

**PMT FORM SELECTION**

**Legend: Elements in bold are required**

HF	Patient ID:
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**ARRIVAL AND ADMISSION INFORMATION**

Internal Tracking ID:	Physician/Provider NPI:
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Arrival Date and Time: ___/___/___ ___:___	<input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown/Date UTD
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Admit Date: ___/___/___	Transferred in (from another ED)? <input type="radio"/> Yes <input type="radio"/> No
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Point of Origin for Admission or Visit:	<input type="radio"/> 1 Non-Health Care Facility Point of Origin <input type="radio"/> 2 Clinic <input type="radio"/> 4 Transfer From a Hospital (Different Facility) <input type="radio"/> 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	<input type="radio"/> 6 Transfer from another Health Care Facility <input type="radio"/> 7 Emergency room <input type="radio"/> 9 Information not available <input type="radio"/> F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
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**DEMOGRAPHIC DATA**

Date of Birth: ___/___/___	Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> UTD
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Gender: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	<b>Hispanic Ethnicity</b> : <input type="radio"/> Yes <input type="radio"/> No/UTD If yes, <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino or Spanish Origin
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Payment Source:	<input type="checkbox"/> Medicaid (Title 19) <input type="checkbox"/> Medicare (Title 18) <input type="checkbox"/> Medicare – Private/HMO/Other	<input type="checkbox"/> No Insurance/Not Documented/UTD <input type="checkbox"/> Private/HMO/Other
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External Tracking ID: _____	Patient Postal Code: _____ - _____
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**MEDICAL HISTORY**

Medical History (Select all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Atrial Flutter (Chronic or Recurrent) <input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Diabetes - Non-insulin treated <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prior MI  <input type="checkbox"/> Valvular Heart Disease	<input type="checkbox"/> Anemia <input type="checkbox"/> CAD <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only) <input type="checkbox"/> Depression <input type="checkbox"/> Dialysis (chronic) <input type="checkbox"/> Hypertension <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prior PCI  <input type="checkbox"/> Ventricular assist device	<input type="checkbox"/> Atrial Fib (Chronic or Recurrent) <input type="checkbox"/> CardioMEMS (implantable hemodynamic monitor) <input type="checkbox"/> COPD or Asthma <input type="checkbox"/> Diabetes - Insulin treated <input type="checkbox"/> Heart failure <input type="checkbox"/> ICD only <input type="checkbox"/> Prior CABG <input type="checkbox"/> Renal insufficiency - chronic (SCr>2.0)
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History of Cigarette Smoking? (in past 12 months):	<input type="radio"/> Yes <input type="radio"/> No
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Heart Failure History	Etiology: Check if history of:	<input type="checkbox"/> Ischemic/CAD <input type="checkbox"/> Non-Ischemic <input type="checkbox"/> Hypertensive <input type="checkbox"/> Alcohol/other drug <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Viral	<input type="checkbox"/> Familial <input type="checkbox"/> Other Etiology <input type="checkbox"/> Unknown/ Idiopathic
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	<b>Known history of HF prior to this admission?</b>	<input type="radio"/> Yes <input type="radio"/> No
	# hospital admissions in past 6 mo. for HF:	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> >2 <input type="radio"/> Unknown
	<input type="checkbox"/> Patient listed for transplant	

**DIAGNOSIS**

<b>Heart Failure Diagnosis</b>	<input type="checkbox"/> Heart Failure, primary diagnosis, with CAD	<input type="checkbox"/> Heart Failure, primary diagnosis, no CAD
	<input type="checkbox"/> Heart Failure, secondary diagnosis	
<b>Atrial Fibrillation (At presentation or during hospitalization)</b>	<input type="radio"/> Yes <input type="radio"/> No	Documented New Onset? <input type="checkbox"/>
<b>Atrial Flutter (At presentation or during hospitalization)</b>	<input type="radio"/> Yes <input type="radio"/> No	Documented New Onset? <input type="checkbox"/>
New Diagnosis of Diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented	
Basis for Diagnosis	<input type="checkbox"/> HbA1c <input type="checkbox"/> Oral Glucose Tolerance	<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Test Other
Characterization of HF at admission or when first recognized	<input type="radio"/> Acute pulmonary edema <input type="radio"/> Dizziness/syncope <input type="radio"/> Dyspnea <input type="radio"/> ICD Shock/Sustained Ventricular Arrhythmia	<input type="radio"/> Pulmonary congestion <input type="radio"/> Volume overload/Weight Gain <input type="radio"/> Worsening fatigue <input type="radio"/> Other
Other Conditions Contributing to HF Exacerbation <i>Select all that apply</i>	<input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pneumonia/respiratory process <input type="checkbox"/> Worsening renal failure <input type="checkbox"/> Noncompliance – medication	<input type="checkbox"/> Ischemia/ACS <input type="checkbox"/> Uncontrolled HTN <input type="checkbox"/> Noncompliance – dietary <input type="checkbox"/> Other

**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"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Angiotensin receptor neprilysin inhibitor (ARNI) <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Anticoagulation Therapy <input type="checkbox"/> Warfarin <input type="checkbox"/> Direct Thrombin Inhibitor <input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Other <input type="checkbox"/> Antiplatelet agent (excluding aspirin) <input type="checkbox"/> Aspirin <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Diabetic Medications (Any) <input type="checkbox"/> Digoxin	<input type="checkbox"/> Diuretic <input type="checkbox"/> Thiazide/Thiazide-like <input type="checkbox"/> Loop <input type="checkbox"/> Hydralazine <input type="checkbox"/> Ivabradine <input type="checkbox"/> Lipid lowering agent (Any) <input type="checkbox"/> Statin <input type="checkbox"/> Other lipid lowering agent <input type="checkbox"/> Nitrate <input type="checkbox"/> Omega-3 fatty acid supplement <input type="checkbox"/> Renin Inhibitor <input type="checkbox"/> Other

**EXAM/LABS AT ADMISSION**

Symptoms (closest to admission) <i>Check all that apply</i>	<input type="checkbox"/> Chest pain <input type="checkbox"/> Dyspnea at rest <input type="checkbox"/> Orthopnea	<input type="checkbox"/> Decreased appetite/early satiety <input type="checkbox"/> Dyspnea on exertion <input type="checkbox"/> Palpitations	<input type="checkbox"/> Dizziness/lightheadedness/syncope <input type="checkbox"/> Fatigue <input type="checkbox"/> PND
Vital Signs (closest to admission)	Height	_____ <input type="radio"/> inches <input type="radio"/> cm	<input type="checkbox"/> Not documented
	Weight	_____ <input type="radio"/> lbs <input type="radio"/> kg	<input type="checkbox"/> Not documented
	Waist Circumference	_____ <input type="radio"/> inches <input type="radio"/> cm	<input type="checkbox"/> Not documented
	BMI	_____ (automatically calculated)	
	Heart Rate	_____ bpm	<input type="checkbox"/> ND
	BP-Supine	_____/_____ mmHg (systolic/diastolic)	<input type="checkbox"/> ND

	Respiratory Rate	_____ breaths per minute		
Exam (closest to admission)	JVP:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, _____ cm	
	Rales:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, <input type="radio"/> <1/3 <input type="radio"/> ≥1/3 <input type="radio"/> N/A	
	Lower extremity edema:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, <input type="radio"/> trace <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+ <input type="radio"/> N/A	
Lipids	TC: _____ mg/dL HDL: _____ mg/dL LDL: _____ mg/dL TG: _____ mg/dL	<input type="checkbox"/> Lipids Not Available		
Labs (closest to admission)	Na	_____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Not Available	
	Hgb	_____ <input type="radio"/> g/dL <input type="radio"/> g/L	<input type="checkbox"/> Not Available	
	Albumin	_____ <input type="radio"/> g/dL <input type="radio"/> g/L	<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	
	NBNP	_____ <input type="radio"/> pg/mL <input type="radio"/> ng/L	<input type="checkbox"/> Not Available	
	SCr	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Not Available	
	BUN	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Not Available	
	Troponin (Peak)	_____ <input type="radio"/> ng/mL <input type="radio"/> ug/L	<input type="checkbox"/> Not Available	
		<input type="radio"/> T <input type="radio"/> I <input type="radio"/> Normal <input type="radio"/> Abnormal		
	K	_____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Not Available	
	HbA1C	_____ %	<input type="checkbox"/> Not Available	
	Fasting Blood Glucose (mg/dL)	_____	<input type="checkbox"/> Not Available	
	EKG QRS Duration (ms)	_____	<input type="checkbox"/> Not Available	
EKG QRS Morphology	<input type="radio"/> Normal <input type="radio"/> LBBB <input type="radio"/> RBBB <input type="radio"/> NS-IVCD <input type="radio"/> Paced		<input type="radio"/> Not Available	

**IN-HOSPITAL CARE**

Procedures	<input type="checkbox"/> No Procedures	<input type="checkbox"/> Atrial Fibrillation Ablation or Surgery	<input type="checkbox"/> Cardiac Cath/Coronary angiography
	<input type="checkbox"/> Cardioversion	<input type="checkbox"/> CardiMEMS (implantable hemodynamic monitor)	<input type="checkbox"/> Coronary artery bypass graft
	<input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD)	<input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only)	<input type="checkbox"/> Dialysis
	<input type="checkbox"/> Dialysis or Ultrafiltration unspecified	<input type="checkbox"/> ICD only	<input type="checkbox"/> Intra-aortic balloon pump
	<input type="checkbox"/> Left Ventricular assist device	<input type="checkbox"/> Mechanical ventilation	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> PCI	<input type="checkbox"/> PCI with Stent	<input type="checkbox"/> Right Cardiac Catheterization
	<input type="checkbox"/> Stress Testing	<input type="checkbox"/> Transplant (Heart)	<input type="checkbox"/> Ultrafiltration

<b>EF – Quantitative</b>	_____ %	Obtained:	<input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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<b>EF – Qualitative</b>	<input type="radio"/> Not applicable <input type="radio"/> Normal or mild dysfunction <input type="radio"/> Qualitative moderate/severe dysfunction <input type="radio"/> Performed/results not available <input type="radio"/> Planned after discharge <input type="radio"/> Not performed	Obtained:	<input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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<b>Documented LVSD?</b>	<input type="radio"/> Yes <input type="radio"/> No
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<b>LVF Assessment?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done, reason documented
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<b>Oral Medications during hospitalization</b> <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> ARNI <input type="checkbox"/> Hydralazine nitrate	<input type="checkbox"/> ACE inhibitor <input type="checkbox"/> Aldosterone antagonist	<input type="checkbox"/> ARB <input type="checkbox"/> Beta Blocker
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Parenteral Therapies during hospitalization <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> Dopamine <input type="checkbox"/> Milrinone <input type="checkbox"/> Nesiritide <input type="checkbox"/> Nitroglycerine <input type="checkbox"/> Vasopressin antagonist	<input type="checkbox"/> Dobutamine <input type="checkbox"/> Loop diuretics <input type="checkbox"/> Intermittent bolus <input type="checkbox"/> Continuous infusion <input type="checkbox"/> Other IV vasodilator
<b>Was the patient ambulating at the end of hospital day 2?</b>		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented
<b>Was DVT prophylaxis initiated by the end of hospital day 2?</b>		<input type="radio"/> Yes <input type="radio"/> No/Not Documented <input type="radio"/> Contraindicated
If yes,	<input type="radio"/> Low dose unfractionated heparin (LDUH) <input type="radio"/> Low molecular weight heparin (LMWH) <input type="radio"/> Warfarin <input type="radio"/> Intermittent pneumatic compression devices (IPC) <input type="radio"/> Factor Xa Inhibitor <input type="radio"/> Direct thrombin inhibitor <input type="radio"/> Venous foot pumps (VFP) <input type="radio"/> Other	
<b>Was DVT or PE (pulmonary embolus) documented?</b>		<input type="radio"/> Yes <input type="radio"/> No/Not Documented
<b>Influenza Vaccination</b>	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/sensitivity to influenza vaccine or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not documented/UTD.	
<b>Pneumococcal Vaccination</b>	<input type="radio"/> Pneumococcal vaccine was given during this hospitalization <input type="radio"/> Pneumococcal vaccine was received in the past, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of pneumococcal vaccine <input type="radio"/> Allergy/sensitivity to pneumococcal vaccine <input type="radio"/> None of the above/Not documented/UTD	
<b>DISCHARGE INFORMATION</b>		
<b>Discharge Date/Time</b>	___/___/___ :___	<input type="checkbox"/> MM/DD/YYYY only
Get With The Guidelines® HF Mortality Risk Score		[Calculated in the PMT]
<b>For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?</b>	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)	
<b>If Other Health Care Facility</b>	<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
If Home, special discharge circumstances	<input type="radio"/> Home Health <input type="radio"/> Homeless <input type="radio"/> International	<input type="radio"/> Prison/Incarcerated <input type="radio"/> None/UTD
Primary Cause of Death	<input type="radio"/> Cardiovascular <input type="radio"/> Non-cardiovascular <input type="radio"/> Unknown If cardiovascular: <input type="radio"/> Acute coronary syndrome <input type="radio"/> Worsening heart failure <input type="radio"/> Sudden death <input type="radio"/> Other cardiovascular	
<b>When is the earliest physician/APN/PA documentation of comfort measures only?</b>	<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	

Symptoms (closest to discharge)		<input type="radio"/> Worse <input type="radio"/> Unchanged <input type="radio"/> Better, symptomatic <input type="radio"/> Better, asymptomatic <input type="radio"/> Unable to determine			
Vital Signs (closest to discharge)	Weight	_____	<input type="radio"/> lbs	<input type="radio"/> kg	<input type="checkbox"/> Not well documented
	Heart Rate	_____	bpm	<input type="checkbox"/> ND	
	BP-Supine	_____ / _____	mmHg (systolic/diastolic)	<input type="checkbox"/> ND	
Exam (closest to discharge)	JVP	_____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, _____ cm	
	Rales	_____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, <input type="radio"/> <1/3 <input type="radio"/> ≥1/3 <input type="radio"/> N/A	
	Lower extremity edema	_____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, <input type="radio"/> trace <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+ <input type="radio"/> N/A	
Labs (closest to discharge)	Na	_____	<input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Not well documented	
	BNP	_____	<input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L	<input type="checkbox"/> Not well documented	
	SCr	_____	<input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Not well documented	
	BUN	_____	<input type="radio"/> mg/dL <input type="radio"/> μmol/L	<input type="checkbox"/> Not well documented	
	NT-BNP (pg/mL)	_____	<input type="radio"/> pg/mL	<input type="checkbox"/> Not well documented	
	K	_____	<input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL	<input type="checkbox"/> Not well documented	

**DISCHARGE MEDICATIONS**

ACEI	<b>Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	If yes,	Medication:	Dosage:	Frequency:	
	<b>Contraindicated?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	<b>Contraindications or Other Documented Reason(s) For Not Providing ACEI:</b>	<input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason			
ARB	<b>Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	If yes,	Medication:	Dosage:	Frequency:	
	<b>Contraindicated?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	<b>Contraindications or Other Documented Reason(s) For Not Providing ARB:</b>	<input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason			
ARNI	<b>Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	If yes,	Medication:	Dosage:	Frequency:	
	<b>Contraindicated?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	<b>Contraindications or Other Documented Reason(s) For Not Providing ARNI:</b>	<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			
	<b>Reasons for not switching to ARNI at discharge:</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ARNI was prescribed at discharge			
	If yes,	<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			
ASA	<b>Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No			
	If yes,	Dosage:	Frequency:		

	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
Anticoagulation Therapy	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,	Class: <input type="radio"/> Warfarin <input type="radio"/> Direct thrombin inhibitor <input type="radio"/> Factor Xa Inhibitor <input type="radio"/> Other	Medication:	Dosage: Frequency:
	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,	Contraindication(s):	<input type="checkbox"/> Allergy to or complication r/t anticoagulation therapy (hx or current) <input type="checkbox"/> Patient/Family refused <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only	
Clopidogrel	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,	Dosage:		Frequency:
	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
Other Antiplatelet(s)	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,	Medication:	Dosage:	Frequency:
Beta Blocker	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes, Class of Beta Blocker	<input type="radio"/> Evidence-Based Beta Blocker <input type="radio"/> Non Evidence-Based Beta Blocker <input type="radio"/> Unknown Class		
	If yes,	Medication:	Dosage:	Frequency:
	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
	Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	<input type="checkbox"/> Low blood pressure <input type="checkbox"/> Fluid overload <input type="checkbox"/> Asthma <input type="checkbox"/> Patient recently treated with an intravenous positive inotropic agent <input type="checkbox"/> Other <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		
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		
	Contraindications or Other Documented Reasons(s) for Not Providing Aldosterone Antagonist at Discharge	<input type="checkbox"/> Allergy due to aldosterone receptor antagonist <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women <input type="checkbox"/> Other medical reasons <input type="checkbox"/> Other contraindications <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		
Diabetic Tx:	<input type="checkbox"/> None prescribed/ND <input type="checkbox"/> Oral agents	<input type="checkbox"/> None – contraindicated <input type="checkbox"/> Other subcutaneous/injectable agents	<input type="checkbox"/> Insulin	
Lipid Lowering Medication(s)	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	If yes,	Class:	Medication:	Dosage: Frequency:
		Class:	Medication:	Dosage: Frequency:
		Class:	Medication:	Dosage: Frequency:
Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No			
Omega-3 fatty acid supplement	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
Hydralazine Nitrate	Prescribed?	<input type="radio"/> Yes <input type="radio"/> No		
	Contraindicated?	<input type="radio"/> Yes <input type="radio"/> No		
	Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	<input type="checkbox"/> Medical Reason <input type="checkbox"/> Patient Reason		

		<input type="checkbox"/> System Reason
Ivabradine	<b>Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Contraindicated?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:</b>	<input type="checkbox"/> Allergy to Ivabradine <input type="checkbox"/> NYHA class I or IV <input type="checkbox"/> Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated <input type="checkbox"/> New Onset HF <input type="checkbox"/> Not in sinus rhythm <input type="checkbox"/> Patient 100% atrial or ventricular paced <input type="checkbox"/> Other medical reasons <input type="checkbox"/> Patient reasons <input type="checkbox"/> System reasons
Other Medications at Discharge	<input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Amiodarone <input type="checkbox"/> Dofetilide <input type="checkbox"/> Sotalol <input type="checkbox"/> Other <input type="checkbox"/> Ca Channel blocker <input type="checkbox"/> Digoxin	<input type="checkbox"/> Diuretic <input type="checkbox"/> Loop Diuretic <input type="checkbox"/> Thiazide Diuretic Nitrate <input type="checkbox"/> Nitrate <input type="checkbox"/> Ranolazine <input type="checkbox"/> Renin inhibitor <input type="checkbox"/> Other anti-hypertensive <input type="checkbox"/> Other

**OTHER THERAPIES**

ICD Therapy	<b>Counseling?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Reason for not counseling?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Documented Medical Reason(s) for Not Counseling?</b>	<input type="checkbox"/> ICD or CRT-D device in patient <input type="checkbox"/> Multiple or significant comorbidities <input type="checkbox"/> Limited life expectancy <input type="checkbox"/> other reasons not eligible for ICD (e.g. EF > 35%, new onset HF) <input type="checkbox"/> other reasons for not counseling
	<b>Placed or Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Reason for not Placing or Prescribing?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Documented Reason(s) for Not Placing or Prescribing ICD Therapy?</b>	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Any other physician documented reason including, AMI in prior 40 days, recent revascularization, recent onset of HF <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason

CRT Therapy	<b>CRT-D Placed or Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>CRT-P Placed or Prescribed?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Reason for not Placing or Prescribing?</b>	<input type="radio"/> Yes <input type="radio"/> No
	<b>Documented Medical Reason(s) for Not Placing or Prescribing CRT Therapy?</b>	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Not NYHA functional Class III or ambulatory Class IV <input type="checkbox"/> Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF <input type="checkbox"/> QRS duration <120 ms <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason

**RISK INTERVENTIONS**

<b>Smoking Cessation Counseling Given</b>	<input type="radio"/> Yes <input type="radio"/> No																		
Activity Level	<input type="radio"/> Yes <input type="radio"/> No																		
Follow-Up	<input type="radio"/> Yes <input type="radio"/> No																		
Symptoms Worsening	<input type="radio"/> Yes <input type="radio"/> No																		
Diet (Salt restricted)	<input type="radio"/> Yes <input type="radio"/> No																		
Medications	<input type="radio"/> Yes <input type="radio"/> No																		
Weight Monitoring	<input type="radio"/> Yes <input type="radio"/> No																		
<b>Follow-Up Visit Scheduled</b>	<input type="radio"/> Yes <input type="radio"/> No																		
<b>Date/Time of first follow-up visit:</b>	___/___/____ :___:___ <input type="checkbox"/> MM/DD/YYYY only <input type="checkbox"/> Unknown																		
<b>Location of first follow-up visit:</b>	<input type="radio"/> Office Visit <input type="radio"/> Home Health Visit <input type="radio"/> Not Documented																		
<b>Medical or Patient Reason for no follow-up appointment being scheduled?</b>	<input type="radio"/> Yes <input type="radio"/> No																		
<b>Follow up Phone Call Scheduled</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Date of first follow-up phone call:</b>	___/___/____ <input type="checkbox"/> Unknown																
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																
Referred to Outpatient Cardiac Rehab Program	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
Anticoagulation Therapy Education	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
Was Diabetes Teaching Provided?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
PT/INR Planned follow-up	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
Referral to Outpatient HF Management Program	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
If Yes,	<input type="checkbox"/> Telemanagement <input type="checkbox"/> Home Visit <input type="checkbox"/> Clinic-based																		
<b>Referral to AHA Heart Failure Interactive Workbook</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
<b>Provision of at least 60 minutes of Heart Failure Education by a qualified educator</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
<b>Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable																
Advance Directive Executed	<input type="radio"/> Yes <input type="radio"/> No																		
<b>POST DISCHARGE TRANSITION</b>																			
Care Transition Record Transmitted	<input type="radio"/> By the seventh post-discharge day <input type="radio"/> Exists, but not transmitted by the seventh post-discharge day <input type="radio"/> No Care Transition Record/UTD																		
Care Transition Record Includes	<input type="checkbox"/> All were included ( <i>Check all yes</i> ) <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">Discharge Medications</td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td>Follow-up Treatment(s) and Service(s) Needed</td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td>Procedures Performed During Hospitalization</td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td>Reason for Hospitalization</td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td>Treatment(s)/Service(s) Provided</td> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> </table>				Discharge Medications	<input type="radio"/> Yes	<input type="radio"/> No	Follow-up Treatment(s) and Service(s) Needed	<input type="radio"/> Yes	<input type="radio"/> No	Procedures Performed During Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	Reason for Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	Treatment(s)/Service(s) Provided	<input type="radio"/> Yes	<input type="radio"/> No
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Treatment(s)/Service(s) Provided	<input type="radio"/> Yes	<input type="radio"/> No																	
<b>OPTIONAL FIELDS</b>																			
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/JOINT COMMISSION			
ICD-9 Principal Diagnosis Code	_____		
ICD-9 Other Diagnoses Codes	1.	2.	3.
	4.	5.	6.
	7.	8.	9.
	10.	11.	12.
	13.	14.	15.
	16.	17.	18.
	19.	20.	21.
	22.	23.	24.
ICD-9-CM Principal Procedure Code	_____ Date: __/__/____ <input type="checkbox"/> Date UTD		
ICD-9 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		
ICD-10-CM Principal Diagnosis Code	_____		
ICD-10-CM Other Diagnoses Codes	1.	2.	3.
	4.	5.	6.
	7.	8.	9.
	10.	11.	12.
	13.	14.	15.
	16.	17.	18.
	19.	20.	21.
	22.	23.	24.
ICD-10-PCS Principal Procedure Code	_____ Date: __/__/____ <input type="checkbox"/> Date UTD		
ICD-10-PCS Principal Procedure Code	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		
What is the patient's source of payment for this episode of care?		<input type="radio"/> Medicare <input type="radio"/> Non-Medicare	
Was this Case Sampled?	<input type="radio"/> Yes <input type="radio"/> No		
During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, PR, SCIP)?			<input type="radio"/> Yes <input type="radio"/> No
PMT used concurrently or retrospectively or combination?		<input type="radio"/> Concurrently <input type="radio"/> Retrospectively <input type="radio"/> Combination	
Standardized order sets used?		<input type="radio"/> Yes <input type="radio"/> No	
Patient adherence contract/compact used?		<input type="radio"/> Yes <input type="radio"/> No	
Discharge checklist used?		<input type="radio"/> Yes <input type="radio"/> No	