COVID-19 Cardiovascular Registry – April 23, 2020

Patient ID:		**Bold Question = Required**
DEMOGRAPHICS		***Demographics Tab***
Sex	○ Male ○ Female ○ Unknown	
Date of Birth:	_____/_____/__________	**Age:** ____________
Zip Code:	__________________ - ____________	Homeless: ☐
Payment Source	☐ Medicare Title 18 ☐ Medicaid – Private/ HMO/ PPO/ Other ☐ Self Pay/ No Insurance ☐ Medicaid Title 19 ☐ Private/ HMO/ PPO/ Other ☐ Other/ Not Documented/ UTD	☐ Medicare – Private/ HMO/ PPO/ Other ☐ VA/ CHAMPVA/ Tricare
RACE AND ETHNICITY		
Race (Select all that apply):	☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Asian [if Asian selected] ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	☐ Native Hawaiian or Pacific Islander [if native Hawaiian or pacific islander selected] ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ UTD
Hispanic Ethnicity:	○ Yes ○ No/UTD	
If Yes,	○ Another Hispanic, Latino or Spanish Origin ○ Cuban	○ Mexican, Mexican American, Chicano/a ○ Puerto Rican
ADMIN		***Admin Tab***
Arrival Date/Time:	_____/_____/____________:_____ ○ MM/DD/YYYY only ○ Unknown	**Admission Date:** ______/_____/_________
Discharge Date/Time:	_____/_____/____________:_____ ☐ MM/DD/YYYY only	
What was the patient's discharge disposition on the day of discharge?	☐ 1 – Home ☐ 2 – Hospice – Home ☐ 3 – Hospice – Health Care 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)	
If Other Health Care Facility	○ Inpatient Rehabilitation Facility (IRF) ○ Intermediate Care facility (ICF) ○ Long Term Care Hospital (LTCH)	○ Skilled Nursing Facility (SNF) ○ Other
ARRIVAL AND ADMISSION INFORMATION		***Admission Tab***
Means of Transport to your Facility:	○ Air ○ Ambulance ○ Transfer from another hospital ○ Walk-In ○ ND or Unknown	
MEDICAL HISTORY		

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Past Medical History:

- ☐ No Medical History
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ Cancer
- ☐ Cerebrovascular Disease
  - ☐ Stroke
  - ☐ TIA
- ☐ Chronic kidney disease
- ☐ Currently on Dialysis
- ☐ DVT
- ☐ Diabetes Mellitus
- ☐ Dyslipidemia
- ☐ eCigarette (vaping)
- ☐ Heart Failure
- ☐ Hypertension
- ☐ Immune disorders
  - ☐ HIV
  - ☐ Lupus
  - ☐ Rheumatoid Arthritis
  - ☐ Other
- ☐ Organ Transplant
- ☐ Peripheral Artery Disease
- ☐ Prior CABG
- ☐ Prior MI
- ☐ Prior PCI
- ☐ Pulmonary embolism
- ☐ Pulmonary disease
  - ☐ COPD
  - ☐ Interstitial lung Disease (ILD)
  - ☐ Asthma
  - ☐ Other
- ☐ Smoking

DIAGNOSIS & EVALUATION

COVID-19 Diagnosis
- ○ Yes, prior to admission
- ○ Yes, during hospitalization
- ○ Yes, after discharge
- ○ Unknown/ND

Method of diagnosis: ○ Clinical diagnosis using hospital specific criteria ○ RT-PCR Test

Date of dx ________/________/________ ☐ Unknown

Date of COVID-19 symptom onset? ________/________/___________ ☐ Unknown

Documented Symptoms
- ☐ Confusion or Altered Mental Status
- ☐ Cough
- ☐ Fatigue
- ☐ Fever/ Chills
- ☐ Headache
- ☐ Loss of Sense of Smell/ Taste
- ☐ Myalgia
- ☐ Nasal Congestion
- ☐ Nausea, Vomiting, or Diarrhea
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Other: _______________
- ☐ Not Documented

Presence of interstitial infiltrates on initial Chest X-ray or CT ○ Yes ○ No ○ ND

During admission, was this patient enrolled in a clinical trial related to COVID-19? ○ Yes ○ No/ND

MEDICATION PRIOR TO ADMISSION

Medications prescribed or taking at time of admission:

Anti-hypertensive ○ Yes ○ No/ND

Anti-hypertensive Tx (Select all that apply)
- ☐ Ace Inhibitors
- ☐ ARB
- ☐ ARNI
- ☐ Beta Blockers
- ☐ CA++ Channel Blockers
- ☐ Diuretics
- ☐ MRA
- ☐ Other anti-hypertensive med

ACEI administered during hospitalization ○ Yes ○ No ○ ND

ARB administered during hospitalization ○ Yes ○ No ○ ND

Lipid Lowering Therapy ○ Yes ○ No/ND

Lipid lowering therapy (Select all that apply)
- ☐ Ezetimibe
- ☐ PCSK 9 Inhibitor
- ☐ Statin
- ☐ Other lipid lowering med

Antiplatelet ○ Yes ○ No/ND

Antiplatelet Tx (Select all that apply)
- ☐ Aspirin
- ☐ P2Y12 Inhibitors
- ☐ Other Antiplatelet

Anticoagulant ○ Yes ○ No/ND

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Anticoagulant Tx (Select all that apply)	☐ Direct Thrombin Inhibitor ☐ Factor Xa Inhibitor ☐ Warfarin ☐ Other Anticoagulant
Anti-hyperglycemic	○ Yes ○ No/ND
Anti-hyperglycemic Tx (select all that apply)	☐ DPP-4 Inhibitors ☐ GLP-1 Receptor Agonist ☐ Insulin ☐ Metformin ☐ SGLT2 Inhibitor ☐ Sulfonylurea ☐ Thiazolidinedione ☐ Other Injectable/ Subcutaneous Agent ☐ Other Oral Agents
Corticosteroid	○ Inhaled ○ Oral ○ None/ND
Immunosuppressive medications (other than steroids)	○ Yes ○ No/ND
Chemo or biological treatment for cancer	○ Yes ○ No/ND
Hydroxychloroquine	○ Yes ○ No/ND

HOSPITALIZATION ***Hospitalization Tab***

During this admission: If multiple events, record Date/Time of first episode.

Documentation of Presenting EKG	○ Yes ○ No/ND
Rhythm	○ Atrial Fibrillation ○ Atrial Flutter ○ Sinus ○ Other
QTC Value	__________ ms ○ Not Documented
EKG abnormalities	☐ None ☐ Left Bundle Branch Block ☐ Right Bundle Branch Block ☐ ST-Segment Depression ☐ ST-Segment Elevation ☐ Not Documented
Sustained ventricular arrhythmias	○ Yes ○ No/ND
Date/Time of sustained ventricular arrythmia	____/_____/______ _____:____ ○ MM/DD/YYYY only ○ Unknown
Atrial Fibrillation	○ Yes ○ No/ND
Date/Time of A-Fib	____/_____/______ _____:____ ○ MM/DD/YYYY only ○ Unknown
Heart block requiring a temporary or permanent pacemaker	○ Yes ○ No/ND
Date/Time of HB intervention	____/_____/______ _____:____ ○ MM/DD/YYYY only ○ Unknown
Acute Myocardial Infarction (AMI):	○ STEMI ○ NSTEMI ○ No/ND
STEMI reperfusion	○ Fibrinolytic Therapy ○ Primary PCI ○ No reperfusion therapy
NSTEMI type	○ Type 1 MI ○ Type 2 (demand-related) MI ○ ND
Date/time of AMI	____/_____/_____ ___:_____ ○ MM/DD/YYYY only ○ Unknown
Percutaneous Coronary Intervention (PCI)	○ Yes ○ No/ND
Date/Time of PCI	____/_____/_____ ______:____ ○ MM/DD/YYYY only ○ Unknown
LVEF assessment:	○ Yes ○ No/ND
Date of LVEF assessment	____/_____/_____ ○ Unknown
EF – Quantitative (%)	____________% ○ Not Documented
Is there documentation of	○ Yes ○ No/ND

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an LVEF assessment within the last year?	
Last Known EF	____________% ○ Not Documented
Coronary Angiogram	○ Yes ○ No/ND
Angiogram type	○ CTA ○ Invasive (cath) ○ ND
Number of vessels with ≥ 50% stenosis	○ 0 ○ 2 ○ Left main CAD ○ 1 ○ ≥ 3 ○ Not Documented
Date/Time of cardiac angiogram	____/_____/______ _____:____ ○ MM/DD/YYYY only ○ Unknown
In-hospital Shock	○ Yes ○ No/ND
Shock type	○ Cardiogenic ○ Mixed ○ Distributive (e.g. Sepsis) ○ Other/Unknown
Shock Management (select all that apply)	☐ IABP ☐ Impella or other PVAD ☐ V-A ECMO ☐ Inotropes/Vasopressors ☐ V-V ECMO
Date/Time of mechanical circulatory support	____/_____/______ _____:____ ○ MM/DD/YYYY only ○ Unknown
New-onset heart failure	○ Yes ○ No/ND
Specify HF:	○ Systolic (HFrEF) ○ Diastolic (HFpEF)
Date of HF	____/_____/______ ○ Unknown
Myocarditis	○ Yes ○ No/ND
Diagnostic test	☐ Cardiac biopsy ☐ CT ☐ MRI ☐ Clinical diagnosis
Date of Myocarditis	____/_____/______ ○ Unknown
Deep Vein Thrombosis (DVT)	○ Yes ○ No/ND
Date of DVT diagnosis	____/_____/______ ○ Unknown
Pulmonary Embolus (PE)	○ Yes ○ No/ND
Date of PE diagnosis	____/_____/______ ○ Unknown
Intracardiac Thrombus	○ Yes ○ No/ND
Date of Intracardiac thrombus diagnosis	____/_____/______ ○ Unknown
Clinical bleeding requiring transfusion	○ Yes ○ No/ND
Date of transfusion	____/_____/______ ○ Unknown
New Hemodialysis or CRRT	○ Yes ○ No/ND
Date of New hemodialysis	____/_____/______ ○ Unknown
Ischemic stroke / intracranial hemorrhage	○ Yes ○ No/ND
Initial NIH Stroke Scale	__________ ○ Not Documented
Imaging	○ CT ○ MRI ○ Not Documented
Imaging shows acute stroke?	○ Yes ○ No/ND
Stroke treatment	○ Thrombolysis ○ Thrombectomy ○ None/ND

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Stroke or intracranial hemorrhage type:	☐ Cerebral Venous Sinus Thrombosis ☐ Intracerebral Hemorrhage ☐ Ischemic Stroke ☐ Stroke Not Otherwise Specified ☐ Subarachnoid Hemorrhage ☐ Subdural/ Epidural Hemorrhage ☐ Transient Ischemic Attack (TIA) ☐ Not Documented
Date of stroke diagnosis	____/_____/______ O Unknown
Seizure	O Yes O No/ND
Date of seizure	____/_____/______ O Unknown
Cardiac Arrest (Code Blue, CPR)	O Yes O No/ND
First documented pulseless rhythm	O Asystole O Pulseless Electrical Activity (PEA) O Pulseless Ventricular Tachycardia (VT) O Ventricular Fibrillation (VF) O Unknown/ND
Date/Time of cardiac arrest	____/_____/______ _____:____ O MM/DD/YYYY only O Unknown
Cause of death documented	O Yes O No/ND
Cause of death:	O AMI O Arrhythmia O HF O Respiratory O Stroke O Other
Date of death	____/_____/______ O Unknown

PULMONARY / CRITICAL CARE

Was this patient managed in an ICU	O Yes O No/ND
Date Transferred to ICU	_______/_______/__________ O Unknown
During this hospitalization was the patient intubated or placed on mechanical ventilation?	O Yes O No/ND
Date mechanical ventilation initiated	_______/_______/__________ O Unknown
Date mechanical ventilation terminated	_______/_______/__________ O Unknown
Was V-V ECMO performed	O Yes O No/ND
Date V-V ECMO initiated	_______/_______/__________ O Unknown
Date V-V ECMO terminated	_______/_______/__________ O Unknown

VITALS (Admission)

Height	______________ O In O cm ☐ ND	**Weight (Admission)**	____________ O lbs O kgs ☐ ND

Temperature:	**Heart Rate:**	**Blood Pressure:**	**Respiratory Rate:**	**SAO2:**
___________ ☐ C ☐ F	_________ bpm	______/______	___________bpm	_________ % O Room air O Supplemental O2 O Unknown
☐ Temp ND	☐ HR ND	☐ BP ND	☐ RR ND	☐ SAO2 ND

ADMISSION LABS

Admission Labs Tab

Labs (Closest to Admission):	**Hemoglobin:**	________	O g/dL O g/L	O Unavailable
	WBC	________	O K/uL O mcL	O Unavailable
	Platelet:	________	O K/uL	O Unavailable
	Absolute lymphocyte count:	________	O $X10^9$	O Unavailable
	Serum Creatinine (SCr)	________	O mg/dL O µmol/L	O Unavailable

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	AST	________	O u/L	O Unavailable
	ALT	________	O u/L	O Unavailable
	Total Bilirubin	________	O mg/dL	O Unavailable
	Bicarbonate	________	O mEq/1 O mmol/L	O Unavailable
	Troponin	_________	O ng/mL O ug/L	O Unavailable
	NT-proBNP	_________	O pg/mL O ng/L	O Unavailable
	BNP	_________	O pg/mL O pmol/L O ng/L	O Unavailable
	Ferritin	_________	O ng/mL	O Unavailable
	CRP	_________	O mg/L O ng/L	O Unavailable
	IL6	_________	O pg/mL O ng/mL	O Unavailable
	D-dimer	_________	O ng/mL O µ/mL	O Unavailable
	Procalcitonin	_________	O µg/L O ng/mL	O Unavailable
	Hemoglobin A1C	_________	O %	O Unavailable

SERIAL LABS

Serial Labs Tab

Enter the date and the first reported lab value for the corresponding labs in the medical record, if available. Click "Add Instance" to enter lab values for subsequent days of the hospitalization. Serial Labs should be collected for each day of hospitalization.

Select if serial labs were NOT performed on this patient:		☐	
Serial Labs (Repeat labs):	**Date:**	______/______/________	
	Troponin	_________	O ng/mL O ug/L
	NT-proBNP	_________	O pg/mL O ng/L
	BNP	_________	O pg/mL O pmol/L O ng/L
	Ferritin	_________	O ng/mL
	CRP	_________	O mg/L O ng/L
	Absolute Lymphocyte count	_________	O X10^9
	Procalcitonin	_________	O µg/L O ng/mL
	IL6	_________	O pg/mL O ng/mL
	Serum Creatinine (SCr)	_________	O mg/dL O µmol/L
	D-dimer	_________	O ng/mL O µ/mL

MEDICATIONS

Medications Tab

During this hospitalization, was the patient treated with any of the following medications? (Enter Date of first administration)

Glucocorticoids	O Yes O No O NC
Date: Glucocorticoids	____/_____/______ ☐ Unknown
Anticoagulation for DVT prophylaxis/treatment	O Yes O No O NC
Anticoagulant type (DVT)	O Full Dose DOAC O Full Dose Enoxaparin O Low Dose DOAC O Low Dose Enoxaparin O SCD O Sub-Q Unfractionated Heparin O Not Documented

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Date: Anticoagulation	____/_____/______	☐ Unknown
Immunoglobulins	○ Yes ○ No	○ NC
Date: Immunoglobulins	____/_____/______	☐ Unknown
Convalescent serum	○ Yes ○ No	○ NC
Date: Convalescent serum	____/_____/______	☐ Unknown
Ritonavir/lopinavir	○ Yes ○ No	○ NC
Date: Ritonavir/lopinavir	____/_____/______	☐ Unknown
Hydroxychloroquine	○ Yes ○ No	○ NC
Date: Hydroxychloroquine	____/_____/______	☐ Unknown
Azithromycin	○ Yes ○ No	○ NC
Date: Azithromycin	____/_____/______	☐ Unknown
Remdesivir	○ Yes ○ No	○ NC
Date: Remdesivir	____/_____/______	☐ Unknown
Tocilizumab	○ Yes ○ No	○ NC
Date: Tocilizumab	____/_____/______	☐ Unknown
Other 1 (not listed):	______________________________	
Date: Other 1	____/_____/______	☐ Unknown
Other 2 (not listed):	______________________________	
Date: Other 2	____/_____/______	☐ Unknown
Other 3 (not listed):	______________________________	
Date: Other 3	____/_____/______	☐ Unknown

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