

PMT FORM SELECTION: Atrial Fibrillation **Legend: Elements in bold are required**

Patient ID: _____

DEMOGRAPHIC DATA

Date of Birth: ___/___/___ **Gender:** Male Female Unknown

Patient Postal Code: _____ - _____

Payment Source:

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare-Private/HMO/PPO/Other	<input type="checkbox"/> Medicaid-Private/HMO/PPO/Other
<input type="checkbox"/> Private/HMO/PPO/Other	<input type="checkbox"/> VA/CHAMPVA/Tricare
<input type="checkbox"/> Self-Pay/No Insurance	<input type="checkbox"/> Other/Not Documented/UTD

RACE AND ETHNICITY

Race:	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White
	<input type="checkbox"/> Asia	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> UTD
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian or Chamorro	
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan	
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	
	<input type="checkbox"/> Korean		
	<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Other Asian			

Hispanic Ethnicity: Yes No/UTD
 If yes,
 Mexican, Mexican American, Chicano/a
 Puerto Rican
 Cuban
 Another Hispanic, Latino or Spanish Origin

ARRIVAL AND ADMISSION INFORMATION

Internal Tracking ID: _____ **Physician/Provider NPI:** _____

Arrival Date and Time: ___/___/___ ___:___ MM/DD/YYYY only
 Unknown/Date UTD

Admit Date: ___/___/___

Point of Origin for Admission or Visit:

<input type="checkbox"/> 1 Non-Health Care Facility Point of Origin	<input type="checkbox"/> 6 Transfer from another Health Care Facility
<input type="checkbox"/> 2 Clinic	<input type="checkbox"/> 7 Emergency room
<input type="checkbox"/> 4 Transfer From a Hospital (Different Facility)	<input type="checkbox"/> 9 Information not available
<input type="checkbox"/> 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	<input type="checkbox"/> F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program

Was patient admitted as inpatient? Yes No

If not admitted, reason: Discharged from Observation Status
 Discharged from the ED

MEDICAL HISTORY		
Medical History (select all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Alcohol use/dependence >20 units/week <input type="checkbox"/> Anemia <input type="checkbox"/> Bioprosthetic valve <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac transplantation <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Ischemic <input type="checkbox"/> Non-Ischemic <input type="checkbox"/> Carotid Disease (clinically diagnosed) <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> CRT-D (cardiac resynchronization therapy w/ICD) <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> ICH <input type="checkbox"/> TIA <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes	<input type="checkbox"/> Dialysis <input type="checkbox"/> Illicit Drug Use <input type="checkbox"/> Family History of AF <input type="checkbox"/> Heart failure <input type="checkbox"/> Hypertension History <input type="checkbox"/> Uncontrolled, >160 mmHg systolic <input type="checkbox"/> ICD only <input type="checkbox"/> LAA Occlusion Device <input type="checkbox"/> Lariat <input type="checkbox"/> Watchman <input type="checkbox"/> Other <input type="checkbox"/> Surgical closure (clip or oversew) <input type="checkbox"/> Left Ventricular Hypertrophy <input type="checkbox"/> Liver Disease (Cirrhosis, Bilirubin >2x Normal, AST/ALT/AP >3x Normal) <input type="checkbox"/> Mechanical Prosthetic Heart Valve <input type="checkbox"/> Mitral Stenosis <input type="checkbox"/> Obstructive Sleep <input type="checkbox"/> Apnea <input type="checkbox"/> CPAP
Other risk factors	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prior Hemorrhage <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Other <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Bare metal stent <input type="checkbox"/> Drug eluting stent <input type="checkbox"/> Renal Disease (Dialysis, transplant, Cr >2.6 mg/dL or >200 μmol/L) <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Sinus Node Dysfunction/Sick Sinus Syndrome <input type="checkbox"/> Smoker <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism	
Prior AF Procedures:	<input type="checkbox"/> None <input type="checkbox"/> Cardioversion <input type="checkbox"/> Ablation <input type="checkbox"/> AF Surgery (Surgical MAZE)	
DIAGNOSIS		
Atrial Arrhythmia Type:	<input type="checkbox"/> Atrial Fibrillation If Atrial Fibrillation: <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="checkbox"/> Atrial Flutter If Atrial Flutter: <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"/> CVA/TIA <input type="radio"/> Surgery	<input type="radio"/> COPD <input type="radio"/> Heart Failure <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"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Stenosis <input type="checkbox"/> Atherosclerotic Vascular Disease <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> ICH <input type="checkbox"/> TIA

MEDICATIONS AT ADMISSION

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 <ul style="list-style-type: none"> <input type="checkbox"/> Amiodarone <input type="checkbox"/> Disopyramide <input type="checkbox"/> Dofetilide <input type="checkbox"/> Dronedarone <input type="checkbox"/> Flecainide <input type="checkbox"/> Propafenone <input type="checkbox"/> Quinidine <input type="checkbox"/> Sotalol <input type="checkbox"/> Other 	<input type="checkbox"/> Aspirin <input type="checkbox"/> Antiplatelet agent (not aspirin) <ul style="list-style-type: none"> <input type="checkbox"/> Aggrenox (Dipyridamole) <input type="checkbox"/> Brilinta (Ticagrelor) <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Prasugrel (Effient) <input type="checkbox"/> Ticlid (Ticlopidine) <input type="checkbox"/> Other <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <ul style="list-style-type: none"> <input type="checkbox"/> Dihydropyridine <input type="checkbox"/> Non-dihydropyridine
	<input type="checkbox"/> Anticoagulation Therapy <ul style="list-style-type: none"> <input type="checkbox"/> Apixaban (Eliquis) <input type="checkbox"/> argatroban <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> desirudin (Iprivask) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> Fondaparinux (Atrixa) <input type="checkbox"/> lepirudin (Refludan) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> Warfarin (Coumadin) <input type="checkbox"/> Other Anticoagulant 	<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 rest <input type="checkbox"/> Palpitations <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dyspnea at exertion <input type="checkbox"/> Exercise intolerance <input type="checkbox"/> Lightheadedness/dizziness <input type="checkbox"/> Syncope		
Initial Vital Signs	Height _____ <input type="checkbox"/> inches <input type="checkbox"/> cm	<input type="checkbox"/> Not documented		
	Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	<input type="checkbox"/> Not documented		
	BMI _____ (automatically calculated)			
	Heart Rate _____ bpm	<input type="checkbox"/> Not documented		
	BP-Supine _____ / _____ mmHg (systolic/diastolic)	<input type="checkbox"/> Not documented		
Initial Presenting Rhythm(s) <i>Select all that apply</i>	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Sinus Rhythm	<input type="checkbox"/> Paced	
	<input type="checkbox"/> Atrial Flutter	<input type="checkbox"/> Atrial Tachycardia	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Initial EKG 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 admission)	Platelet Count	_____ mm ³	<input type="checkbox"/> Not Available
	SCr	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Not Available
	Estimated Creatinine Clearance	_____ mL/min (<i>auto-calculated</i>)	
	PT/INR	_____	<input type="checkbox"/> Not Available
	Hematocrit	_____ %	<input type="checkbox"/> Not Available
	Hemoglobin	_____ g/dl	<input type="checkbox"/> Not Available
	TSH	_____ mIU/L	<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"/> μmol/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 CARE			
Procedures this hospitalization	<input type="checkbox"/> No Procedures <input type="checkbox"/> A-Fib Ablation <input type="checkbox"/> A-Flutter Ablation <input type="radio"/> Cryoablation <input type="radio"/> Radio Frequency 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="radio"/> Lariat <input type="radio"/> Watchman <input type="radio"/> Surgical closure (clip or oversew) <input type="radio"/> 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 <input type="checkbox"/> Surgical MAZE	
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
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	Obtained:	<input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
Oral Medications during hospitalization <i>(Select all that apply)</i>	<input type="checkbox"/> None <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Amiodarone <input type="checkbox"/> Disopyramide <input type="checkbox"/> Dofetilide <input type="checkbox"/> Dronedarone <input type="checkbox"/> Flecainide <input type="checkbox"/> Propafenone <input type="checkbox"/> Quinidine <input type="checkbox"/> Sotalol <input type="checkbox"/> Other <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Warfarin <input type="checkbox"/> Dabigatran <input type="checkbox"/> Rivaroxaban <input type="checkbox"/> Apixaban <input type="checkbox"/> Edoxaban	<input type="checkbox"/> Antiplatelet agent (not aspirin) <input type="checkbox"/> Aggrenox (Dipyridamole) <input type="checkbox"/> Brilinta (Ticagrelor) <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Prasugrel (Effient) <input type="checkbox"/> Ticlid (Ticlopidine) <input type="checkbox"/> Other <input type="checkbox"/> Aspirin <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Digoxin	
Parenteral In-Hospital Anticoagulation	<input type="checkbox"/> Unfractionated Heparin IV <input type="checkbox"/> full dose LMW Heparin <input type="checkbox"/> Other IV Anticoagulant <input type="checkbox"/> None		
CHADS2-VASc reported?	<input type="radio"/> Yes <input type="radio"/> No	If yes, total reported score in medical record _____	
CHADS2-VASc Risk Factors Assessed	<input type="checkbox"/> All were assessed	Prior stroke or TIA assessed: <input type="radio"/> Yes <input type="radio"/> No Age ≥ 65 years assessed: <input type="radio"/> Yes <input type="radio"/> No Hypertension assessed: <input type="radio"/> Yes <input type="radio"/> No Diabetes mellitus assessed: <input type="radio"/> Yes <input type="radio"/> No	HF or impaired LV systolic function assessed: <input type="radio"/> Yes <input type="radio"/> No Vascular disease hx assessed: <input type="radio"/> Yes <input type="radio"/> No Female gender assessed: <input type="radio"/> Yes <input type="radio"/> No
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

CHADS2-VASc Score Calculator:	<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Hypertension (blood pressure consistently above 140/90 or treated with hypertension medication) <input type="checkbox"/> Age \geq 75 <input type="checkbox"/> Age 65-74 <input type="checkbox"/> Diabetes <input type="checkbox"/> Prior stroke/TIA/Thromboembolism <input type="checkbox"/> Vascular Disease History (CAD, Prior MI, or PAD) <input type="checkbox"/> Female Gender
<p><i>Adapted from a methodology used by the American College of Chest Physicians: Lip GY, Niewlatt R, Pisters R, Lane DA, Crijns HJ, et al. Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. CHEST 2010 Feb;137(2):263-72. doi: 10.1378/chest.09-1584. Epub 2009 Sep 17.</i></p> <p><u>http://journal.publications.chestnet.org/article.aspx?articleid=1045174</u></p>	

DISCHARGE INFORMATION	
Discharge Date/Time	___/___/___ ___:___ <input type="checkbox"/> 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	<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
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"/> Sinus Rhythm <input type="checkbox"/> Atrial Tachycardia <input type="checkbox"/> Paced <input type="checkbox"/> Other
EKG 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 EKG 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 _____ mm ³ <input type="checkbox"/> Not Available
	SCr _____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L <input type="checkbox"/> Not Available
	Estimated Creatinine Clearance _____ mL/min (auto-calculated)
	INR _____ <input type="checkbox"/> Not Available

DISCHARGE MEDICATIONS	
ACEI	Prescribed? <input type="radio"/> Yes <input type="radio"/> No If yes, Medication: _____ Dosage: _____ Frequency: _____ Contraindicated? <input type="radio"/> Yes <input type="radio"/> No
ARB	Prescribed? <input type="radio"/> Yes <input type="radio"/> No If yes, Medication: _____ Dosage: _____ Frequency: _____ Contraindicated? <input type="radio"/> Yes <input type="radio"/> No
Aldosterone Antagonist	Prescribed? <input type="radio"/> Yes <input type="radio"/> No If yes, Medication: _____ Dosage: _____ Frequency: _____ Contraindicated? <input type="radio"/> Yes <input type="radio"/> No

<p>Prescribed? If yes,</p> <p>Antiarrhythmic</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Medication: Dosage: Frequency:</p> <p>Medication: Dosage: Frequency:</p> <p>Were Dofetilide or Sotalol newly initiated or dose increased this hospitalization? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, was a QT interval documented after 5 doses and prior to discharge? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA</p>
<p>Prescribed? If yes,</p> <p>Contraindicated?</p> <p>Contraindications or Other Documented Reason(s) For Not Providing ARNI:</p> <p>Reasons for not switching to ARNI at discharge: If yes,</p> <p>ARNI</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Medication: Dosage: Frequency:</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="checkbox"/> ACE inhibitor use within the prior 36 hours</p> <p><input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> Hyperkalemia</p> <p><input type="checkbox"/> Hypotension</p> <p><input type="checkbox"/> Other medical reasons</p> <p><input type="checkbox"/> Patient Reason</p> <p><input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women</p> <p><input type="checkbox"/> System Reason</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ARNI was prescribed at discharge</p> <p>New onset heart failure</p> <p>NYHA Class I</p> <p>NYHA Class IV</p> <p>Not previously tolerating ACEI or ARB</p>
<p>Prescribed? If yes,</p> <p>Anticoagulation Therapy</p> <p>Contraindicated? Are there any relative or absolute contraindications to oral anticoagulant therapy? (Check all that apply)</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Class: Medication: Dosage: Frequency:</p> <p>Class: Medication: Dosage: Frequency:</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event</p> <p><input type="checkbox"/> Comorbid illness (e.g. renal/liver) <input type="checkbox"/> Current pregnancy</p> <p><input type="checkbox"/> Frequent falls/frailty <input type="checkbox"/> High bleeding risk</p> <p><input type="checkbox"/> Need for dual antiplatelet therapy <input type="checkbox"/> Occupational risk</p> <p><input type="checkbox"/> Patient refusal/preference <input type="checkbox"/> Physician preference</p> <p><input type="checkbox"/> Prior intracranial hemorrhage pregnancy <input type="checkbox"/> Recent operation</p> <p><input type="checkbox"/> Transient or reversible causes of atrial fibrillation <input type="checkbox"/> Unable to adhere/monitor</p> <p><input type="checkbox"/> Cardiac Surgery</p>
<p>Prescribed? If yes,</p> <p>Antiplatelet(s)</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Medication: Dosage: Frequency:</p> <p>Medication: Dosage: Frequency:</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>

<p>Are there any relative or absolute contraindications to oral antiplatelet(s) therapy? (Check all that apply)</p>	<input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <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"/> Cardiac Surgery <input type="checkbox"/> Unable to adhere/monitor
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<p>Aspirin</p> <p>Prescribed? If yes,</p> <p>Contraindicated?</p> <p>Are there any relative or absolute contraindications to Aspirin therapy? (Check all that apply)</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Dosage: _____ Frequency: _____</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <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"/> Cardiac Surgery <input type="checkbox"/> Unable to adhere/monitor
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<p>Beta Blocker</p> <p>Prescribed? If yes,</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Medication: _____ Dosage: _____ Frequency: _____</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Calcium Channel Blocker</p> <p>Prescribed? If yes,</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Medication: _____ Dosage: _____ Frequency: _____</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Digoxin</p> <p>Prescribed? If yes,</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Dosage: _____ Frequency: _____</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Statin Therapy</p> <p>Prescribed?</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Hydralazine Nitrate</p> <p>Prescribed?</p> <p>Contraindicated?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Other Medications at Discharge</p>	<input type="checkbox"/> Diuretic <input type="checkbox"/> NSAIDS/COX-2 Inhibitor
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RISK INTERVENTIONS

<p>Smoking Cessation Counseling Given</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
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<p>Rhythm Control/Rate Control Strategy Planned/Intended</p>	<input type="checkbox"/> Rhythm Control Strategy Planned <input type="checkbox"/> Rate Control Strategy Planned <input type="checkbox"/> No Documentation of Strategy
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Patient and/or caregiver received education and/or resource materials regarding all of the following:	<input type="checkbox"/> All were addressed (<i>Check all yes</i>) 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 Followup?	<input type="radio"/> Yes <input type="radio"/> No
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

OPTIONAL FIELDS					
Field 1	Field 2	Field 3	Field 4	Field 5	
Field 6	Field 7	Field 8	Field 9	Field 10	
Field 11		Field 12			
Additional Comments					
ADMIN					
ICD-9 or ICD-10-CM Principal Diagnosis Code	_____				
ICD-9 or ICD-10-CM Other Diagnoses Codes	1. _____ 4. _____ 7. _____ 10. _____ 13. _____ 16. _____ 19. _____ 22. _____	2. _____ 5. _____ 8. _____ 11. _____ 14. _____ 17. _____ 20. _____ 23. _____	3. _____ 6. _____ 9. _____ 12. _____ 15. _____ 18. _____ 21. _____ 24. _____		
ICD-9 or ICD-10-PCS Principal Procedure Code	_____ Date: __/__/____ <input type="checkbox"/> Date UTD				
ICD-9 or ICD-10-PCS Other Procedure Codes	1. _____ Date: __/__/____ <input type="checkbox"/> Date UTD 2. _____ Date: __/__/____ <input type="checkbox"/> Date UTD 3. _____ Date: __/__/____ <input type="checkbox"/> Date UTD 4. _____ Date: __/__/____ <input type="checkbox"/> Date UTD 5. _____ Date: __/__/____ <input type="checkbox"/> Date UTD				
CPT Code	_____				
CPT Code Date	__/__/____ <input type="checkbox"/> Unknown				
Was this Case Sampled?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
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="checkbox"/> Yes <input type="checkbox"/> No	

OTHER RISK SCORES

DISCLAIMER: These tools (ATRIA and HAS-BLED) are presented for informational purposes only and not as an endorsement of their use in clinical decision making. Many of the same risk factors for warfarin-related hemorrhage are also risk factors for AF-associated ischemic stroke. The use of these tools as an exclusion for anticoagulation is not part of AHA/ACC guideline-recommended care for patients with AF. Additionally, some of the component elements in the HAS-BLED score, such as Labile INR and Prior Major Bleeding or Pre-Disposition to Bleeding may be difficult to reliably ascertain from the information available in the health record. The HASBLED score should be interpreted with this in mind.

ATRIA Risk Score

- Age \geq 75 years
- Anemia (Defined as Hemoglobin $<$ 13 g/dL in men and $<$ 12 g/dL in women)
- Severe Renal Disease (defined as a GFR $<$ 30ml/min or on dialysis) History of Hypertension
- Prior hemorrhage (intracranial, gastrointestinal, other hemorrhage)

Adapted from a methodology used by the American College of Cardiology: Fang MC, Go AS, Chang Y, et al. A New Risk Scheme to Predict Warfarin-Associated Hemorrhage: The ATRIA (Anticoagulation and Risk Factors in Atrial Fibrillation) Study. *J Am Coll Cardiol.* 2011;58(4):395-401. doi:10.1016/j.jacc.2011.03.031. <http://content.onlinejacc.org/article.aspx?articleid=1146658#Abstract>

HAS-BLED Score

- Hypertension History (uncontrolled, $>$ 160 mmHg systolic)
- Renal Disease (Dialysis, transplant, Cr $>$ 2.6 mg/dL or $>$ 200 μ mol/L)
- Liver Disease (Chronic Hepatic Disease, including (e.g.) Cirrhosis, Bilirubin $>$ 2x Normal, AST/ALT/AP $>$ 3x Normal)
- Stroke History
- Prior Major Bleeding or Predisposition to Bleeding (bleeding diathesis, anemia, etc.)
- Labile INR (Unstable/high INRs or time in therapeutic range $<$ 60%) Age $>$ 65
- Medication Usage Predisposing to Bleeding (Antiplatelet agents, NSAIDs)
- Alcohol Usage History ($>$ 20 units per week)

Adapted from a methodology used by the American College of Chest Physicians: Pisters R, Lane DA, Nieuwlaat R, de Vos CB, Crijns HM, Lip GH. A novel user-friendly score (has-bleed) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the euro heart survey. *Chest.* 2010;138(5):1093-1100. <http://journal.publications.chestnet.org/article.aspx?articleid=1086288>