### Demographics Tab

**Vendor Name:** _____________  **Vendor Software Version:** ____________

**Patient ID:** _____________

**Patient not admitted at this facility and transferred out to another acute care facility?**  
- [x] Yes  
- [ ] No

**Gender:**  
- [x] Male  
- [ ] Female  
- [ ] Unknown

**Date of Birth:** __/__/______

**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:**  
- [ ] American Indian or Alaska Native  
- [ ] Black or African American  
- [ ] White  
- [ ] Asian  
- [ ] Asian Indian  
- [ ] Black or African American  
- [ ] Chinese  
- [ ] Filipino  
- [ ] Japanese  
- [ ] Korean  
- [ ] Vietnamese  
- [ ] Other Asian  
- [ ] Native Hawaiian or Pacific Islander  
- [ ] Native Hawaiian  
- [ ] Guamanian or Chamorro  
- [ ] Samoan  
- [ ] Other Pacific Islander  
- [ ] UTD

**Hispanic Ethnicity:**  
- [x] Yes  
- [ ] No/UTD

If Yes:  
- [ ] Mexican, Mexican American, Chicano/a  
- [ ] Cuban  
- [ ] Puerto Rican  
- [ ] Another Hispanic, Latino, or Spanish Origin

### Admin Tab

**Attending Physician/Provider NPI:** ________________

**Arrival Date/Time:** __/__/______  __:__

**Admission Date:** __/__/______  __:__

**Patient first evaluated:**  
- [x] ED  
- [ ] Cath Lab  
- [ ] Other

**Date/time of ED discharge/transfer out:** __/__/______  __:__

**ED Physician:** ________________

**Cardiac Diagnosis:**  
- [x] Confirmed AMI – STEMI  
- [x] Confirmed AMI – non-STEMI  
- [ ] Confirmed AMI – STEMI/non-STEMI unspecified  
- [ ] Unstable Angina  
- [ ] Coronary Artery Disease  
- [ ] Other

**Enrolled in Clinical Trial During Hospitalization:**  
- [x] 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 new antiplatelet therapies  
- [ ] Involving renin-angiotensin-aldosterone system inhibitor  
- [ ] Related to lipid lowering therapy  
- [ ] Related to AMI  
- [ ] Related to STEMI
### Pre-Hospital/Arrival Tab

#### Pre-Hospital

**Means of transport to first facility:**
- O Air
- O Ambulance
- O Walk-in

**EMS Agency name/number:**

Run/Sequence number:

**Cardiac arrest prior to arrival?**
- O Yes  O No

**If yes, was bystander CPR performed?**
- O Yes  O No

**If yes, was therapeutic hypothermia initiated during this episode of care?**
- O Yes  O No

### Pre-Hospital Time Tracker

**EMS First Medical Contact:**

**Non-EMS First Medical Contact:**

**EMS Non-System Reason for Delay:**

**Date/time of Initial 911 Call for Help**

**EMS Dispatch:**

**EMS arrive on scene:**

**EMS depart scene:**

**Destination Pre-arrival alert or notification:**

**Method of 1st notification:**
- O ECG Transmission  O Phone call  O Radio  O ND

### Transfers

**Transferred from other facility?**
- O Yes  O No

**Transferring Facility:**

### Transfer Time Tracker

**Arrival at First hospital:**

**Transport requested:**

**Transport Arrived Date/Time:**

**Transfer out:**

**Facility the patient was transferred to:**

**Mode of transport**
- O Air  O Ambulance

**Inter-facility transport EMS Agency name/number:**

### ECG

**1st ECG Date/Time:**

**1st ECG obtained:**
- O Prior to Hospital Arrival  O After First Hospital Arrival

**1st ECG Non-System Reason for Delay:**

**STEMI or STEMI Equivalent?**
- O Yes  O No

If yes, STEMI or STEMI equivalent first noted:
- O First ECG  O Subsequent ECG

If subsequent ECG, Date/Time of positive ECG:

**If No, other ECG finding:**
- New or presumed new ST depression.

**Arrival**

**Symptom onset Date/Time:**

Heart rate documented on first medical contact

**Systolic blood pressure on first medical contact**

**Heart failure documented on first medical contact**
- O Yes  O No

**Cardiogenic shock documented on first medical contact**
- O Yes  O No

**Patient Current Medications**
- O Dabigatran
- O Rivaroxaban
- O Apixaban
- O Warfarin
- O None

**Initial Serum Creatinine**

**Aspirin within 24 hours of arrival?**
- O Yes  O No  O Contraindicated

**Positive cardiac biomarkers in the first 24 hours?**
- O Yes  O No

**Initial Troponin value**

**Initial Troponin**
### Active bacterial or viral infection at admission or during hospitalization:

- None/ND
- Bacterial Infection
- Emerging Infectious Disease
- MERS
- SARS-COV-1
- SARS-COV-2 (COVID-19)
- Other Emerging Infectious Disease
- Influenza
- Seasonal Cold
- Other Viral Infection

### Patient Medical History:

- Atrial Fibrillation
- Atrial Flutter
- Cancer
- Cerebrovascular Disease [parent]
- If yes, Stroke [child] If yes, TIA [child]
- Currently on Dialysis
- Diabetes Mellitus
- Dyslipidemia [parent] If yes, Familial Hypercholesterolemia [child]
- Emerging Infectious Disease [parent]
- MERS [child]
- SARS-COV-1 [child]
- SARS-COV-2 (COVID-19) [child]
- Heart Failure
- Hypertension
- Peripheral Artery Disease
- Prior CABG [parent], If Yes, Most Recent CABG Date ___/___/____ [child]
- Prior MI
- Prior PCI [parent], If Yes, Most Recent PCI Date ___/___/____ [child]

### History of Smoking?

- Yes
- No

### History of vaping or e-cigarette use in the past 12 months?

- Yes
- No/ND

### Height ______ cm

### Weight ______ kg

### In-hospital Risk Adjusted Mortality Score ___________ (calculated)
## Hospitalization Tab

### Reperfusion

<table>
<thead>
<tr>
<th>Thrombolytics?</th>
<th>O Yes</th>
<th>O No</th>
<th>If yes, Dose Start Date/Time:</th>
<th>Documented non-system reason for delay-thrombolytics?</th>
<th>O Yes</th>
<th>O No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>/</strong>/______ ___: ___</td>
<td>If yes, reason (check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Cardiac Arrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Intubation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Need for additional PPE for suspected/confirmed infectious disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Patient refusal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reasons for not administering a thrombolytic

| Reason for not administering a thrombolytic | O Active peptic ulcer | O Any prior intracranial hemorrhage | O DNR at time of treatment decision | O Expected DTB ≤ 90 minutes | O Intracranial neoplasm, AV malformation, or aneurysm | O Ischemic stroke w/in 3 months except acute ischemic stroke within 3hrs | O Known bleeding diathesis | O No Reason documented | O Pregnancy | O Prior allergic reaction to thrombolytics | O Recent bleeding within 4 weeks | O Recent surgery/trauma | O Severe uncontrolled hypertension | O Significant close head or facial trauma within previous 3 months | O Suspected aortic dissection | O Transferred for PCI | O Traumatic CPR that precludes thrombolytics | O Other |

### PCI?

<table>
<thead>
<tr>
<th>O Yes</th>
<th>O No</th>
</tr>
</thead>
</table>

Physician interventionalist NPI ____________

### PCI Time Tracker

| Cath Lab Activation: __/__/______ ___: ___ | Patient Arrival to Cath Lab: __/__/______ ___: ___ |
| Attending Arrival to Cath Lab: __/__/______ ___: ___ | Team Arrival to Cath Lab: __/__/______ ___: ___ |
| First PCI Date/Time: __/__/______ ___: ___ |

### PCI Indication

| O Primary PCI for STEMI | O PCI for STEMI (unstable, >12 hr from sx onset) | O PCI for STEMI (stable, >12 hr from sx onset) | O Rescue PCI for STEMI (after failed full-dose lytic) |

### Non-system reason for delay- PCI?

| □ Difficult vascular access | □ Emergent placement of LV support device |
| □ Cardiac arrest and/or need for intubation | □ Need for additional PPE for suspected/confirmed infectious disease |
| □ Patient delays in providing consent | □ Other |
| □ Difficulty crossing the culprit lesion | □ None |

### Hospitalization

<table>
<thead>
<tr>
<th>LVF Assessment _____________%</th>
<th>Obtained:</th>
<th>O This Admission</th>
<th>O &gt; 1 year ago</th>
<th>O W/in the last year</th>
<th>O Planned After Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was early diagnostic coronary angiography performed?</td>
<td>O Yes</td>
<td>O No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and time of diagnostic angiography: <strong>/</strong>/______ ___: ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for not performing early diagnostic Angiography

<p>| □ Yes, medical reason | □ Yes, system reason |
| □ Yes, patient reason | □ No reason documented |</p>
<table>
<thead>
<tr>
<th>GWTG-CAD Case Review Form</th>
<th>Page 5</th>
</tr>
</thead>
</table>

### CABG During This Admission
- **Yes**
- **No**

<table>
<thead>
<tr>
<th>LDL Cholesterol Value:</th>
<th>mg/dl</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LDL Not Documented</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-Stratification Score Documented?</th>
<th>O EDACS</th>
<th>O GRACE</th>
<th>O HEART</th>
<th>O SYNTAX Score</th>
<th>O TIMI</th>
<th>O Other</th>
<th>O No Risk-Stratification Score Documented</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Grace Risk Score</th>
<th>TIMI Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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):
- Education
- Employment
- Financial Strain
- Food
- Living Situation/Housing
- Mental Health
- Personal Safety
- Substance Use
- Transportation Barriers
- Utilities
- None of the areas of unmet social needs listed were identified

**Vaccinations and Testing**

Influenza Vaccination: [hfs_fluvacc]
- 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

Was patient tested for influenza during this hospitalization? [flutest]
- **Yes**
- **No/ND**

Influenza rapid Ag Result:  
Influenza PCR Result:  
If positive, Influenza Type

<table>
<thead>
<tr>
<th>COVID-19 Vaccination [covidvacc]:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o COVID-19 vaccine was given during this hospitalization</td>
</tr>
<tr>
<td>o COVID-19 vaccine was received prior to admission, not during this hospitalization</td>
</tr>
<tr>
<td>o Documentation of patient’s refusal of COVID-19 vaccine</td>
</tr>
<tr>
<td>o Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated</td>
</tr>
<tr>
<td>o Vaccine not available</td>
</tr>
<tr>
<td>o None of the above/Not documented/UTD</td>
</tr>
</tbody>
</table>

COVID-19 Vaccination Date: [covidvaccdate]

Is there documentation that this patient was included in a COVID-19 vaccine trial?
- **Yes**
- **No/ND**
### Discharge Information

**Discharge Date/Time:** __/__/______ __: ___

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>1 - Home</th>
<th>2 - Hospice-Home</th>
<th>3 - Hospice-Healthcare Facility</th>
<th>4 - Acute Care Facility</th>
<th>5 – Other Health Care Facility</th>
<th>6 - Expired</th>
<th>7 – Left Against Medical Advice/AMA</th>
<th>8 – Not Documented or Unable to Determine (UTD)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comfort Measures Only?</th>
<th>O Yes</th>
<th>O No</th>
<th>If Yes, Date/Time <strong>/</strong>/______ __: ___</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referrals/Counseling</th>
<th><strong>Patient Referred to Cardiac Rehab?</strong></th>
<th>O Yes</th>
<th>O No referral documented</th>
<th>O No-Medical Reason</th>
<th>O No-Patient Oriented Reason</th>
<th>O No-Health Care System Reason</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Smoking Cessation Counseling?</th>
<th>O Yes</th>
<th>O No</th>
</tr>
</thead>
</table>

### Discharge Medications

**ACEI at discharge** | Prescribed | O Yes | O No | O NC |
|---------------------|------------|-------|------|------|

**ARB at discharge** | Prescribed | O Yes | O No | O NC |
|---------------------|------------|-------|------|------|

**Aspirin at discharge** | Prescribed | O Yes | O No | O NC |
|------------------------|------------|-------|------|------|

**Clopidogrel at discharge** | Prescribed | O Yes | O No | O NC |
|--------------------------|------------|-------|------|------|

**Prasugrel at discharge** | Prescribed | O Yes | O No | O NC |
|--------------------------|------------|-------|------|------|

**Ticagrelor at discharge** | Prescribed | O Yes | O No | O NC |
|--------------------------|------------|-------|------|------|

**Ticlopidine at discharge** | Prescribed | O Yes | O No | O NC |
|---------------------------|------------|-------|------|------|

**Anticoagulation at discharge** | Prescribed | O Yes | O No | O NC |
|-----------------------------|------------|-------|------|------|

**Beta Blocker at discharge** | Prescribed | O Yes | O No | O NC |
|-------------------------------|------------|-------|------|------|

**Statin at discharge** | Prescribed | O Yes | O No | O NC |
|---------------------------|------------|-------|------|------|

**Is there a non-system reason for not prescribing a high intensity statin medication?**

- □ Yes, medical reason
- □ Yes, patient reason
- □ No

**PCSK9 Inhibitor** | Prescribed | O Yes | O No | O NC |
|----------------|------------|-------|------|------|