IRP FORM SELECTION

Legend:
BOLD = Required (required when shown in eCRF)
t

Vendor Name: _____ Vendor Software Version: _____

Patient ID: _____

Patient transferred out to another acute care facility (not admitted as in-patient) 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:**	___/___/_____ ___: ____ ☐ Not admitted, transferred out another acute care facility.

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

Pre-Hospital/Arrival Tab			
Pre-Hospital			
Means of transport to first facility:	O Air OAmbulance 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 ☐		

Active bacterial or viral infection at admission or during hospitalization:	☐ None/ND ☐ Bacterial Infection ☐ Seasonal Cold or Flu	☐ Emerging Infectious Disease ☐ MERS ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ Other Infectious Respiratory Pathogen
Patient Medical History:	☐ 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] ☐ Other Infectious Respiratory Pathogen [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]	
History of Smoking?	O Yes O No	
Height _____cm	**Weight _____kg**	
In-hospital Risk Adjusted Mortality Score _____		

Hospitalization Tab

Reperfusion

Thrombolytics?	If yes, Dose Start Date/Time:	Documented non-system reason for delay- thrombolytics?
O Yes **O** No	___/___/_____ ___: ____	**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** Prior allergic reaction to thrombolytics
	O Any prior intracranial hemorrhage	**O** Recent bleeding within 4 weeks
	O DNR at time of treatment decision	**O** Recent surgery/trauma
	O Expected DTB ≤ 90 minutes	**O** Severe uncontrolled hypertension
	O Intracranial neoplasm, AV malformation, or aneurysm	**O** Significant close head or facial trauma within previous 3 months
	O Ischemic stroke w/in 3 months except acute ischemic stroke within 3hrs	**O** Suspected aortic dissection
	O Known bleeding diathesis	**O** Transferred for PCI
	O No Reason documented	**O** Traumatic CPR that precludes thrombolytics
	O Pregnancy	**O** Other

PCI? O Yes O No

Physician interventionalist NPI _____

Reasons for not performing PCI			
	O Non-compressible vascular puncture(s)	**O** Spontaneous reperfusion (documented by cath only)	**O** Other
	O Active bleeding on arrival or within 24 hours	**O** Patient/family refusal	**O** Not performed
	O Quality of life decision	**O** DNR at time of treatment decision	**O** No reason documented
	O Anatomy not suitable to primary PCI	**O** Prior allergic reaction to IV contrast	**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 (unstable, >12 hr from sx onset)	**O** PCI for STEMI (stable, >12 hr from sx onset)
	O PCI for STEMI (stable after successful full-dose lytic)	**O** Rescue PCI for STEMI (after failed full-dose lytic)	**O** PCI for NSTEMI
			O Other

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

Hospitalization

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

Was diagnostic coronary angiography performed? O Yes O No

Date and time of diagnostic angiography: **:** ___/___/_____ ___: ____

Reason for Not Performing Diagnostic Angiography		
	☐ Yes, medical reason	☐ Yes, system reason
	☐ Yes, patient reason	☐ No reason documented

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	_____

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	
	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**	O Yes O No	
	If yes,	Dose: Frequency:	
	Contraindicated	O Yes O No	
Ticlopidine at discharge	**Prescribed**	O Yes O No	
	If yes,	Dose: Frequency:	
	Contraindicated	O Yes O No	
Anticoagulation at discharge	**Prescribed**	O Yes O No	
	If yes,	**Class:** **Medication:** Dose: Frequency:	
	Contraindicated	O Yes O No	
Beta Blocker at discharge	**Prescribed**	O Yes O No	
	Contraindicated	O Yes O No	

Statin at discharge	**Prescribed**	O Yes O No
	Contraindicated	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
	Contraindicated	O Yes O No