American Heart Association®
Get With The Guidelines®
Coronary Artery Disease

GWTG-CAD Case Record Form (CRF) **October 2026**

Patient ID:	_____
STEMI Band ID:	_____
STEMI Band Not Documented:	☐

DEMOGRAPHICS TAB

Sex:	○ Male ○ Female ○ Unknown
Patient Gender Identity:	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, Neither Exclusively Male nor Female ○ Additional Gender Category or Other ○ Did not Disclose
Other Patient Gender Identity	_____
Patient-Identified Sexual Orientation:	○ Straight or heterosexual ○ Lesbian or gay ○ Bisexual ○ Queer, pansexual, and/or questioning ○ Something else; please specify ○ Don't know ○ Declined to answer
Other Patient-Identified Sexual Orientation:	_____
Date of Birth:	____/____/_____
Age:	_____ (auto calculated)
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 and/or Ethnicity:	☐ American Indian or Alaska Native ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino or Spanish Origin ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ White ☐ UTD

ADMIN

NPI

Attending Physician/Provider NPI:	_____
Admitting Physician:	_____
ED Physician:	_____

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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:	○ Air ○ Ambulance (ground) ○ Private vehicle ○ Transfer from another acute care facility
Patient first evaluated (at this facility):	○ ED ○ Cath Lab ○ Observation ○ Inpatient ○ Other (please specify) _____
Date/Time of ED discharge	___/___/_____ ___: ___ ☐ Unknown
ED Disposition	○ Admission ○ Expired ○ Home ○ Left Against Medical Advice ○ Transfer to Acute Care ○ Transfer to Observation Unit
Admission Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Discharge Date/Time:	___/___/_____ ___: ___
TRANSFER DATA [shows when ED Disposition = Transfer to Acute Care]	
Facility the patient was transferred to:	_____
Reason(s) for transfer from this facility:	☐ Administrative ☐ Advanced Cardiac Care (monitoring) ☐ CABG ☐ Patient/Family Choice ☐ Post Thrombolytic Care ☐ Primary PCI ☐ Other medical reason ☐ Other reason (please specify) _____
Mode of transport (transfer out):	○ Air ○ Ambulance
Inter-facility transport EMS Agency name/number (transfer out):	_____
Transport requested Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Transport Arrived Date/Time (transfer out):	___/___/_____ ___: ___ ☐ Unknown
ECG	
1st ECG Date/Time:	___/___/_____ ___: ___ ☐ Unknown
1st ECG obtained:	○ Prior to Hospital Arrival ○ After First Hospital Arrival
Pre-hospital ECG Finding	○ STEMI ○ LBBB (new or presumed new)

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	○ Isolated Posterior MI ○ Other ○ Not Documented
ED Physician Review of Pre-hospital ECG	○ No STEMI Noted ○ STEMI Noted ○ ND
Was there a documented reason for delay in obtaining 1st ECG?	○ Yes ○ No
Reason(s) for delay in obtaining 1st ECG:	☐ Cardiac Arrest ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Need for advanced airway placement (Intubation) ☐ Other concomitant emergent/acute conditions (e.g., stroke or trauma) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ ECG equipment failure* ☐ Other reason* (please specify) _____
ECG Read Date/Time	___/___/_____ ___: ___ ☐ Unknown
ECG Revealed STEMI or STEMI Equivalent?	○ Yes ○ No
If yes, ECG revealed:	○ ST Elevation ○ Isolated Posterior MI ○ New LBBB
If yes, STEMI or STEMI equivalent first noted:	○ First ECG ○ Subsequent ECG
If subsequent ECG, Date/Time of positive ECG:	___/___/_____ ___: ___ ☐ Unknown
Was there a documented reason for delay in transfer (from this facility)?	○ Yes ○ No
Reason(s) for delay in transfer (from this facility):	☐ Inclement Weather ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ Awaiting air transport* ☐ Delay in receiving hospital accepting patient* ☐ Ground transport unavailable* ☐ Other reason* (please specify) _____
STEMI Alert Activated	○ Yes ○ No
Date/Time of STEMI Alert	___/___/_____ ___: ___ ☐ Unknown
STEMI Alert Activated by:	○ Emergency Department ○ EMS ○ Inpatient ○ Observation ○ Transferring Facility ○ Other
Final Clinical Diagnosis	○ Confirmed AMI – STEMI ○ Confirmed AMI – non-STEMI ○ Confirmed AMI - STEMI/Non-STEMI unspecified ○ Unstable Angina ○ Angina not specified ○ Chest Pain (cardiac) ○ Chest Pain (non cardiac) (please specify) _____ ○ Noncardiac condition
PRE-HOSPITAL TAB	
Patient location where cardiac symptoms discovered:	○ Not in a healthcare setting

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	○ ACS event occurred after hospital arrival (in ED/Obs/Inpatient) ○ Another acute care facility ○ Chronic healthcare facility ○ Outpatient healthcare setting ○ ND or Cannot be determined
Symptom onset Date/Time:	__/__/_____ __: ___ ☐ Unknown
Means of arrival at first facility:	○ Air ○ Ambulance (ground) ○ Private vehicle ○ Transfer from acute care facility
EMS Time Tracker Data	
Date/time of Initial 911 Call for Help:	__/__/_____ __: ___ ☐ Unknown
EMS Dispatch Date/Time:	__/__/_____ __: ___ ☐ Unknown
EMS arrive on scene:	__/__/_____ __: ___ ☐ Unknown
EMS First Medical Contact:	__/__/_____ __: ___ ☐ Unknown
Non-EMS First Medical Contact:	__/__/_____ __: ___ ☐ Unknown
Was there a documented reason for scene delay by EMS?	○ Yes ○ No
Reason(s) for scene delay by EMS:	☐ Access to patient (EMS Documented) ☐ Cardiac Arrest ☐ Inclement weather ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Need for advanced airway placement (Intubation) ☐ Other concomitant emergent/acute conditions (e.g., stroke or trauma) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ Awaiting transport* ☐ Language barrier* ☐ Mechanical issue (transport unit)* ☐ Other reason* (please specify) _____
EMS depart scene:	__/__/_____ __: ___ ☐ Unknown
Destination Pre-arrival alert or notification:	__/__/_____ __: ___ ☐ Unknown
EMS Agency name/number:	_____
Method of 1st notification:	○ ECG Transmission ○ Phone call ○ Radio ○ ND
Run/Sequence number:	_____
Out of Hospital Cardiac Arrest	
Cardiac Arrest prior to Arrival?	○ Yes ○ No
If yes, was CPR performed by a bystander?	○ Yes ○ No
Return of Spontaneous Circulation (ROSC)	○ Yes ○ No
Date and time of ROSC	__/__/_____ __: ___ ☐ Unknown
If yes, was therapeutic hypothermia initiated during this episode of care?	○ Yes ○ No

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Transfer Time Tracker Data [show when means of transport to this facility = transfer from another acute care facility]	
Transferring Facility:	_____
Mode of transport to this facility:	○ Air ○ Ambulance
Inter-facility transport EMS Agency name/number:	_____
Reason(s) for transfer to this facility:	☐ Administrative ☐ Advanced Cardiac Care (monitoring) ☐ CABG ☐ Patient/Family Choice ☐ Post Thrombolytic Care ☐ Primary PCI ☐ Other medical reason ☐ Other reason (please specify) _____
Arrival at First hospital Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Transport Arrived Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Transfer out Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Was there a documented reason for delay in transfer (to this facility)?	○ Yes ○ No
Reason(s) for delay in transfer (to this facility):	☐ Inclement weather ☐ Management of concomitant emergent/acute conditions such as cardiopulmonary arrest, respiratory failure (requiring intubation) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ Awaiting air transport* ☐ Delay in receiving hospital accepting patient* ☐ Ground transport unavailable* ☐ Other reason* (please specify) _____

CARDIAC EVALUATIONS TAB		
Patient Medical History:	☐ No Previous Medical History ☐ Atrial Fibrillation ☐ Atrial Flutter ☐ Cancer ☐ Cerebrovascular Disease ☐ Stroke ☐ TIA ☐ Chronic Kidney Disease (CKD) ☐ Currently on Dialysis ☐ Diabetes Mellitus ☐ Type 1 ☐ Type 2 ☐ ND ☐ Dyslipidemia ☐ Familial Hypercholesterolemia	☐ Emerging Infectious Disease ☐ SARS-COV-2 (COVID-19) ☐ Heart Failure ☐ Hypertension ☐ Hypertriglyceridemia ☐ Long COVID ☐ Obesity/Overweight ☐ Peripheral Artery Disease ☐ Prior CABG If Prior CABG, Most Recent CABG Date: ___/___/_____ ☐ Unknown ☐ Prior MI ☐ Prior PCI If Prior PCI, Most Recent PCI Date: ___/___/_____ ☐ Unknown
History of Smoking?	○ Yes	○ No
History of vaping or e-cigarette use in the past 12 months?	○ Yes	○ No/ND

Medications Prior to Admission
☐ No medications prior to admission Anticoagulants prior to admission ○ Yes ○ No/ND Anticoagulant Medication: ○ Apixaban

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○ Asundexian
○ Dabigitran
○ Milvexian
○ Rivaroxaban
○ Warfarin
○ Other

Anti-hyperglycemics prior to admission ○ Yes ○ No/ND

Anti-hyperglycemic Medications:
☐ Biguanide
☐ DPP-4 Inhibitor
☐ GLP-1 Receptor Agonist
☐ Insulin
☐ SGLT2 Inhibitor
☐ Sulfonylurea
☐ Thiazolidinedrone
☐ Other

Anti-hypertensives prior to admission ○ Yes ○ No/ND

Anti-hypertensive Medications:
☐ ACEI
☐ Alpha-blocker
☐ ARB
☐ ARNI
☐ Beta-blocker
☐ Calcium channel blocker
☐ Diuretic
☐ Other

Antiplatelets prior to admission ○ Yes ○ No/ND

Antiplatelet Medications:
☐ Aspirin
☐ Clopidogrel (Plavix)
☐ Prasurel (Effient)
☐ Ticagrelor (Brilinta)
☐ Ticlopidine (Ticlid)

Cholesterol Reducer prior to admission ○ Yes ○ No/ND

Cholesterol Reducer Medications:
☐ ACL Inhibitors
☐ Bile Acid Sequestrants
☐ Ezetimbe
☐ Fibrates
☐ Niacin
☐ Omega-3 Fatty Acid
☐ PCSK9 Inhibitor
☐ Statin

Vitals	
Heart rate documented on first medical contact:	_____
Heart rate documented - ND	☐
Systolic blood pressure on first medical contact:	_____
Systolic blood pressure – ND	☐
Heart failure documented on first medical contact	○ Yes ○ No ○ ND
Cardiogenic shock documented on first medical contact	○ Yes ○ No ○ ND

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Height	_____ ○ in ○ cm	Weight	_____ ○ lbs ○ kg
Height - ND	☐	Weight - ND	☐
BMI (auto-calculated):	_____		
Waist Circumference:	_____ ○ in ○ cm	Waist Circumference - ND	☐

Labs	
Positive cardiac biomarkers in the first 24 hours?	○ Yes ○ No
Initial Troponin value	_____ ○ ng/mL ○ng/L ○ ug/L ○ pg/ml
Initial Troponin – ND	☐
Date/Time of initial troponin results:	__/__/_____ __: ___ ☐ Unknown
Initial Serum Creatinine (mg/dL):	_____
Initial Serum Creatinine - ND	☐

Total Cholesterol (mg/dL):	_____	Total Cholesterol Not Documented:	☐
HDL (mg/dL):	_____	HDL Not Documented:	☐
LDL (mg/dL):	_____	LDL Not Documented:	☐
Triglycerides (mg/dL):	_____	Triglycerides Not Documented:	☐
HBA1C (%):	_____	HBA1C Not Documented:	☐

LP(a) measurement obtained:	○ This hospitalization ○ Prior to this hospitalization ○ Planned after discharge ○ No measurement documented		
LP(a) Value:	_____	LP(a) Unit:	○ nmol/L ○ mg/dl
LP(a) Not Documented:	☐		

Risk Scores			
Risk-Stratification Score Documented?	☐ EDACS ☐ GRACE ☐ HEART	☐ TIMI ☐ Other ☐ No Risk-Stratification Score Documented	
EDACS Score:	_____	Grace Risk Score:	_____
HEART Score:	_____	TIMI Risk:	_____
LVF Obtained	○ This Admission ○ W/in the last year ○ > 1 year ago ○ Planned After Discharge ○ Not Documented	LVF Assessment (%)	_____
Was early diagnostic coronary angiography performed?		○ Yes ○ No	
Date and time of diagnostic angiography:		__/__/_____ __: __ ☐ Unknown	
Date and time of diagnostic angiography Not Documented:		☐	
Reason for not performing early diagnostic angiography		☐ Yes, medical reason ☐ Yes, patient reason ☐ Yes, system reason	

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	☐ No Reason documented
Non-invasive cardiac stress test during this hospital episode:	○ Yes ○ No ○ NC
New Diagnosis During this Admission	
Diabetes Mellitus	○ Yes ○ No/ND
Active bacterial or viral infection at admission or during hospitalization:	☐ None/ND ☐ Bacterial Infection ☐ Emerging Infectious Disease ☐ SARS-COV-2 (COVID-19) ☐ Other Emerging Infectious Disease ☐ Influenza ☐ Seasonal Cold ☐ Other Viral Infection
Health Related Social Needs Assessment	
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 apply)	☐ None ☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing ☐ Mental Health ☐ Personal Safety ☐ Substance Use Disorder ☐ Transportation Barriers ☐ Utilities ☐ Other (please specify): _____
If unmet social need(s) identified, were resources provided to the patient?	○ Yes ○ No
If yes, what resources were provided?	☐ 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 (please specify) _____
Enrolled in Clinical Trial During Hospitalization	○ Yes ○ No
If Yes, Type of Clinical Trials(s) (select all that apply)	☐ Precluding the use of aspirin in protocol ☐ Related to reperfusion therapy ☐ Involving antiplatelet therapies ☐ Involving renin-angiotensin-aldosterone system inhibitor ☐ Related to lipid lowering therapy ☐ Related to AMI ☐ Related to STEMI ☐ Related to hyperglycemic control ☐ Other (please specify):_____
IN-HOSPITAL MEDICATIONS & VACCINATIONS	
Antiplatelet & Anticoagulant Medications & Loading Dose During this Episode of Care	
No antiplatelet or anticoagulant medications	☐
Aspirin Administration Was aspirin administered at this facility within 24 hours of arrival?	○ Yes ○ No ○ NC
Was aspirin administered within 24 hours prior to arrival?	○ Yes ○ No ○ NC
Was aspirin administered prior to transfer?	○ Yes ○ No ○ NC
Other Antiplatelet Medications Clopidogrel (Plavix) During this Episode	○ Yes ○ No ○ NC

Dosage:	○75mg ○300mg ○600mg ○Other ○Unknown
Prasugrel (Effient) During this Episode	○ Yes ○ No ○ NC
Dosage:	○ 5mg ○ 10mg ○ Other ○ Unknown
Ticagrelor (Brilinta) During this Episode	○ Yes ○ No ○ NC
Dosage:	○ 90mg ○ 180mg ○ Other ○ Unknown
Ticlopidine (Ticlid) During this Episode	○ Yes ○ No ○ NC
Dosage:	○ 250mg ○ Other ○ Unknown
Anticoagulant Medications	
Bivalirudin (Angiomax) During this Episode	○ Yes ○ No ○ NC
Heparin During this Episode	○ Yes ○ No ○ NC
Low Molecular Weight Heparin (LMWH) During this Episode	○ Yes ○ No ○ NC

Vaccinations	
Influenza Vaccination:	○ Influenza vaccine was given during this hospitalization during the current flu season ○ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ○ Documentation of patient's refusal of influenza vaccine ○ Allergy/sensitivity to influenza vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD
COVID-19 Vaccination:	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD

COVID-19 Vaccination Date	___/___/____ ☐ Unknown	Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND

REPERFUSION	
Thrombolytics administered at this facility?	○ Yes ○ No/ND
Thrombolytics administered prior to arrival?	○ Yes, by transferring facility ○ Yes, by EMS ○ No/ND
Thrombolytic Dose Start Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Thrombolytic medication:	○ tenecteplase (TNKase) ○ alteplase (Activase) ○ reteplase (Retavase) ○ Other (please specify) _____
Was there a documented reason for delay in thrombolytics?	○ Yes ○ No
Reason(s) for delay in thrombolytics:	☐ Cardiac Arrest

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	☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Need for advanced airway placement (Intubation) ☐ Other concomitant emergent/acute conditions (e.g. stroke or trauma) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ Change in reperfusion strategy* ☐ Provider unable to administer thrombolytics* ☐ Other reason* (please specify) _____
Reasons for not administering a thrombolytic	☐ Active peptic ulcer ☐ Any prior intracranial hemorrhage ☐ Dementia ☐ DNR at time of treatment decision ☐ Expected DTB <= 90 Minutes ☐ History of chronic, severe, poorly controlled hypertension ☐ History of prior ischemic stroke >3 months ☐ Intracranial neoplasm, AV malformation, or aneurysm ☐ Intracranial or intraspinal surgery within 2 months ☐ Ischemic stroke within 3 months except acute ischemic stroke within 4.5 hours ☐ Known bleeding diathesis ☐ Major surgery (<3 weeks) ☐ No reason documented ☐ Noncompressible vascular punctures ☐ Oral anticoagulant therapy ☐ Other intracranial pathology ☐ Patient/family refusal ☐ Pregnancy ☐ Prior allergic reaction to thrombolytics ☐ Recent bleeding within 4 weeks ☐ Severe uncontrolled hypertension (SBP >180 mmHg or DBP >110 mmHg and unresponsive to therapy) ☐ Significant closed-head or facial trauma within 3 months ☐ Suspected aortic dissection ☐ Transferred for PCI ☐ Traumatic or prolonged CPR (>10 mins) ☐ Other (please specify) _____
Was the patient brought to the cath lab with the intention of performing PCI?	○ Yes ○ No
PCI performed during this episode of care?	○ Yes ○ No
Reasons for not performing PCI	☐ Active bleeding on arrival or within 24 hours ☐ Anatomy not suitable to primary PCI ☐ DNR at time of treatment decision ☐ No PCI Capability ☐ No reason documented ☐ Non-compressible vascular puncture(s) ☐ Patient/family refusal ☐ Prior allergic reaction to IV contrast ☐ Quality of life decision ☐ Spontaneous reperfusion (documented by cath only) ☐ Thrombolytic Administered ☐ Other (please specify) _____
PCI Time Tracker Data	
Cath Lab Activation:	___/___/_____ ___: ___ ☐ Unknown
Patient Arrival to Cath Lab:	___/___/_____ ___: ___ ☐ Unknown
Team Arrival to Cath Lab:	___/___/_____ ___: ___ ☐ Unknown
Interventionalist Arrival to Cath Lab:	___/___/_____ ___: ___ ☐ Unknown

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First PCI Date/Time:	___/___/_____ ___: ___ ☐ Unknown
PCI Indication	○ Primary PCI for STEMI ○ PCI for STEMI (unstable, >12 hr from sx onset) ○ PCI for STEMI (stable, >12 hr from sx onset) ○ PCI for STEMI (stable after successful full-dose lytic) ○ PCI for STEMI (facilitated PCI after half/reduced-dose lytic) ○ Rescue PCI for STEMI (after failed full-dose lytic) ○ PCI for NSTEMI ○ Other _____
Was there a documented reason for delay in PCI?	○ Yes ○ No
Reasons for delay in PCI:	☐ Cardiac Arrest ☐ Difficult vascular access ☐ Difficulty crossing the culprit lesion ☐ Need for additional PPE for suspected/ confirmed infectious disease ☐ Need for advanced airway placement (Intubation) ☐ Need for Mechanical circulatory support prior to PCI ☐ Other concomitant emergent/acute conditions (e.g., stroke or trauma) ☐ Patient/ family consent ☐ Presenting signs and symptoms inconsistent with ACS ☐ Other reason* (please specify) _____
CABG During This Admission:	○ Yes ○ No
Mechanical Circulatory Support Device / VAD During This Admission?	○ Yes ○ No
Date/Time of FIRST MCS:	___/___/_____ ___: ___ ☐ Unknown
Percutaneous Assist Devices:	☐ IABP ☐ Impella ☐ TandemHeart ☐ VA ECMO ☐ iVAC ☐ Other VAD
Complications from procedures during this admission:	☐ No complications from procedures ☐ Acute Limb ischemia ☐ Arterial non-CNS thrombosis ☐ Bleeding - Vascular access site – MCS-Related ☐ Bleeding - Vascular access site – Other access site ☐ Bleeding – Other site ☐ Cardiac tamponade ☐ Coronary dissection ☐ Vascular Injury (any) ☐ Venous thromboembolism ☐ Other_____

MCS	
Section to be completed for each device implanted	
Implanted Device – VA ECMO:	☐

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Date/Time of Implant Procedure – VA ECMO:	___/___/_____ ___: ___ ☐ Unknown
Died with implant in place – VA ECMO:	○ Yes ○ No
Device explant date - VA ECMO:	___/___/_____ ___: ___ ☐ Unknown
Arterial Implant Site - VA ECMO:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Venous Implant Site - VA ECMO:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Receiving CPR at time of Implant – VA ECMO:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – VA ECMO:	☐ Critical Left Main / Severe CAD ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock ☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) - ECMO:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair ☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown
Implanted Device – IABP:	☐
IABP Manufacturer:	○ MAQUET (Getinge) ○ Teleflex Corporation ○ Datascope (Getinge) ○ Abiomed ○ Edwards Lifesciences ○ Unknown
IABP Model:	MAQUET (Getinge) ○ Cardiosave Rescue ○ Cardiosave IABP Hybrid ○ Unknown Teleflex Corporation ○ Arrow AutoCAT 2 WAVE IABP ○ Arrow AC3 Optimus IABP ○ Unknown Datascope (Getinge) ○ CS100 ○ CS100i ○ 97E ○ 90T ○ 98XT ○ CS300 ○ Unknown Abiomed ○ iPulse ○ Unknown

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	Edwards Lifesciences ○ Aquarius ○ Unknown Unknown ○ Unknown
IABP Catheter Manufacturer:	○ Getinge ○ Teleflex
IABP Catheter Model:	Getinge ○ Linear ○ Mega ○ Sensation ○ Sensation Plus Teleflex ○ Arrow RediGuard IAB catheters ○ Arrow Ultra 8 Fiber-Optic IAB Catheters ○ Arrow Ultra 8 Fluid-Filled IAB Catheters ○ Arrow UltraFlex 7.5 IAB Catheters
IABP Balloon Size:	○ 25cc ○ 40cc ○ 30cc ○ 50cc ○ 34cc ○ Unknown
Date/Time of Implant Procedure – IABP:	__/__/_____ __: ___ ☐ Unknown
Died with implant in place – IABP:	○ Yes ○ No
Device explant date - IABP:	__/__/_____ __: ___ ☐ Unknown
Arterial Implant Site - IABP:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Receiving CPR at time of Implant – IABP:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – IABP:	☐ Critical Left Main / Severe CAD ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock ☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) - IABP:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair ☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown
Implanted Device – Impella:	☐ Impella ☐ Impella CP ☐ Impella 5.5 ☐ Impella ECP ☐ Impella RP ☐ Impella RP Flex
Date/Time of Implant Procedure – Impella	__/__/_____ __: ___ ☐ Unknown
Died with implant in place – Impella:	○ Yes ○ No

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Device explant date – Impella:	___/___/_____ ___: ___ ☐ Unknown
Arterial Implant Site – Impella:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Venous Implant Site – Impella RP or RP Flex:	☐ Right ☐ Right – Femoral ☐ Right- Internal Jugular ☐ Left ☐ Left – Femoral ☐ Left – Internal Jugular ☐ Other
Receiving CPR at time of Implant – Impella:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – Impella:	☐ Critical Left Main / Severe CAD *(*will not appear for Impella RP or RP Flex)* ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock ☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO *(*will not appear for Impella RP or RP Flex)* ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) - Impella:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair ☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown
Implanted Device – iVAC:	☐
Date/Time of Implant Procedure – iVAC:	___/___/_____ ___: ___ ☐ Unknown
Died with implant in place – iVAC:	○ Yes ○ No
Device explant date – iVAC:	___/___/_____ ___: ___ ☐ Unknown
Arterial Implant Site – iVAC:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Receiving CPR at time of Implant – iVAC:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – iVAC:	☐ Critical Left Main / Severe CAD ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock

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	☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) – iVAC:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair ☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown
Implanted Device – TandemHeart:	☐
Date/Time of Implant Procedure – TandemHeart:	___/___/_____ ___: ___ ☐ Unknown
Died with implant in place – TandemHeart:	○ Yes ○ No
Device explant date – TandemHeart:	___/___/_____ ___: ___ ☐ Unknown
Arterial Implant Site – TandemHeart:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Venous Implant Site - TandemHeart:	☐ Right ☐ Right – Axillary ☐ Right – Femoral ☐ Right - Jugular ☐ Left ☐ Left – Axillary ☐ Left – Femoral ☐ Left- Jugular ☐ Central ☐ N/A
Receiving CPR at time of Implant – TandemHeart:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – TandemHeart:	☐ Critical Left Main / Severe CAD ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock ☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) – TandemHeart:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair

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	☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown
Implanted Device – Other:	☐
Specify other device:	_____
Date/Time of Implant Procedure – Other:	___/___/_____ ___: ___ ☐ Unknown
Died with implant in place – Other:	○ Yes ○ No
Device explant date – Other:	___/___/_____ ___: ___ ☐ Unknown
Arterial Implant Site – Other:	☐ Right ☐ Right – Axillary ☐ Right - Femoral ☐ Left ☐ Left – Axillary ☐ Left - Femoral ☐ Central
Receiving CPR at time of Implant – Other:	○ Yes ○ No ○ Unknown/ND
Reason for device implant – Other:	☐ Critical Left Main / Severe CAD ☐ Incessant Arrhythmia ☐ Refractory Ischemia ☐ Shock ☐ Severe Heart Failure without Shock ☐ Severe Valvular Dysfunction ☐ Supported PCI ☐ Ventricular Septal Defect ☐ Left-ventricular venting during VA-ECMO ☐ Other reason for device implant (Specify): _____
Vascular closure applied (select all that apply) – Other:	☐ Collagen-based plug with MANTA ☐ Dry-based ☐ Manual compression (e.g., Femostop) ☐ Planned open surgical repair ☐ Suture-based (e.g., Proglide, Prostar XL) ☐ Unknown

DISCHARGE			
In-hospital Risk Adjusted Mortality Score:	_____ (auto calculated)		
Discharge Disposition:	○ 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?	○ Yes ○ No	If Yes, Date/Time:	___/___/_____ ___: ___ ☐ Unknown
Referrals/Counseling and Follow-up			
Patient Referred to Cardiac Rehab?	○ Yes ○ No referral documented ○ No-Medical Reason ○ No-Patient Oriented Reason ○ No-Healthcare System Reason		

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Smoking Cessation Counseling?	○ Yes ○ No			
Follow-up for lipid management:	○ Yes ○ No ○ NC			
LP(a) treatment plan:	☐ None ☐ Lipoprotein apheresis ☐ Patient education on LP(a) ☐ Referred to lipid management ☐ Risk factor management ☐ Other			
Follow-up visit scheduled?	○ Yes ○ No			
Date of first follow-up visit	_____/_____/_____ ☐ Unknown			
Location of first follow-up visit	○ Home health visit ○ Office visit ○ Telehealth ○ Not documented			
Discharge Medications				
ACEI at discharge	Prescribed	○ Yes	○ No	○ NC
ARB at discharge	Prescribed	○ Yes	○ No	○ NC
ARNI at discharge	Prescribed	○ Yes	○ No	○ NC
Aspirin at discharge	Prescribed	○ Yes	○ No	○ NC
	If yes,	Dose:	○ 75-100 mg ○ >100 mg ○ Other ○ Unknown	
		Frequency:	○ Every Day ○ 2 Times a day ○ 3 Times a day ○ 4 Times a day ○ Other ○ Unknown	
Clopidogrel at discharge	Prescribed	○ Yes	○ No	○ NC
	If yes,	Dose:	○ 75mg ○ Other ○ Unknown	
		Frequency:	○ Every Day ○ Other ○ Unknown	
Prasugrel at discharge	Prescribed	○ Yes	○ No	○ NC
	If yes,	Dose:	○ 5mg ○ 10mg ○ Other ○ Unknown	
		Frequency:	○ Every Day ○ Other ○ Unknown	
Ticagrelor at discharge	Prescribed	○ Yes	○ No	○ NC
	If yes,	Dose:	○ 90mg ○ Other	

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			○ Unknown
		Frequency:	○ 2 Times a day ○ Other ○ Unknown
Ticlopidine at discharge	Prescribed	○ Yes	○ No ○ NC
	If yes,	Dose:	○ 250mg ○ Other ○ Unknown
		Frequency:	○ 2 Times a day ○ Other ○ Unknown
Anticoagulation at discharge	Prescribed	○ Yes	○ No ○ NC
	If yes,	Class:	○ Warfarin ○ Direct Thrombin Inhibitor ○ Factor Xa Inhibitor ○ Factor XIa Inhibitor
		Medication:	○ Coumadin (warfarin) ○ Dabigatran ○ Other Direct Thrombin Inhibitor ○ Apixaban ○ Edoxaban ○ Rivaroxaban ○ Other Factor Xa Inhibitor ○ Asundexian ○ Milvexian
		Dose:	N/A ○ 75mg ○ 150 mg ○ Other ○ Unknown 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
		Frequency:	N/A ○ 2 Times a day ○ Other ○ Unknown 1. _____ 2. _____ 3. _____
Beta Blocker at discharge	Prescribed	○ Yes	○ No ○ NC
Statin at discharge	Prescribed	○ Yes	○ No ○ NC
	If yes,	Medication:	○ amlodipine + atorvastatin (Caduet) ○ atorvastatin (Lipitor) ○ ezetimibe + simvastatin (Vytorin) ○ fluvastatin (Lescol) ○ fluvastatin (Lescol XL) ○ lovastatin (Mevacor) ○ lovastatin extended release (Altoprev) ○ lovastatin + niacin (Advicor) ○ pitavastatin (Livalo) ○ pravastatin (Pravachol) ○ rosuvastatin (Crestor) ○ simvastatin (Zocor) ○ simvastatin + niacin (Simcor)
		Dose:	1. _____ 2. _____

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			3. _____ 4. _____ 5. _____
		Statin Level of Intensity:	○ Low ○ Moderate ○ High
Is there a non-system reason for not prescribing a high intensity statin medication?	☐ Yes, medical reason ☐ Yes, patient reason ☐ No		
Anti-hyperglycemic Medication Prescribed	○ Yes ○ No ○ 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?	○ Yes ○ No/ND		
PCSK9 Inhibitor Prescribed	○ Yes ○ No ○ NC		
PCSK9 Medication	○ alirocumab (Praluent) ○ evolocumab (Repatha) ○ inclisiran		
Comments:			
Feedback Report Comments:			

TIME METRICS (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	

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