

Legend:

Yellow Highlight = Changes since last version of CRF

Patient ID:		
STEMI Band ID:		
STEMI Band Not Documented:	<input type="checkbox"/>	
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	
Other Patient Gender Identity		
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	
Other Patient-Identified Sexual Orientation:		
Date of Birth:	____/____/____	
Age:	____ (auto calculated)	
Patient Zip Code:	____-____	
Payment Source:	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare-Private/HMO/PPO/Other <input type="checkbox"/> Medicaid <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"/> Indian Health Services <input type="checkbox"/> Other/Not Documented/UTD	
Race and Ethnicity		
Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <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"/> 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"/> 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"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino or Spanish Origin	
ADMIN TAB		

NPI	
Attending Physician/Provider NPI:	_____
Admitting Physician:	_____
ED Physician:	_____
Cardiology Consult:	_____
Physician interventionalist NPI:	_____
Discharge Physician/Provider NPI:	_____
Advanced Practitioner Provider NPI:	_____
Other Physician:	_____
ARRIVAL TAB	
Arrival Date/Time:	___/___/___ __:___
Means of transport to this facility:	<input type="radio"/> Air <input type="radio"/> Ambulance (ground) <input type="radio"/> Private vehicle <input type="radio"/> Transfer from another acute care facility
Patient first evaluated (at this facility):	<input type="radio"/> ED <input type="radio"/> Cath Lab <input type="radio"/> Observation <input type="radio"/> Inpatient <input type="radio"/> Other (please specify) _____
Date/Time of ED discharge	___/___/___ __:___ <input type="checkbox"/> Unknown
ED Disposition	<input type="radio"/> Admission <input type="radio"/> Expired <input type="radio"/> Home <input type="radio"/> Left Against Medical Advice <input type="radio"/> Transfer to Acute Care <input type="radio"/> Transfer to Observation Unit
TRANSFER DATA	
Facility the patient was transferred to:	_____
Reason(s) for transfer from this facility:	<input type="checkbox"/> Administrative <input type="checkbox"/> Advanced Cardiac Care (monitoring) <input type="checkbox"/> CABG <input type="checkbox"/> Patient/Family Choice <input type="checkbox"/> Post Thrombolytic care <input type="checkbox"/> Primary PCI <input type="checkbox"/> Other medical reason <input type="checkbox"/> Other reason (please specify) _____
Mode of transport (transfer out):	<input type="radio"/> Air <input type="radio"/> Ambulance
Inter-facility transport EMS Agency name/number (transfer out):	_____
Transport requested Date/Time:	___/___/___ __:___ <input type="checkbox"/> Unknown
Was there a documented reason for delay in transfer (from this facility)?	<input type="radio"/> Yes <input type="radio"/> No
Reason(s) for delay in transfer (from this facility):	<input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Patient/family consent

		<input type="checkbox"/> Travel advisory due to inclement weather <input type="checkbox"/> Awaiting air transport* <input type="checkbox"/> Delay in receiving hospital accepting patient* <input type="checkbox"/> Ground transport unavailable* <input type="checkbox"/> Other reason* (please specify) _____	
ECG			
1 st ECG Date/Time:		___/___/___ __:___ <input type="checkbox"/> Unknown	
1 st ECG obtained:		<input type="radio"/> Prior to Hospital Arrival <input type="radio"/> After First Hospital Arrival	
Pre-hospital ECG Finding		<input type="radio"/> STEMI <input type="radio"/> LBBB (new or presumed new) <input type="radio"/> Isolated Posterior MI <input type="radio"/> Other _____ <input type="radio"/> Not Documented	
ED Physician Review of Pre-hospital ECG		<input type="radio"/> No STEMI Noted <input type="radio"/> STEMI Noted <input type="radio"/> ND	
Was there a documented reason for delay in obtaining 1 st ECG?		<input type="radio"/> Yes <input type="radio"/> No	
Reason(s) for delay in obtaining 1 st ECG:		<input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Need for additional PPE for suspected/ confirmed infectious disease <input type="checkbox"/> Need for advanced airway placement (Intubation) <input type="checkbox"/> Patient or family refused treatment <input type="checkbox"/> ECG equipment failure* <input type="checkbox"/> Other reason* (please specify) _____	
ECG Read Date/Time		___/___/___ __:___ <input type="checkbox"/> Unknown	
ECG Revealed STEMI or STEMI Equivalent?		<input type="radio"/> Yes <input type="radio"/> No	
If yes, ECG revealed:		<input type="radio"/> ST Elevation <input type="radio"/> Isolated Posterior MI <input type="radio"/> New LBBB	
If yes, STEMI or STEMI equivalent first noted:		<input type="radio"/> First ECG <input type="radio"/> Subsequent ECG	
If subsequent ECG, Date/Time of positive ECG:		___/___/___ __:___ <input type="checkbox"/> Unknown	
STEMI Alert Activated		<input type="radio"/> Yes <input type="radio"/> No	
Date/Time of STEMI Alert		___/___/___ __:___ <input type="checkbox"/> Unknown	
STEMI Alert Activated by:		<input type="radio"/> Emergency Department <input type="radio"/> EMS <input type="radio"/> Inpatient <input type="radio"/> Observation <input type="radio"/> Transferring Facility <input type="radio"/> Other _____	
Admission Date/Time:		___/___/___ __:___ <input type="checkbox"/> Unknown	
PRE-HOSPITAL TAB			
Patient location where cardiac symptoms discovered:		<input type="radio"/> Not in a healthcare setting <input type="radio"/> ACS Event occurred after hospital arrival (in ED/Obs/Inpatient) <input type="radio"/> Another Acute care facility <input type="radio"/> Chronic healthcare Facility <input type="radio"/> Outpatient healthcare setting <input type="radio"/> ND or Cannot be Determined	

Symptom onset Date/Time:	__/__/____ __: __ <input type="checkbox"/> Unknown	
EMS Time Tracker Data		
Date/time of Initial 911 Call for Help:	__/__/____ __: __ <input type="checkbox"/> Unknown	
EMS Dispatch Date/Time:	__/__/____ __: __ <input type="checkbox"/> Unknown	
EMS arrive on scene:	__/__/____ __: __ <input type="checkbox"/> Unknown	
EMS First Medical Contact:	__/__/____ __: __ <input type="checkbox"/> Unknown	
Non-EMS First Medical Contact:	__/__/____ __: __ <input type="checkbox"/> Unknown	
Was there a documented reason for scene delay by EMS?	<input type="radio"/> Yes <input type="radio"/> No	
Reason(s) for scene delay by EMS:	<input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Need for additional PPE for suspected/confirmed infectious disease <input type="checkbox"/> Need for advanced airway placement (Intubation) <input type="checkbox"/> Patient/family consent <input type="checkbox"/> Access to patient (EMS Documented)* <input type="checkbox"/> Awaiting transport* <input type="checkbox"/> Language barrier* <input type="checkbox"/> Mechanical issue (transport unit)* <input type="checkbox"/> Weather* <input type="checkbox"/> Other reason* (please specify) _____	
EMS depart scene:	__/__/____ __: __ <input type="checkbox"/> Unknown	
Destination Pre-arrival alert or notification:	__/__/____ __: __ <input type="checkbox"/> Unknown	
EMS Agency name/number:	_____	
Method of 1st notification:	<input type="radio"/> ECG Transmission <input type="radio"/> Phone call <input type="radio"/> Radio <input type="radio"/> ND	
Run/Sequence number:	_____	
Out of Hospital Cardiac Arrest		
Cardiac Arrest prior to Arrival?	<input type="radio"/> Yes <input type="radio"/> No	
If yes, was CPR performed by a bystander?	<input type="radio"/> Yes <input type="radio"/> No	
Return of Spontaneous Circulation (ROSC)	<input type="radio"/> Yes <input type="radio"/> No	
Date and time of ROSC	__/__/____ __: __ <input type="checkbox"/> Unknown	
If yes, was therapeutic hypothermia initiated during this episode of care?	<input type="radio"/> Yes <input type="radio"/> No	
Transfer Time Tracker Data		
Means of arrival at first facility:	<input type="radio"/> Air <input type="radio"/> Ambulance (ground) <input type="radio"/> Private vehicle <input type="radio"/> Transfer from acute care facility	
Transferring Facility:	_____	
Mode of transport to this facility:	<input type="radio"/> Air <input type="radio"/> Ambulance	
Inter-facility transport EMS Agency name/number:	_____	
Reason(s) for transfer to this facility:	<input type="checkbox"/> Administrative <input type="checkbox"/> Advanced Cardiac Care (monitoring) <input type="checkbox"/> CABG <input type="checkbox"/> Patient/Family Choice <input type="checkbox"/> Post Thrombolytic care	

	<input type="checkbox"/> Primary PCI <input type="checkbox"/> Other reason (please specify) _____
Arrival at First hospital Date/Time:	___/___/___ __:___ <input type="checkbox"/> Unknown
Transport Arrived Date/Time:	___/___/___ __:___ <input type="checkbox"/> Unknown
Transfer out Date/Time:	___/___/___ __:___ <input type="checkbox"/> Unknown
Was there a documented reason for delay in transfer (to this facility)?	<input type="radio"/> Yes <input type="radio"/> No
Reason(s) for delay in transfer (to this facility):	<input type="checkbox"/> Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) <input type="checkbox"/> Patient/family consent <input type="checkbox"/> Travel advisory due to inclement weather <input type="checkbox"/> Awaiting air transport* <input type="checkbox"/> Delay in receiving hospital accepting patient* <input type="checkbox"/> Ground transport unavailable* <input type="checkbox"/> Other reason* (please specify) _____
CARDIAC EVALUATIONS TAB	
Patient Medical History:	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebrovascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Currently on Dialysis <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> ND <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Familial Hypercholesterolemia <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) </div> <div style="width: 50%;"> <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Peripheral Artery Disease <input type="checkbox"/> Prior CABG If Prior CABG, Most Recent CABG Date: ___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI If Prior PCI, Most Recent PCI Date: ___/___/___ <input type="checkbox"/> Unknown </div> </div>
History of Smoking?	<input type="radio"/> Yes <input type="radio"/> No
History of vaping or e-cigarette use in the past 12 months?	<input type="radio"/> Yes <input type="radio"/> No/ND
Medications Prior to Admission	
<input type="checkbox"/> No medications prior to admission Anticoagulants prior to admission <input type="radio"/> Yes <input type="radio"/> No/ND Anticoagulant Medication: <input type="radio"/> Apixaban <input type="radio"/> Dabigatran <input type="radio"/> Rivaroxaban <input type="radio"/> Warfarin <input type="radio"/> Other _____ Anti-hyperglycemics prior to admission <input type="radio"/> Yes <input type="radio"/> No/ND	

Anti-hyperglycemic Medications: <input type="checkbox"/> Biguanide <input type="checkbox"/> DPP-4 Inhibitor <input type="checkbox"/> GLP-1 Receptor Agonist <input type="checkbox"/> Insulin <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Thiazolidinedrone <input type="checkbox"/> Other			
Anti-hypertensives prior to admission <input type="radio"/> Yes <input type="radio"/> No/ND Anti-hypertensive Medications: <input type="checkbox"/> ACEI <input type="checkbox"/> Alpha-blocker <input type="checkbox"/> ARB <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Calcium channel blocker <input type="checkbox"/> Diuretic <input type="checkbox"/> Other			
Antiplatelet prior to admission <input type="radio"/> Yes <input type="radio"/> No/ND Antiplatelet Medications: <input type="checkbox"/> Aspirin <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> prasurel (Effient) <input type="checkbox"/> P2Y12 Inhibitor <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid)			
Cholesterol Reducer prior to admission <input type="radio"/> Yes <input type="radio"/> No/ND Cholesterol Reducer Medications: <input type="checkbox"/> ACL Inhibitors <input type="checkbox"/> Bile Acid Sequestrants <input type="checkbox"/> Ezetimibe <input type="checkbox"/> Fibrates <input type="checkbox"/> Niacin <input type="checkbox"/> Omega-3 Fatty Acid <input type="checkbox"/> PCSK9 Inhibitor <input type="checkbox"/> Statin			
Vitals			
Heart rate documented on first medical contact:		_____	
Heart rate documented - ND		<input type="checkbox"/>	
Systolic blood pressure on first medical contact:		_____	
Systolic blood pressure – ND		<input type="checkbox"/>	
Heart failure documented on first medical contact		<input type="radio"/> Yes <input type="radio"/> No	
Cardiogenic shock documented on first medical contact		<input type="radio"/> Yes <input type="radio"/> No	
Height (cm)	_____	Weight (kg)	_____
Height - ND	<input type="checkbox"/>	Weight - ND	<input type="checkbox"/>
Labs			
Positive cardiac biomarkers in the first 24 hours?		<input type="radio"/> Yes <input type="radio"/> No	
Initial Troponin value		_____ <input type="radio"/> ng/mL <input type="radio"/> ng/L <input type="radio"/> ug/L <input type="radio"/> pg/ml	
Initial Troponin – ND		<input type="checkbox"/>	

Date/Time of initial troponin results:		___/___/___ __:___ <input type="checkbox"/> Unknown	
Initial Serum Creatinine (mg/dL):		_____	
Initial Serum Creatinine - ND		<input type="checkbox"/>	
LDL Cholesterol Value (mg/dL):	_____	LDL Not Documented:	<input type="checkbox"/>
LP(a) Value:	_____	LP(a) Not Documented:	<input type="checkbox"/>
LP(a) Unit:	<input type="radio"/> nmol/L <input type="radio"/> mg/dl		
Risk Scores			
Risk-Stratification Score Documented?	<input type="checkbox"/> EDACS <input type="checkbox"/> GRACE <input type="checkbox"/> HEART <input type="checkbox"/> SYNTAX Score <input type="checkbox"/> TIMI <input type="checkbox"/> Other <input type="checkbox"/> No Risk-Stratification Score Documented		
EDACS Score:	_____	Grace Risk Score:	_____
HEART Score:	_____	SYNTAX Score:	_____
LVF Obtained <input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago <input type="radio"/> Planned After Discharge <input type="radio"/> Not Documented		LVF Assessment (%)	_____
Was early diagnostic coronary angiography performed?		<input type="radio"/> Yes <input type="radio"/> No	
Date and time of diagnostic angiography:		___/___/___ __:___ <input type="checkbox"/> Unknown	
Date and time of diagnostic angiography Not Documented:		<input type="checkbox"/>	
Reason for not performing early diagnostic angiography		<input type="checkbox"/> Yes, medical reason <input type="checkbox"/> Yes, patient reason <input type="checkbox"/> Yes, system reason <input type="checkbox"/> No Reason documented	
Non-invasive cardiac stress test during this hospital episode:		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
New Diagnosis During this Admission			
Diabetes Mellitus	<input type="radio"/> Yes <input type="radio"/> No/ND		
Active bacterial or viral infection at admission or during hospitalization:	<input type="checkbox"/> None/ND <input type="checkbox"/> Bacterial Infection <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 Emerging Infectious Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal Cold <input type="checkbox"/> Other Viral Infection		
Health Related Social Needs Assessment			
During this admission, was a standardized health related social needs form or assessment completed?			<input type="radio"/> Yes <input type="radio"/> No/ND
If Yes, identify the areas of unmet social need (select all apply)	<input type="checkbox"/> None of the areas of unmet social needs listed were identified <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Financial Strain <input type="checkbox"/> Food <input type="checkbox"/> Living Situation/Housing <input type="checkbox"/> Mental Health <input type="checkbox"/> Personal Safety <input type="checkbox"/> Substance Use <input type="checkbox"/> Transportation Barriers		

		<input type="checkbox"/> Utilities
Enrolled in Clinical Trial During Hospitalization		<input type="radio"/> Yes <input type="radio"/> No
If Yes, Type of Clinical Trials(s) (select all that apply)	<input type="checkbox"/> Precluding the use of aspirin in protocol <input type="checkbox"/> Related to reperfusion therapy <input type="checkbox"/> Involving antiplatelet therapies <input type="checkbox"/> Involving renin-angiotensin-aldosterone system inhibitor <input type="checkbox"/> Related to lipid lowering therapy <input type="checkbox"/> Related to AMI <input type="checkbox"/> Related to STEMI <input type="checkbox"/> Related to hyperglycemic control <input type="checkbox"/> Other (please specify):	
IN-HOSPITAL MEDICATIONS & VACCINATIONS TAB		
Antiplatelet and Anticoagulant Medications During this Episode of Care		
No antiplatelet or anticoagulant medications Aspirin Administration Was aspirin administered at this facility within 24 hours of arrival? Was aspirin administered within 24 hours prior to arrival? Was aspirin administered prior to transfer? Other Antiplatelet Medications Clopidogrel (Plavix) During this episode Dosage: Prasugrel (Effient) During this episode Dosage: Ticagrelor (Brilinta) During this episode Dosage: Ticlopidine (Ticlid) During this episode Dosage: Anticoagulant Medications Bivalirudin (Angiomax) During this episode Heparin During this episode Low Molecular Weight Heparin (LMWH) During this episode		<input type="checkbox"/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> 75mg <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> 5mg <input type="radio"/> 10mg <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> 90mg <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> 250mg <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Vaccinations		
Influenza Vaccination:	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/sensitivity to influenza vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD	
COVID-19 Vaccination:	<input type="radio"/> COVID-19 vaccine was given during this hospitalization <input type="radio"/> COVID-19 vaccine was received prior to admission, not during this hospitalization	

		<input type="radio"/> Documentation of patient's refusal of COVID-19 vaccine <input type="radio"/> Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD	
COVID-19 Vaccination Date	__/__/____ <input type="checkbox"/> Unknown	Is there documentation that this patient was included in a COVID-19 vaccine trial?	<input type="radio"/> Yes <input type="radio"/> No/ND
REPERFUSION TAB			
Thrombolytics administered at this facility?		<input type="radio"/> Yes <input type="radio"/> No/ND	
Thrombolytics administered prior to arrival?		<input type="radio"/> Yes, by transferring facility <input type="radio"/> Yes, by EMS <input type="radio"/> No/ND	
Thrombolytic Dose Start Date/Time:		__/__/____ __:__ <input type="checkbox"/> Unknown	
Thrombolytic medication:	<input type="radio"/> tenecteplase (TNKase) <input type="radio"/> alteplase (Activase) <input type="radio"/> reteplase (Retavase) <input type="radio"/> Other (please specify) _____		
Was there a documented reason for delay in thrombolytics?		<input type="radio"/> Yes <input type="radio"/> No	
Reason(s) for delay in thrombolytics:		<input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Need for additional PPE for suspected/confirmed infectious disease <input type="checkbox"/> Need for advanced airway placement (Intubation) <input type="checkbox"/> Patient/family consent <input type="checkbox"/> Change in reperfusion strategy* <input type="checkbox"/> Provider unable to administer thrombolytics* <input type="checkbox"/> Other reason (please specify) _____	
Reasons for not administering a thrombolytic	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Active peptic ulcer <input type="checkbox"/> Any prior intracranial hemorrhage <input type="checkbox"/> DNR at time of treatment decision <input type="checkbox"/> Expected DTB <input type="checkbox"/> Intracranial neoplasm, AV malformation, or aneurysm <input type="checkbox"/> Ischemic stroke w/in 3 months except acute ischemic stroke within 3hrs <input type="checkbox"/> Known bleeding diathesis <input type="checkbox"/> No Reason documented <input type="checkbox"/> Patient/family refusal <input type="checkbox"/> Pregnancy </div> <div> <input type="checkbox"/> Prior allergic reaction to thrombolytics <input type="checkbox"/> Recent bleeding within 4 weeks <input type="checkbox"/> Recent surgery/trauma <input type="checkbox"/> Severe uncontrolled hypertension <input type="checkbox"/> Significant close head or facial trauma within previous 3 months <input type="checkbox"/> Suspected aortic dissection <input type="checkbox"/> Transferred for PCI <input type="checkbox"/> Traumatic CPR that precludes thrombolytics <input type="checkbox"/> Other (please specify) _____ </div> </div>		
Was the patient brought to the cath lab with the intention of performing PCI?	<input type="radio"/> Yes <input type="radio"/> No		
PCI performed during this episode of care?	<input type="radio"/> Yes <input type="radio"/> No		
Reasons for not performing PCI	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Active bleeding on arrival or within 24 hours <input type="checkbox"/> Anatomy not suitable to primary PCI <input type="checkbox"/> DNR at time of treatment decision </div> <div> <input type="checkbox"/> Patient/family refusal <input type="checkbox"/> Prior allergic reaction to IV contrast <input type="checkbox"/> Quality of life decision </div> </div>		

	<input type="checkbox"/> No PCI Capability <input type="checkbox"/> No reason documented <input type="checkbox"/> Non-compressible vascular puncture(s)	<input type="checkbox"/> Spontaneous reperfusion (documented by cath only) <input type="checkbox"/> Thrombolytic Administered <input type="checkbox"/> Other (please specify) _____
PCI Time Tracker Data		
Cath Lab Activation:	___/___/___ __:___ <input type="checkbox"/> Unknown	
Patient Arrival to Cath Lab:	___/___/___ __:___ <input type="checkbox"/> Unknown	
Team Arrival to Cath Lab:	___/___/___ __:___ <input type="checkbox"/> Unknown	
Interventionalist Arrival to Cath Lab:	___/___/___ __:___ <input type="checkbox"/> Unknown	
First PCI Date/Time:	___/___/___ __:___ <input type="checkbox"/> Unknown	
PCI Indication	<input type="radio"/> Primary PCI for STEMI <input type="radio"/> PCI for STEMI (unstable, >12 hr from sx onset) <input type="radio"/> PCI for STEMI (stable, >12 hr from sx onset) <input type="radio"/> PCI for STEMI (stable after successful full-dose lytic) <input type="radio"/> PCI for STEMI (facilitated PCI after half/reduced-dose lytic) <input type="radio"/> Rescue PCI for STEMI (after failed full-dose lytic) <input type="radio"/> PCI for NSTEMI <input type="radio"/> Other _____	
Was there a documented reason for delay in PCI?	<input type="radio"/> Yes <input type="radio"/> No	
Reasons for delay in PCI:	<input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Difficult vascular access <input type="checkbox"/> Difficulty crossing the culprit lesion <input type="checkbox"/> Need for additional PPE for suspected/confirmed infectious disease <input type="checkbox"/> Need for advanced airway placement (Intubation) <input type="checkbox"/> Need for Mechanical circulatory support prior to PCI <input type="checkbox"/> Patient/family consent <input type="checkbox"/> Other reason please specify) _____	
CABG During This Admission:	<input type="radio"/> Yes <input type="radio"/> No	
DISCHARGE TAB		
In-hospital Risk Adjusted Mortality Score:	_____ (auto calculated)	
Discharge Date/Time:	___/___/___ __:___	
Discharge Disposition:	<input type="radio"/> 1 – Home <input type="radio"/> 2 – Hospice-Home <input type="radio"/> 3 – Hospice-Healthcare Facility <input type="radio"/> 4 – Acute Care Facility <input type="radio"/> 5 – Other Health Care Facility <input type="radio"/> 6 – Expired <input type="radio"/> 7 – Left Against Medical Advice/AMA <input type="radio"/> 8 – Not Documented or Unable to Determine (UTD)	
Comfort Measures Only?	<input type="radio"/> Yes <input type="radio"/> No	If Yes, Date/Time: ___/___/___ __:___ <input type="checkbox"/> Unknown
Final Clinical Diagnosis	<input type="radio"/> Confirmed AMI – STEMI <input type="radio"/> Confirmed AMI – non-STEMI <input type="radio"/> Angina not specified <input type="radio"/> Chest Pain (cardiac)	

	<input type="radio"/> Confirmed AMI - STEMI/Non-STEMI unspecified <input type="radio"/> Unstable Angina	<input type="radio"/> Chest Pain (non cardiac) (please specify) _____ <input type="radio"/> Noncardiac condition	
Referrals/Counseling and Follow-up			
Patient Referred to Cardiac Rehab?	<input type="radio"/> Yes <input type="radio"/> No referral documented <input type="radio"/> No-Medical Reason <input type="radio"/> No-Patient Oriented Reason <input type="radio"/> No-Healthcare System Reason		
Smoking Cessation Counseling?	<input type="radio"/> Yes <input type="radio"/> No		
Follow-up visit scheduled?	<input type="radio"/> Yes <input type="radio"/> No		
Date of first follow-up visit	___/___/___ : __ <input type="checkbox"/> Unknown		
Location of first follow-up visit	<input type="radio"/> Home health visit <input type="radio"/> Office visit <input type="radio"/> Telehealth <input type="radio"/> Not documented		
Discharge Medications			
ACEI at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
ARB at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Aspirin at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Dose:	<input type="radio"/> 75-100 mg <input type="radio"/> >100 mg <input type="radio"/> Other <input type="radio"/> Unknown
		Frequency:	<input type="radio"/> Every Day <input type="radio"/> 2 Times a day <input type="radio"/> 3 Times a day <input type="radio"/> 4 Times a day <input type="radio"/> Other <input type="radio"/> Unknown
Clopidogrel at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Dose:	<input type="radio"/> 75mg <input type="radio"/> Other <input type="radio"/> Unknown
		Frequency:	<input type="radio"/> Every Day <input type="radio"/> Other <input type="radio"/> Unknown
Prasugrel at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Dose:	<input type="radio"/> 5mg <input type="radio"/> 10mg <input type="radio"/> Other <input type="radio"/> Unknown
		Frequency:	<input type="radio"/> Every Day <input type="radio"/> Other <input type="radio"/> Unknown
Ticagrelor at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	If yes,	Dose:	<input type="radio"/> 90mg <input type="radio"/> Other <input type="radio"/> Unknown

		Frequency:	<input type="radio"/> 2 Times a day <input type="radio"/> Other <input type="radio"/> Unknown		
Ticlopidine at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC			
	If yes,	Dose:	<input type="radio"/> 250mg <input type="radio"/> Other <input type="radio"/> Unknown		
		Frequency:	<input type="radio"/> 2 Times a day <input type="radio"/> Other <input type="radio"/> Unknown		
Anticoagulation at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC			
	If yes,	Class:	<input type="radio"/> Warfarin	<input type="radio"/> Direct Thrombin Inhibitor	<input type="radio"/> Factor Xa Inhibitor
		Medication:	<input type="radio"/> Coumadin (warfarin)	<input type="radio"/> Dabigatran <input type="radio"/> Other Direct Thrombin Inhibitor	<input type="radio"/> Apixaban <input type="radio"/> Edoxaban <input type="radio"/> Rivaroxaban <input type="radio"/> Other Factor Xa Inhibitor
		Dose:	N/A	<input type="radio"/> 75mg <input type="radio"/> 150 mg <input type="radio"/> Other <input type="radio"/> Unknown	1. _____ 2. _____ 3. _____ 4. _____ 5. _____
		Frequency:	N/A	<input type="radio"/> 2 Times a day <input type="radio"/> Other <input type="radio"/> Unknown	1. _____ 2. _____ 3. _____
Beta Blocker at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC			
Statin at discharge	Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC			
	If yes,	Medication:	<input type="radio"/> amlodipine + atorvastatin (Caduet) <input type="radio"/> atorvastatin (Lipitor) <input type="radio"/> ezetimibe + simvastatin (Vytorin) <input type="radio"/> fluvastatin (Lescol) <input type="radio"/> fluvastatin (Lescol XL) <input type="radio"/> lovastatin (Mevacor) <input type="radio"/> lovastatin extended release (Altoprev) <input type="radio"/> lovastatin + niacin (Advicor) <input type="radio"/> pitavastatin (Livalo) <input type="radio"/> pravastatin (Pravachol) <input type="radio"/> rosuvastatin (Crestor) <input type="radio"/> simvastatin (Zocor) <input type="radio"/> simvastatin + niacin (Simcor)		
		Dose:	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
		Statin Level of Intensity:	<input type="radio"/> Low	<input type="radio"/> Moderate	<input type="radio"/> High
Is there a non-system reason for not prescribing	<input type="checkbox"/> Yes, medical reason <input type="checkbox"/> Yes, patient reason				

a high intensity statin medication?	<input type="checkbox"/> No
Anti-hyperglycemic Medication Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Anti-hyperglycemic Class	1. _____ 2. _____ 3. _____ 4. _____
Anti-hyperglycemic Medication	1. _____ 2. _____ 3. _____ 4. _____
Was there a documented reason for not prescribing a medication with proven CVD benefit?	<input type="radio"/> Yes <input type="radio"/> No/ND
PCSK9 Inhibitor Prescribed	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
PCSK9 Medication	<input type="radio"/> alirocumab (Praluent) <input type="radio"/> evolocumab (Repatha) <input type="radio"/> inclisiran
Comments	
TIME METRICS TAB (AUTO-POPULATED)	
Symptom onset to FMC	
EMS FMC to ECG	
EMS Depart Scene to Hospital Arrival	
Arrival at this Hospital to First ECG	
Time in ED	
Arrival to Transfer Out (DIDO) (Referring Hospital)	
Arrival at First Hospital to Transfer Out	
EMS FMC to Cath Lab Activation	
Arrival to Cath Lab Activation	
EMS FMC to PCI	
Arrival at Referring Hospital to PCI	
Arrival at Receiving Hospital to PCI	