

Admission

Arrival and Admission Information

Internal Tracking ID:

Physician/Provider NPI:

Arrival Date and Time: MM/DD/YYYY HH: MM or MM/DD/YYYY format

Admission Date: MM/DD/YYYY format

Point of Origin for Admission or Visit:
1 Non-Health Care Facility Point of Origin
2 Clinic
4 Transfer from a Hospital (Different Facility)
5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6 Transfer from another Health Care Facility
7 Emergency Room
9 Information not available
F Transfer from Hospice and is under a Hospice Plan of Care or enrolled in a Hospice Program

Medical History

- | | | |
|--|--|---|
| Medical History
(Select all that apply): | <input type="checkbox"/> No medical history reported | <input type="checkbox"/> Heart Failure |
| | <input type="checkbox"/> Alcohol use/dependence > 20 units/week | <input type="checkbox"/> Hypertension History
<input type="checkbox"/> Uncontrolled > 160 mmHg systolic |
| | <input type="checkbox"/> Anemia | <input type="checkbox"/> ICD only |
| | <input type="checkbox"/> Bioprosthetic valve | <input type="checkbox"/> Illicit Drug Use |
| | <input type="checkbox"/> Bleeding Diathesis | <input type="checkbox"/> Left Ventricular Hypertrophy |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease (Cirrhosis, Bilirubin > 2x Normal, AST/ALT/AP > 3x Normal) |
| | <input type="checkbox"/> Cardiac Transplantation | <input type="checkbox"/> Mechanical Prosthetic Heart Valve |
| | <input type="checkbox"/> Cardiomyopathy
<input type="checkbox"/> Ischemic
<input type="checkbox"/> Non-ischemic | <input type="checkbox"/> Mitral Stenosis |
| | <input type="checkbox"/> Carotid Disease (clinically diagnosed) | <input type="checkbox"/> Obstructive Sleep Apnea
<input type="checkbox"/> CPAP |
| | <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Pacemaker |
| | <input type="checkbox"/> COPD | <input type="checkbox"/> Peripheral Vascular Disease |
| | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Prior Hemorrhage
<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Other |
| | <input type="checkbox"/> CRT-D (cardiac resynchronization therapy w/ICD) | <input type="checkbox"/> Prior MI |
| | <input type="checkbox"/> CVA/TIA
<input type="checkbox"/> Ischemic Stroke
<input type="checkbox"/> ICH
<input type="checkbox"/> TIA | <input type="checkbox"/> Prior PCI
<input type="checkbox"/> Bare metal stent
<input type="checkbox"/> Drug eluting stent |
| | <input type="checkbox"/> Depression | <input type="checkbox"/> Renal Disease
<input type="checkbox"/> Dialysis |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Heart Disease |
| | <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 infectious respiratory pathogen | <input type="checkbox"/> Sinus Node Dysfunction / Sick Sinus Syndrome |
| | <input type="checkbox"/> Familial Hypercholesterolemia | <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Hypothyroidism |
| | <input type="checkbox"/> Family History of AF | |

History of cigarette smoking in the past 12 months Yes No

History of vaping or e-cigarette use in the past 12 months Yes No

Other Risk Factor Labile INR (Unstable/high INRs or time in therapeutic range <60%)?
 Yes No
 Unable to determine from the information available in the medical record

Prior AF Procedures	<input type="checkbox"/> None	<input type="checkbox"/> LAA Occlusion Device
	<input type="checkbox"/> Cardioversion	<input type="radio"/> Lariat
	<input type="checkbox"/> Ablation	<input type="radio"/> Surgical closure (clip or oversew)
	Month/Year of prior ablation ____/____/____	<input type="radio"/> Watchman
	<input type="checkbox"/> AF Surgery (Surgical MAZE)	<input type="radio"/> Other

Diagnosis		
Atrial Arrhythmia Type:	<input type="checkbox"/> Atrial Fibrillation If Atrial Fibrillation:	<input type="checkbox"/> Atrial Flutter If Atrial Flutter:
	<input type="radio"/> First Detected Atrial Fibrillation <input type="radio"/> Paroxysmal Atrial Fibrillation <input type="radio"/> Persistent Atrial Fibrillation <input type="radio"/> Permanent/long standing Persistent Atrial Fibrillation <input type="radio"/> Unable to Determine	<input type="radio"/> Typical Atrial Flutter <input type="radio"/> Atypical Atrial Flutter <input type="radio"/> Unable to Determine
Was Atrial Fibrillation/Flutter the patient's primary diagnosis? <input type="radio"/> Yes <input type="radio"/> No		
If no, what was the patient's primary diagnosis?	<input type="radio"/> Acute MI <input type="radio"/> COPD <input type="radio"/> CVA/TIA	<input type="radio"/> Heart Failure <input type="radio"/> Surgery <input type="radio"/> Other
Were any of the following first detected on this admission?	<input type="checkbox"/> None <input type="checkbox"/> Acute MI <input type="checkbox"/> Atherosclerotic Vascular Disease <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Stenosis <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> ICH <input type="checkbox"/> TIA
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
Medications Used Prior to Admission <i>Select all that apply</i>	<input type="checkbox"/> Patient on no meds prior to admission <input type="checkbox"/> ACE inhibitor <input type="checkbox"/> Aldosterone Antagonist <input type="checkbox"/> Alpha Blockers <input type="checkbox"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> amiodarone (Cordarone) <input type="checkbox"/> disopyramide (Norpace, Norpace CR) <input type="checkbox"/> dofetilide (Tikosyn) <input type="checkbox"/> dronedarone (Multaq) <input type="checkbox"/> flecainide (Tambocor) <input type="checkbox"/> propafenone (Rythmol, Rythmol SR) <input type="checkbox"/> quinidine <input type="checkbox"/> sotalol (Betapace, Betapace AF) <input type="checkbox"/> Other <input type="checkbox"/> Anticoagulation Therapy <input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> fondaparinux (Atrixa) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> warfarin (Coumadin)) <input type="checkbox"/> Other Anticoagulant	<input type="checkbox"/> Antiplatelet agent <input type="checkbox"/> aspirin <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> dipyridamole/aspirin (Aggrenox) <input type="checkbox"/> effient (Prasugrel) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid) <input type="checkbox"/> Other <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> dihydropyridine (nifedipine) (nicardipine) <input type="checkbox"/> non-dihydropyridine (verapamil) (diltiazem) <input type="checkbox"/> Digoxin <input type="checkbox"/> Diuretic <input type="checkbox"/> Hydralazine Nitrate <input type="checkbox"/> NSAIDS/COX-2 Inhibitor <input type="checkbox"/> Statin

Exam/ Labs at Admission			
Presenting symptoms related to AF <i>Select all that apply</i>	<input type="checkbox"/> No reported symptoms <input type="checkbox"/> Chest pain/tightness/discomfort <input type="checkbox"/> Dyspnea at exertion <input type="checkbox"/> Dyspnea at rest <input type="checkbox"/> Exercise intolerance	<input type="checkbox"/> Fatigue <input type="checkbox"/> Lightheadedness/dizziness <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope <input type="checkbox"/> Weakness	
Initial Vital Signs	Height _____ <input type="checkbox"/> inches <input type="checkbox"/> cm Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Heart Rate _____ bpm BP-Supine _____ / _____ mmHG	<input type="checkbox"/> Not documented <input type="checkbox"/> Not documented <input type="checkbox"/> Not documented <input type="checkbox"/> Not documented	
Initial Presenting Rhythm(s) <i>Select all that apply</i>	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atrial Tachycardia	<input type="checkbox"/> Sinus Rhythm <input type="checkbox"/> Paced (6) <input type="checkbox"/> Other	
If paced, underlying Atrial Rhythm	<input type="radio"/> Sinus Rhythm <input type="radio"/> Atrial fib/flutter <input type="radio"/> Sinus arrest <input type="radio"/> Unknown		
If paced, pacing type:	<input type="radio"/> Atrial Pacing <input type="radio"/> Ventricular Pacing <input type="radio"/> Atrioventricular		
Automated ECG Interpretation :	<input type="radio"/> Yes <input type="radio"/> No		
Initial ECG Findings:	Resting Heart Rate (bpm) _____ <input type="checkbox"/> Not Available QRS duration (ms) _____ <input type="checkbox"/> Not Available QTc (ms) _____ <input type="checkbox"/> Not Available PR interval (ms) _____ <input type="checkbox"/> Not Available		
Labs: (closest to arrival)	Platelet Count _____ μ L <input type="checkbox"/> Not Available SCr _____ <input type="radio"/> mg/dL <input type="radio"/> μ mol/L <input type="checkbox"/> Not Available PT/INR _____ <input type="checkbox"/> Not Available Hematocrit _____ % <input type="checkbox"/> Not Available Hemoglobin _____ g/dl <input type="checkbox"/> Not Available TSH _____ μ IU/ML <input type="checkbox"/> Not Available K _____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL <input type="checkbox"/> Not Available Mg _____ mg/dL <input type="checkbox"/> Not Available BUN _____ <input type="radio"/> mg/dL <input type="radio"/> μ mol/L <input type="checkbox"/> Not Available NT-BNP _____ (pg/mL) <input type="checkbox"/> Not Available BNP _____ <input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L <input type="checkbox"/> Not Available		

In Hospital

Cardiac Procedures this hospitalization (select all that apply)	<input type="checkbox"/> No Procedures <input type="checkbox"/> A-Fib Ablation <input type="checkbox"/> A-Flutter Ablation <input type="checkbox"/> Bioprosthetic valve <input type="checkbox"/> Cardioversion <input type="checkbox"/> Chemical <input type="checkbox"/> Electrical <input type="checkbox"/> TEE Guided <input type="checkbox"/> CRT-D (cardiac resynchronization therapy/ICD) <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only)	<input type="checkbox"/> ICD only <input type="checkbox"/> LAA Occlusion Device <input type="checkbox"/> Lariat <input type="checkbox"/> Watchman <input type="checkbox"/> Surgical closure (clip or oversew) <input type="checkbox"/> Other <input type="checkbox"/> Mechanical Prosthetic Heart Valve <input type="checkbox"/> Pacemaker <input type="checkbox"/> PCI/Cardiac Catheterization <input type="checkbox"/> Bare metal stent <input type="checkbox"/> Drug eluting stent
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Cardiac Function and Structural Assessment

Echocardiogram Date for left atrial assessment	____/____/____ MM/DD/YYYY
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EF – Quantitative _____ % <input type="checkbox"/> Not available	Obtained: <input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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EF – Qualitative <input type="checkbox"/> Not applicable <input type="checkbox"/> Normal or mild dysfunction <input type="checkbox"/> Qualitative moderate/severe dysfunction <input type="checkbox"/> Performed/results not available <input type="checkbox"/> Planned after discharge <input type="checkbox"/> Not performed (6)	Obtained: <input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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Left atrial diameter _____ (cm)	<input type="radio"/> ND
Left atrial volume _____ (cm)	<input type="radio"/> ND
Left atrial volume index (mL/m ²) _____	<input type="radio"/> ND

If Left atrial diameter ND, how was the atrial enlargement described?	<input type="radio"/> Normal <input type="radio"/> Mild enlargement <input type="radio"/> Moderate enlargement <input type="radio"/> Severe enlargement <input type="radio"/> Unknown
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Oral Medications during hospitalization (Select all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> amiodarone (Cordarone) <input type="checkbox"/> disopyramide <input type="checkbox"/> dofetilide (Tikosyn) <input type="checkbox"/> dronedarone (Multaq) <input type="checkbox"/> flecainide (Tambocor) <input type="checkbox"/> propafenone (Rythmol, Rythmol SR) <input type="checkbox"/> quinidine <input type="checkbox"/> sotalol (Betapace, Betapace AF) <input type="checkbox"/> Other <input type="checkbox"/> Anticoagulant <input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> warfarin (Coumadin)	<input type="checkbox"/> Antiplatelet agent <input type="checkbox"/> aspirin <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> dipyridamole/aspirin (Aggrenox) <input type="checkbox"/> effient (Prasugrel) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid) <input type="checkbox"/> Other <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Digoxin
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Parenteral In-Hospital Anticoagulation	<input type="radio"/> Unfractionated Heparin IV <input type="radio"/> full dose LMW Heparin <input type="radio"/> Other IV Anticoagulant	<input type="radio"/> None
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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 that apply)	<input type="checkbox"/> None of the areas of unmet social need listed <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
CHA2DS2-VASc reported? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA		
CHA2DS2-VASc Total reported score:		
Medical reason(s) documented by a physician, nurse practitioner, or physician assistant for not assessing risk factors:		<input type="radio"/> Yes <input type="radio"/> No

Ablation	
Pre-Ablation Diagnosis and Evaluation	
Indication for ablation:	<ul style="list-style-type: none"> <input type="radio"/> First-line therapy for longstanding persistent AF <input type="radio"/> First-line therapy in paroxysmal AF before antiarrhythmic therapy <input type="radio"/> First-line therapy in persistent AF before antiarrhythmic therapy <input type="radio"/> Long-standing persistent AF that has failed ≥ 1 antiarrhythmic drug <input type="radio"/> Paroxysmal AF that is refractory or intolerant to ≥ 1 antiarrhythmic drugs <ul style="list-style-type: none"> <input type="radio"/> Persistent AF that is refractory or intolerant to ≥ 1 antiarrhythmic drug <input type="radio"/> Other (left atrial flutter, left atrial tachycardia, etc.)
Modified EHRA Symptoms Score:	<ul style="list-style-type: none"> <input type="radio"/> I – No symptoms <input type="radio"/> IIA – Mild symptoms (Normal daily activity not affected and symptoms not considered troublesome by patient) <input type="radio"/> IIB – Moderate symptoms (Normal daily activity not affected but patient troubled by symptoms) <input type="radio"/> III - Severe symptoms (Normal daily activity affected) <input type="radio"/> IV – Disabling symptoms (Normal daily activity discontinued) <input type="radio"/> ND
Baseline Rhythm	<input type="radio"/> Atrial fibrillation <input type="radio"/> Atrial flutter, typical right <input type="radio"/> Atrial flutter, atypical <input type="radio"/> Sinus rhythm <input type="radio"/> Other (specify) _ <input type="radio"/> Unknown/ND
Did the patient have prior ablations for atrial fibrillation <input type="radio"/> 0 (no prior AF ablation) <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> ≥ 3 (do not count ablations for other arrhythmias):	
What was the peri-procedural anticoagulation strategy?	<ul style="list-style-type: none"> <input type="radio"/> Bridging anticoagulation strategy <ul style="list-style-type: none"> <input type="radio"/> bivalirudin <input type="radio"/> LMWH <input type="radio"/> Unfractionated heparin <input type="radio"/> Other <input type="radio"/> Interrupted anticoagulation strategy <ul style="list-style-type: none"> <input type="radio"/> apixaban <ul style="list-style-type: none"><input type="radio"/> More than one dose held <input type="radio"/> dabigatran <ul style="list-style-type: none"><input type="radio"/> More than one dose held <input type="radio"/> edoxaban <ul style="list-style-type: none"><input type="radio"/> More than one dose held <input type="radio"/> rivaroxaban <ul style="list-style-type: none"><input type="radio"/> More than one dose held <input type="radio"/> warfarin <ul style="list-style-type: none"><input type="radio"/> More than one dose held <ul style="list-style-type: none"> <input type="radio"/> Uninterrupted anticoagulation strategy <ul style="list-style-type: none"> <input type="radio"/> apixaban <input type="radio"/> dabigatran <input type="radio"/> edoxaban <input type="radio"/> rivaroxaban <input type="radio"/> warfarin pre-procedure INR _____ <input type="radio"/> None
What was the primary intraprocedural parenteral anticoagulant used?	<ul style="list-style-type: none"> <input type="radio"/> Bivalirudin <input type="radio"/> Heparin <input type="radio"/> Other _____ <input type="radio"/> None, Reason for not prescribing (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Major bleeding event <input type="checkbox"/> Minor bleeding event <input type="checkbox"/> Risk of bleeding

Anesthesia used during the procedure:	<input type="radio"/> General anesthesia with endotracheal tube intubation <input type="radio"/> General anesthesia with JET or high frequency ventilation <input type="radio"/> General anesthesia with laryngeal mask airway <input type="radio"/> IV conscious sedation without intubation or mechanical airway <input type="radio"/> Other <input type="radio"/> Unable to determine
Type of Ablation Procedure	<input type="radio"/> Percutaneous catheter ablation <input type="radio"/> Surgical ablation <input type="radio"/> Hybrid approach (surgical and percutaneous) <input type="radio"/> Other _____
Epicardial access was attempted: <input type="checkbox"/>	
Imaging/mapping used: (check all that apply):	<input type="checkbox"/> 3D electroanatomic mapping <input type="checkbox"/> Intracardiac echocardiography (ICE) <input type="checkbox"/> Intraoperative TEE <input type="checkbox"/> Preprocedure CT <input type="checkbox"/> Preprocedure MRI <input type="checkbox"/> Preprocedure TEE <input type="checkbox"/> Rotational angiography
Trans-septal approach used for the ablation procedure:	<input type="radio"/> Brockenbrough/mechanical needle <input type="radio"/> Radiofrequency needle <input type="radio"/> SafeSept (wire needle) <input type="radio"/> Other, such as entry through patent foramen ovale <input type="radio"/> Trans-septal method not utilized
Was an Atrial Septal Closure Device Present <input type="radio"/> Yes <input type="radio"/> No	
Procedure Date and Time:	Date (MM/DD/YYYY): ____/____/____
	Total Procedure Time __:__(MM:SS)
	Total Ablation time: __:__(MM:SS)
	Total Fluoroscopy time: __:__(MM:SS)
	Total Fluoroscopy Dose: _____ o mGy/cm ² o mGy
Procedure Operator NPI	
Energy and catheter type used (check all that apply):	<input type="checkbox"/> A-Fib Ablation <input type="checkbox"/> Cryoablation balloon <input type="checkbox"/> Electroporation <input type="checkbox"/> Irrigated RFA with contact force sensing <input type="checkbox"/> Irrigated RFA without contact force sensing <input type="checkbox"/> Laser balloon <input type="checkbox"/> Radiofrequency balloon <input type="checkbox"/> Other _____ <input type="checkbox"/> A-Flutter Ablation <input type="checkbox"/> Cryoablation balloon <input type="checkbox"/> Electroporation <input type="checkbox"/> Irrigated RFA with contact force sensing <input type="checkbox"/> Irrigated RFA without contact force sensing <input type="checkbox"/> Laser balloon <input type="checkbox"/> Radiofrequency balloon <input type="checkbox"/> Other _____

Ablation Approach
(Check all that apply)

- Left superior PV isolation attempted
Technique: Circumferential Segmental
Outcome: Entrance Block Exit Block First Pass Isolation
- Left inferior PV isolation attempted
Technique: Circumferential Segmental
Outcome: Entrance Block Exit Block First Pass Isolation
- Right superior PV isolation was attempted
Technique: Circumferential Segmental
Outcome: Entrance Block Exit Block First Pass Isolation
- Right inferior PV isolation was attempted
Technique: Circumferential Segmental
Outcome: Entrance Block Exit Block First Pass Isolation
- Right Middle PV isolation was attempted
Technique: Circumferential Segmental
Outcome: Entrance Block Exit Block First Pass Isolation

Lines and Additional Strategies
(Check all that apply):

- Anterior Lateral Mitral Isthmus Line (Left Superior to Mitral Annulus)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- Complex Fractionated Atrial Electrogram (CFAE Ablation)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- CTI
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- Inferolateral Mitral Isthmus Line (left Inferior to Mitral Annulus)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- LA Appendage Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- LA Floor (low posterior line)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- LA Roofline
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- Posterior Wall Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- Superior Septal Mitral Isthmus Line (Right Superior to Mitral Annulus)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- SVC Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
- Targeted Ganglia Ablation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved

Non-Pulmonary Vein Triggers
(Check all that apply):

- Accessory Pathway
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- AVNRT
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Coronary Sinus
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Crista Terminalis
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Eustachian Ridge
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- LA appendage
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Left side of intra atrial septum
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Ligament of Marshall
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Mitral Valve Annulus
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Posterior Wall
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Right Atrial Appendage
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Right side of intra atrial septum
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Superior Vena Cava
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Tricuspid Valve annulus
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
- Other (specify) _____
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested

Phrenic Nerve Strategy	<input type="radio"/> Phrenic Nerve Pacing Not Done <input type="radio"/> Course of Phrenic Nerve Delineated with Pacing <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 50	
Phrenic Nerve Outcome:	<input type="radio"/> No Capture <input type="radio"/> Capture <input type="radio"/> Phrenic Nerve Sites of Capture Avoided <input type="radio"/> Lesions placed at sites of capture during phrenic pacing	
Radiofrequency delivery strategy	<input type="radio"/> Point by Point <input type="radio"/> Drag Technique <input type="radio"/> Other	
Energy	High Power Anterior (watts) _____ High power duration (seconds) _____ Low Power Posterior (watts) _____ Low power duration (seconds) _____	
Lesion Index Used	Anterior Target _____ Posterior Target _____ <input type="checkbox"/> N/A	
Esophageal Protection Strategies (select all that apply)	<input type="checkbox"/> Esophageal Cooling <input type="checkbox"/> Esophageal Deviation Performed <input type="checkbox"/> Esophageal Temp Probe <input type="radio"/> One sensor <input type="radio"/> Multi-sensor <input type="checkbox"/> No Strategy Utilized	
Scar Assessment:	<input type="radio"/> Not assessed <input type="radio"/> Assessed <input type="radio"/> Voltage cutoff <input type="radio"/> 0.2 <input type="radio"/> 0.5 <input type="radio"/> Not noted <input type="radio"/> Scar not present <input type="radio"/> Scar present (select all locations that apply) Location: <input type="checkbox"/> LA posterior wall <input type="checkbox"/> LA Roofline <input type="checkbox"/> LA Septum <input type="checkbox"/> RA Free Wall <input type="checkbox"/> RA Septum <input type="checkbox"/> Other	
Provocation testing (Check all that apply):	<input type="checkbox"/> Adenosine <input type="radio"/> Heart Block not achieved <input type="radio"/> Heart Block achieved <input type="radio"/> Left pulmonary vein reconnection <input type="radio"/> Right pulmonary vein reconnection <input type="radio"/> Triggers noted (NPV) <input type="radio"/> No reconnection or triggers noted <input type="checkbox"/> Burst pacing <input type="radio"/> AF induced <input type="radio"/> AF not induced <input type="checkbox"/> Isoproterenol <input type="radio"/> A-Fib NPVT noted <input type="radio"/> APDs observed <input type="radio"/> A-Tach or A-Flutter induced <input type="radio"/> Left pulmonary vein reconnection <input type="radio"/> Right pulmonary vein reconnection Maximum Dose: _____	<input type="checkbox"/> Response to cardioversion of induced A-Fib <input type="radio"/> No ERAF <input type="radio"/> On Isuprel <input type="radio"/> Off Isuprel <input type="radio"/> ERAF <input type="radio"/> On Isuprel <input type="radio"/> Off Isuprel <input type="radio"/> Other <input type="checkbox"/> Provocation Testing Not Done
	Did cardioversion occur? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Electrical <input type="radio"/> Pharmacological <input type="radio"/> During ablation lesion delivery	

Post ablation rhythm: Atrial fibrillation Atrial flutter, typical right
 Atrial flutter, atypical Sinus rhythm
 Other (specify) _____
 Unknown/ND

Complications noted during and post-procedure: Yes No

If yes, Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Air embolus | <input type="checkbox"/> Hemorrhage requiring transfusion |
| <input type="checkbox"/> Atrioesophageal fistula | <input type="checkbox"/> Phrenic nerve injury |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Pseudo aneurysm |
| <input type="checkbox"/> AV fistula | <input type="checkbox"/> Requiring surgical repair |
| <input type="checkbox"/> Requiring surgical repair | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Complication from anesthesia | <input type="checkbox"/> PV stenosis |
| <input type="checkbox"/> Death | <input type="checkbox"/> Retroperitoneal bleed |
| <input type="checkbox"/> Deep venous thrombosis | <input type="checkbox"/> Stiff LA Syndrome |
| <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Hemopericardium (check all that apply): | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Tamponade | <input type="checkbox"/> Volume overload/pulmonary edema) |
| <input type="checkbox"/> Pericardiocentesis | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Requiring surgical drainage and/or repair | |

Discharge	
Discharge Information	
Discharge Date/Time ___/___/___ ___:___ MM/DD/YYYY or MM/DD/YYYY HH:MM	
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	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Long Term Care Hospital (LTCH) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Other
When is the earliest physician/APN/PA documentation of comfort measures only?	<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented/UTD
Patient is currently enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AFib, STK, VTE)? <input type="radio"/> Yes <input type="radio"/> No	
Vital Signs (closest to discharge)	BP-Supine _____ / _____ mmHg (systolic/diastolic) <input type="checkbox"/> Not documented Heart Rate _____ bpm <input type="checkbox"/> Not documented
Reason documented by a physician, nurse practitioner, or physician assistant for discharging patient with heart rate >110 bpm? <input type="radio"/> Yes <input type="radio"/> No	
Discharge Rhythm(s) (closest to discharge)	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atrial Tachycardia <input type="checkbox"/> Sinus Rhythm <input type="checkbox"/> Paced <input type="checkbox"/> Other
ECG findings (closest to discharge):	Resting Heart Rate (bpm) _____ <input type="checkbox"/> Not Available QRS duration (ms) _____ <input type="checkbox"/> Not Available QTc (ms) _____ <input type="checkbox"/> Not Available PR interval (ms) _____ <input type="checkbox"/> Not Available
Discharge ECG QRS Morphology	<input type="radio"/> Normal <input type="radio"/> RBBB <input type="radio"/> LBBB <input type="radio"/> NS-IVCD <input type="radio"/> Not Available
Labs (closest to discharge)	Platelet Count _____ μ L <input type="checkbox"/> Not Available
	SCr _____ mg/dL O $\mu\text{mol/L}$ <input type="checkbox"/> Not Available
	Estimated Creatinine Clearance _____ mL/min <input type="checkbox"/> Not Available
	INR _____ <input type="checkbox"/> Not Available
Discharge Medications	
ACEI Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication: _____	
If Yes Dosage: _____	
Frequency: _____	
ARB Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication: _____	
If Yes Dosage: _____	
Frequency: _____	

Aldosterone Antagonist Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication:	
If Yes Dosage:	
Frequency:	
Antiarrhythmic Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication :	
Dosage:	
If Yes Frequency:	
Medication :	
Dosage:	
Frequency:	
ARNI Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication:	
If Yes Dosage:	
Frequency:	
Contraindications or Other Documented Reason(s) For Not Providing ARNI:	<input type="checkbox"/> ACE inhibitor use within the prior 36 hours <input type="checkbox"/> Allergy <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hypotension <input type="checkbox"/> Other medical reasons <input type="checkbox"/> Patient Reason <input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women <input type="checkbox"/> System Reason
Reasons for not switching to ARNI at discharge <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ARNI was prescribed at discharge	
Reason ARNI not prescribed:	<input type="checkbox"/> New onset heart failure <input type="checkbox"/> NYHA Class I <input type="checkbox"/> NYHA Class IV <input type="checkbox"/> Not previously tolerating ACEI or ARB
Anticoagulation Therapy Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Class:	
If Yes Medication:	
Dosage:	
Frequency:	
Are there any relative or absolute contraindications to oral anticoagulant therapy? (Check all that apply)	<input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Comorbid illness (e.g. renal/liver) <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Frequent falls/frailty <input type="checkbox"/> High bleeding risk <input type="checkbox"/> Need for dual antiplatelet therapy
	<input type="checkbox"/> Occupational risk <input type="checkbox"/> Patient refusal/preference <input type="checkbox"/> Physician preference <input type="checkbox"/> Prior intracranial hemorrhage <input type="checkbox"/> Recent operation <input type="checkbox"/> Transient or reversible causes of atrial fibrillation <input type="checkbox"/> Unable to adhere/monitor
Antiplatelet(s) Prescribed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
Medication :	
Dosage:	
If Yes Frequency:	
Medication :	
Dosage:	
Frequency:	

Are there any relative or absolute contraindications to oral antiplatelet therapy? (Check all that apply)	<input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Comorbid illness (e.g. renal/liver) <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Frequent falls/frailty <input type="checkbox"/> High bleeding risk	<input type="checkbox"/> Occupational risk <input type="checkbox"/> Patient refusal/preference <input type="checkbox"/> Physician preference <input type="checkbox"/> Prior intracranial hemorrhage <input type="checkbox"/> Recent operation <input type="checkbox"/> Transient or reversible causes of atrial fibrillation <input type="checkbox"/> Unable to adhere/monitor	
Beta Blocker Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
If Yes	Medication: Dosage: Frequency:		
Ca Channel Blocker Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
If Yes	Medication: Dosage: Frequency:		
Digoxin Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
If Yes	Dosage: Frequency:		
Statin Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
Hydralazine Nitrate Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC		
Other Medications at Discharge	<input type="checkbox"/> Diuretic <input type="checkbox"/> NSAIDS/COX-2 Inhibitor <input type="checkbox"/> PCSK-9 Inhibitor		
Discharge Instructions			
Smoking Cessation Counseling Given	<input type="radio"/> Yes <input type="radio"/> No		
Rhythm Control/Rate Control Strategy Planned/Intended	<input type="radio"/> Rhythm Control Strategy Planned <input type="radio"/> Rate Control Strategy Planned <input type="radio"/> No Documentation of Strategy		
Patient and/or caregiver received education and/or resource materials regarding all the following:	Risk factors <input type="radio"/> Yes <input type="radio"/> No Stroke Risk <input type="radio"/> Yes <input type="radio"/> No Management <input type="radio"/> Yes <input type="radio"/> No Medication Adherence <input type="radio"/> Yes <input type="radio"/> No Follow-up <input type="radio"/> Yes <input type="radio"/> No When to call provider <input type="radio"/> Yes <input type="radio"/> No		
Anticoagulation Therapy Education Given:	<input type="radio"/> Yes <input type="radio"/> No		
PT/INR Planned Follow-up	<input type="radio"/> Yes <input type="radio"/> No		
Who will be following patients PT/INR?	<input type="radio"/> Home INR Monitoring <input type="radio"/> Anticoagulation Warfarin Clinic <input type="radio"/> Managed by Physician associated with hospital <input type="radio"/> Managed by outside physician <input type="radio"/> Not documented		
Date of PT/INR test planned post discharge:	____ / ____ / ____ <input type="checkbox"/> Not documented		
System Reason for no PT/INR Planned Follow-up?	<input type="radio"/> Yes <input type="radio"/> No		
Risk Interventions			
TLC (Therapeutic Lifestyle Change) Diet	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		
Obesity Weight Management	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		
Activity Level/Recommendation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		
Screening for obstructive sleep apnea	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		
Referral for evaluation of obstructive sleep apnea if positive screen	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		
Discharge medication instruction provided	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable		

Clinical Codes and Risk Scores
ICD-10-CM Principal Diagnosis Code
ICD-10-CM Other Diagnoses Codes
ICD-10-PCS Principal Procedure Code
ICD-10-PCS Other Procedure Codes
CPT Code
CPT Code Date