"/> ND/Unable to Determine
Signs and Symptoms of Inadequate Perfusion present?	<input type="radio"/> Yes	<input type="radio"/> No
Presenting Physiology	<input type="radio"/> Biventricular Failure <input type="radio"/> Left Ventricular Failure <input type="radio"/> Right Ventricular Failure	<input type="radio"/> Primary Other Cardiac (Arrhythmia, Valvular Stenosis, etc.) <input type="radio"/> Not Documented
Cardiogenic shock category	<input type="radio"/> Acute, de novo HF <input type="radio"/> Acute-on-chronic HF	<input type="radio"/> Unable to determine
Etiologies and Contributors to Cardiogenic Shock:	<input type="checkbox"/> None of the causes below <input type="checkbox"/> Acute Transplant Rejection <input type="checkbox"/> ACS/AMI <input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Bradyarrhythmia <input type="checkbox"/> Tachyarrhythmia <input type="checkbox"/> COVID-19 related complication <input type="checkbox"/> Isolated Right Heart Failure <input type="checkbox"/> Acute PE <input type="checkbox"/> Pulmonary HTN	<input type="checkbox"/> LVAD complication <input type="checkbox"/> Mechanical complication of MI <input type="checkbox"/> Myocarditis <input type="checkbox"/> Peripartum <input type="checkbox"/> Post-cardiac arrest <input type="checkbox"/> Post-cardiopulmonary bypass <input type="checkbox"/> Takotsubo cardiomyopathy <input type="checkbox"/> Tamponade <input type="checkbox"/> Valvular dysfunction <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Unknown

MEDICATIONS AT SHOCK ONSET *Shock Onset Tab*

Medications administered at Onset of Shock (Select all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Anticoagulation Therapy <input type="radio"/> Direct oral anticoagulant <input type="radio"/> Warfarin <input type="radio"/> IV heparin <input type="radio"/> Other	<input type="checkbox"/> Vasoactive Medications (IV Continuous, during <u>first 6hrs</u> after shock onset) <input type="checkbox"/> Dobutamine <input type="checkbox"/> Dopamine <input type="checkbox"/> Epinephrine
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	<input type="checkbox"/> Antiplatelet Medication: <input type="checkbox"/> Aspirin <input type="checkbox"/> P2Y12 Inhibitors <input type="checkbox"/> Other Antiplatelet	<input type="checkbox"/> Levosimendan <input type="checkbox"/> Milrinone <input type="checkbox"/> Nitroprusside <input type="checkbox"/> Norepinephrine <input type="checkbox"/> Phenylephrine <input type="checkbox"/> Vasopressin <input type="checkbox"/> Not Documented
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EXAMS/LABS AT SHOCK ONSET Shock Onset Tab

Enter parameters closest to shock onset. (To be entered only if shock onset was after arrival)

Date/Time of vital signs (closest to shock onset)		<input type="checkbox"/> Not Documented
Vital signs (closest to shock onset)	Weight	_____ ○Lbs. ○Kgs. <input type="checkbox"/> Not Documented
	BMI	_____ (Automatically Calculated)
	BSA	_____ (Automatically Calculated)
	Heart Rate	_____ bpm <input type="checkbox"/> Not Documented
	BP	___ / ___ mmHg (systolic/diastolic) <input type="checkbox"/> Not Documented
Labs (Closest to shock onset)	Lactate	_____ (mmol/L) <input type="checkbox"/> Unavailable
	Hgb	_____ ○ g/dL ○ g/L <input type="checkbox"/> Unavailable
	NT-proBNP	_____ ○ pg/mL ○ ng/L <input type="checkbox"/> Unavailable
	BNP	_____ ○ pg/mL ○ pmol/L ○ ng/L <input type="checkbox"/> Unavailable
	SCr	_____ ○ mg/dL ○ μmol/L <input type="checkbox"/> Unavailable
	ALT	_____ ○ IU/L <input type="checkbox"/> Unavailable
	Platelet Count	_____ (mm ³) <input type="checkbox"/> Unavailable
	Troponin (Peak related to shock onset)	_____ ○ng/mL ○ug/L ○ng/L ○ T ○ I ○ Normal ○ Abnormal <input type="checkbox"/> Unavailable
	Random Blood Glucose	_____ (mg/dL) <input type="checkbox"/> Unavailable

IN-HOSPITAL CARE In-Hospital Tab

Cardiovascular Procedures during this hospitalization

<input type="checkbox"/> No Procedures <input type="checkbox"/> Cardiac Cath/Coronary Angiography <input type="checkbox"/> Percutaneous Cardiac Intervention (PCI) <i>Date/Time of PCI: ___/___/___ :__:</i> <input type="checkbox"/> Cardiac Transplantation <i>Date/Time of transplantation: ___/___/___ :__:</i> <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) <i>Date/Time of CABG: ___/___/___ :__:</i> <input type="checkbox"/> Electrophysiology (EP) procedure <i>Date/Time of EP: ___/___/___ :__:</i> <input type="checkbox"/> Pulmonary embolectomy (surgical or transcatheter) <input type="checkbox"/> Targeted temperature management <input type="checkbox"/> Other Procedures/Advanced therapies (Specify): _____	<input type="checkbox"/> Mechanical Circulatory Support Device/VAD <u>Percutaneous Assist Devices</u> <input type="checkbox"/> IABP <input type="checkbox"/> Impella <input type="checkbox"/> TandemHeart <input type="checkbox"/> VA ECMO <input type="checkbox"/> iVAC <input type="checkbox"/> Other <u>Surgical Assist Devices</u> <input type="checkbox"/> Temporary external device (e.g. CentriMag) <input type="checkbox"/> Implanted surgical assist device <i>Date/Time of implantation: ___/___/___ :__:</i> <input type="radio"/> Pulsatile-Flow Devices <input type="radio"/> Continuous-Flow Devices
Was a right heart catheterization or pulmonary artery catheterization performed?	○ Yes ○ No ○ Unknown/Not Documented
Date/time of <u>first</u> RHC/PAC	<i>___/___/___ :__:</i> ○ Unknown
Was the PA catheter used for a period of hemodynamic monitoring?	○ Yes ○ No ○ Unknown/Not Documented

Clinical Outcomes		In-Hospital Tab
<i>Record the Time/Date of the FIRST event of each type</i>		
Severe/Moderate GUSTO bleeding event	<input type="radio"/> Yes	<input type="radio"/> No
If Yes, Date/Time detected:	___/___/____ :__	<input type="radio"/> Not Documented
Intracranial Hemorrhage	<input type="radio"/> Yes	<input type="radio"/> No
If Yes, Date/Time detected	___/___/____ :__	<input type="radio"/> Not Documented
Cardiac Arrest	<input type="radio"/> Yes	<input type="radio"/> No
If Yes, Date/Time detected	___/___/____ :__	<input type="radio"/> Not Documented
Stroke	<input type="radio"/> Yes	<input type="radio"/> No
If Yes, Date/Time detected	___/___/____ :__	<input type="radio"/> Not Documented
Complications from procedures during this admission:	<input type="checkbox"/> No complications from procedures <input type="checkbox"/> Acute Limb ischemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Vascular access site <input type="checkbox"/> Other site	<input type="checkbox"/> Vascular injury <input type="checkbox"/> Other (Specify): _____
DISCHARGE INFORMATION		Discharge Tab
Date/Time of Discharge from hospital:	___/___/____ :__ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Not Documented
Discharge disposition	<input type="radio"/> Home <input type="radio"/> Hospice – Home <input type="radio"/> Hospice – Health Care Facility <input type="radio"/> Acute Care Facility <input type="radio"/> Other Health Care Facility	<input type="radio"/> Expired <input type="radio"/> Left Against Medical Advise/AMA <input type="radio"/> Not documented or Unable to Determine (UTD)
If patient died, Date/Time of death	___/___/____ :__ (MM/DD/YYYY HH:MM)	<input type="radio"/> Not Documented
Primary cause of death	<input type="radio"/> Cardiovascular <input type="radio"/> Non-Cardiovascular <input type="radio"/> Unknown	
If Cardiovascular:	<input type="radio"/> Acute Coronary Syndrome <input type="radio"/> Cardiogenic Shock/HF <input type="radio"/> Stroke	<input type="radio"/> Sudden Cardiac Death <input type="radio"/> Unknown <input type="radio"/> Other Cardiovascular
If Non-Cardiovascular	<input type="radio"/> Anoxic brain injury	<input type="radio"/> Other non-cardiovascular
If Other Health Care Facility:	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Inpatient Rehabilitation Facility (IRF)	<input type="radio"/> Long Term Care Hospital (LTCH) <input type="radio"/> Intermediate Care Facility (ICF) <input type="radio"/> Other
END OF FORM		