

AORTIC STENOSIS CRF FORM				Legend: Elements in bold are required, italicized elements are conditionally required	
Patient ID: _____					
Date of Assessment/Encounter: ____/____/____					
FORM TYPE/ENCOUNTER				Form Type/Encounter Tab	
Type of form being entered <i>(Select all that apply)</i> <i>[Form Control, with each option applying to the pertinent tab]</i>		☐ Resting Echocardiogram ☐ Dobutamine Echocardiogram ☐ Treadmill Stress Test ☐ CT Scan with AV Score ☐ Cath Lab/Coronary Angiogram ☐ Outpatient Clinical encounter ☐ Hospitalization/In-patient admission ☐ Treatment Decision/MDT ☐ Discontinued follow-up/Death			
MEDICAL HISTORY				Medical History Tab	
Medical History (Select all that apply)					
☐ None ☐ Atrial Fibrillation ☐ Active Cancer (Any) ☐ Chronic Kidney Disease ☐ Coronary Artery Disease (CAD) ☐ Chronic Obstructive Pulmonary Disease ☐ Depression ☐ Diabetes ☐ Dyslipidemia ☐ History of cigarette smoking? (In the past 12 months) ☐ History of vaping or e-cigarette use in the past 12 months ☐ History of Emerging Infectious Diseases: ☐ SARS-COV-2 (COVID-19) ☐ Long COVID ☐ Other Emerging Infectious Disease			☐ Heart Failure ☐ Hypertension ☐ Myocardial Infarction ☐ Peripheral Artery Disease ☐ Prior Stroke ☐ Significant Dementia or Alzheimer's Disease and Related Dementia ☐ Renal Dysfunction ☐ Multiple Valvular Heart Disease (VHD) ☐ Ventricular Assist Device		
RESTING ECHOCARDIOGRAM				Resting Echo Tab	
Date of Echocardiogram		____/____/____ (MM/DD/YYYY)		☐ Unknown	
Echo Results		Echo - AV Area: ____ cm ²		Echo - AVA Indexed: ____ cm ² /m ² <i>[Auto-calculated]</i>	
		☐ Echo - AV Area Not Documented		☐ Echo - AVA Indexed Not Documented	
		Echo - Mean Gradient: ____ mmHg		Echo - Peak Gradient: ____ mmHg	
		☐ Echo - Mean Gradient Not Documented		☐ Echo - Peak Gradient Not Documented	
		Echo - LVOT VTI: ____ (cm)		Echo - AV VTI: ____ (cm)	
☐ Echo - LVOT VTI Not Documented		☐ Echo - AV VTI Not Documented		☐ Echo - Peak Aortic Velocity Not Documented	
Echo - Peak Aortic Velocity:		____ o m/s o cm/s		☐ Echo - Peak Aortic Velocity Not Documented	
Echo - LVEF		____ %		☐ Echo - LVEF Not Assessed	

Echo - Stroke Volume	_____	☐ Echo - Stroke Volume Not Documented
Echo - Stroke Volume Index	_____ ml/m ² <i>[Auto-calculated]</i>	☐ Echo - Stroke Volume Index Not Documented
Characterization of AS Severity per Echo:	☐ Mild AS ☐ Mild-Moderate AS ☐ Moderate AS	☐ Moderate-Severe AS ☐ Severe AS ☐ Physician observed no AS present ☐ Not Documented
AS Measurements in Echocardiogram Summary (Select all that apply)	☐ None ☐ Aortic Valve Area ☐ Aortic velocity/max gradient ☐ AS Severity ☐ LVEF ☐ Mean gradient	
Clinical Recommendation in Echo Summary	☐ None ☐ A reminder/inclusion of AHA/ACC guideline on AS ☐ Dobutamine echo recommended ☐ Further eval/referral recommended	

DOBUTAMINE ECHOCARDIOGRAM
Dobutamine Echo Tab

Date of Dobutamine Echo	____/____/____ (MM/DD/YYYY)		☐ Unknown	
Dobutamine Echo Results	DSE - AV Area: _____ cm ²	DSE - AVA Indexed: _____ cm ² /m ² <i>[Auto-calculated]</i>	DSE - Mean Gradient: _____ mmHg	DSE - Peak Gradient: _____ mmHg
	☐ DSE - AV Area Not Documented	☐ DSE - AVA Indexed Not Documented	☐ DSE - Mean Gradient Not Documented	☐ DSE - Peak Gradient Not Documented
	DSE - LVOT VTI: _____ (cm) ☐ DSE - LVOT VTI Not Documented	DSE - AV VTI: _____ (cm) ☐ DSE - AV VTI Not Documented	DSE - Dimensionless Index _____ (m) <i>[Auto-calculated]</i>	
DSE - Peak Aortic Velocity:	_____ o m/s o cm/s	☐ DSE - Peak Aortic Velocity Not Documented		
DSE - LVEF	_____ %	☐ DSE - LVEF Not Assessed		
DSE - Stroke Volume	_____	☐ DSE - Stroke Volume Not Documented		
DSE - Stroke Volume Index	_____ ml/m ² <i>[Auto-calculated]</i>	☐ DSE - Stroke Volume Index Not Documented		
Characterization of AS Severity per DSE:	☐ Indeterminate due to lack of contractile reserve ☐ Pseudo-severe AS (Moderate AS) ☐ Truly Severe ☐ Not Documented			

TREADMILL STRESS TEST
Treadmill Stress Tab

Date of Treadmill Stress Test	____/____/____ (MM/DD/YYYY)		☐ Unknown
Were there any symptoms during the test (select all that apply)	☐ None ☐ Chest Pain ☐ Pre-syncope ☐ Syncope	☐ Dyspnea or fatigue that required stopping ☐ Other: (Specify): _____	
How many metabolic equivalents (METs) were achieved during the Stress Test?	_____	☐ Unknown	

AV CALCIFICATION BY CT
AV Calcification Tab

Date of CT	____/____/____ (MM/DD/YYYY)		☐ Unknown
Aortic Valve Calcium Score	_____		

CATH LAB/CORONARY ANGIOGRAM		Cath Lab Tab	
Date of Cardiac Catheterization	____/____/____ (MM/DD/YYYY)	☐ Unknown	
Invasive hemodynamic assessment of AS (Cath)	☐ Yes	☐ No	☐ Unknown
If Yes, Cath results:	AV Area: ☐ ____ cm ²	☐ Mean Gradient: ____ mmHg	☐ Peak to peak Gradient: ____ mmHg
	☐ AV Area Not Documented	☐ Mean Gradient Not Documented	☐ Peak Gradient Not Documented
Characterization of AS Severity per Catheterization	☐ Severe AS ☐ Moderate to Severe		☐ Moderate AS ☐ Mild AS
OUTPATIENT CLINICAL ENCOUNTER		Clinical Encounter Tab	
Physician/Provider NPI:	_____		
Physician/Provider Specialty (Select all that apply):	☐ Cardiac Surgeon ☐ General Cardiologist or General Cardiovascular APP ☐ Primary Care Physician (PCP) or Advanced-Practice Provider (APP) ☐ Valve Cardiologist (member of MDT--could be an interventionalist or an imaging cardiologist) ☐ Other ☐ Unknown/Unable to Determine		
Did the patient have any of these symptoms of AS? (Select all that apply):	☐ Shortness of breath ☐ Exertional dyspnea ☐ Decreased exercise tolerance ☐ Angina / chest pain ☐ Pre-syncope ☐ Syncope		
Was the patient referred for AVR (TAVI or SAVR) consideration?	☐ Yes	☐ No/Not Documented	☐ N/A
Why was the patient not referred for consideration of AVR? (check all that apply)	☐ AS deemed not severe based on AV Calcification and/or Dobutamine Stress Echo or based on remeasurement ☐ Concomitant cancer diagnosis or other life limiting comorbidity with life expectancy < 1 year ☐ Patient already received AVR ☐ Patient referred for AVR at prior encounter ☐ Patient refused referral or treatment despite their recommendation ☐ Significant dementia ☐ Treatment decision is palliative care ☐ Other ☐ Unknown		
Was KCCQ-12 Assessment done?	☐ No/None ☐ Yes ☐ Not done – Medical Reasons	☐ Not done – Hospital Related or Other Reasons ☐ Not Done – Patient Reasons	
If Yes, Enter Date:	____/____/____ (MM/DD/YYYY)	Unknown	
KCCQ-12 Assessment Score:	KCCQ Summary Score: ____	Score Not Documented	
During this visit, was a standardized health related social needs form or assessment completed?	☐ Yes		☐ No/ND

If an assessment was completed during this visit, identify the areas of unmet social need. (select all that apply):	☐ None ☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing	☐ Mental Health ☐ Personal Safety ☐ Substance Use Disorder ☐ Transportation Barriers ☐ Utilities
<i>If unmet social need(s) identified, were resources provided to the patient during this visit?</i>	☐ Yes	☐ No
<i>If yes, what resources were provided during this visit?</i>	☐ Access to a Community Health Worker ☐ Access to a Social Worker ☐ Access to another Case Worker/Support Specialist	☐ Resources for a digital-based community platform (e.g. findhelp.org) ☐ Other resources provided during this visit: (Specify):
HOSPITALIZATION/IN-PATIENT ADMISSION		
Date of Admission	/ / (MM/DD/YYYY)	☐ Unknown
Potential AS-related reason(s) for admission (Select all that apply):	☐ None ☐ Shortness of breath / heart failure ☐ Chest pain	☐ Syncope or pre-syncope ☐ Myocardial infarction ☐ Atrial arrhythmia (new onset or RVR)
Was there an inpatient referral/evaluation for AVR?	☐ Yes	☐ No
If no, reason for no inpatient AVR referral (Select all that apply)	☐ Another acute medical issue took precedence ☐ AS deemed not severe based on AV Calcification and/or Dobutamine Stress Echo or based on remeasurement ☐ Concomitant cancer diagnosis or other life limiting comorbidity with life expectancy < 1 year ☐ Patient already received AVR ☐ Patient from outside the system and desired evaluation at their primary facility ☐ Patient referred for AVR at prior encounter ☐ Patient refused despite recommendation ☐ Significant dementia ☐ Treatment decision is palliative care ☐ Other (Specify): _____ ☐ Unable to determine	
During this admission, was a standardized health related social needs form or assessment completed?	☐ Yes	☐ No/ND
If yes, identify the areas of unmet social need. (select all that apply):	☐ None ☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing	☐ Mental Health ☐ Personal Safety ☐ Substance Use Disorder ☐ Transportation Barriers ☐ Utilities
<i>If unmet social need(s) identified, were resources provided to the patient during this admission?</i>	☐ Yes	☐ No

If yes, what resources were provided during this admission?	☐ Access to a Community Health Worker ☐ Access to a Social Worker ☐ Access to another Case Worker/Support Specialist	☐ Resources for a digital-based community platform (e.g. findhelp.org) ☐ Other resources provided during this visit: (Specify):
TREATMENT DECISION/MDT		Treatment Decision Tab
Treatment decision:	☐ TAVI	☐ SAVR ☐ Non-procedural treatment
If SAVR/TAVI, enter Date:	____/____/____ (MM/DD/YYYY)	☐ Date Unknown/ND
Why was non-procedural treatment pursued? (select all that apply):	☐ Multidisciplinary heart valve team determined AVR would be futile ☐ AS not felt to be severe based on multi-modality assessment ☐ Patient's symptoms not felt to be due to AS ☐ Patient refused AVR despite its recommendation ☐ No reason and not referred for AVR consideration ☐ Treatment decision is palliative care ☐ Other reason (Specify): _____ ☐ Unable to determine	
Was the decision based on a multidisciplinary heart valve team review/discussion (including a surgeon & a cardiologist)?	☐ Yes	☐ No ☐ Unknown/Not Documented
If yes, what was the date of the MDT discussion?	____/____/____ (MM/DD/YYYY)	☐ Unknown
Is there a documented reason why patient bypassed MDT evaluation?	☐ Yes	☐ No
Documented reasons why patient bypassed MDT evaluation (select all that apply):	☐ Patient has a bicuspid valve ☐ Concomitant grafting of ascending aorta required ☐ Multivessel coronary disease requiring CABG in a low/intermediate risk patient ☐ Other (specify) _____	
Was there any delay documented in scheduling or performing SAVR/TAVI?	☐ Yes	☐ No ☐ Unknown/ND
If Yes, select the reason(s) why (Select all that apply)	☐ Dental work/tooth extraction ☐ Incidental finding on the CT Scan required further evaluation before SAVR/TAVI ☐ Insurance denial ☐ Patient's preference for a delay ☐ Treatment or management of another medical problem (Specify): _____ ☐ Other	
DISCONTINUED FOLLOW-UP/DEATH		Discontinued Tab
Date Discontinued Follow-up:	____/____/____ (MM/DD/YYYY)	☐ Unknown/ND
Reasons for discontinuation:	☐ Patient moved, or was traveling through ☐ Change of insurance ☐ Changed physicians ☐ Patient died ☐ Patient lost to follow-up after at least 3 attempts to re-engage ☐ Patient transferred to another facility ☐ Other (Specify): _____ ☐ Unknown	

<i>If Patient Died, Date of Death:</i>	/ / (MM/DD/YYYY)	☐ Unknown/ND
END OF FORM		