PMT FORM SELECTION

Legend:
BOLD = Required
^ = MLL Data Element

Admin (Tab)

^Patient ID: _____		Physician/Provider NPI: _____	
DOB: ___/___/_____	**Gender:** O Male O Female OUnknown		Patient Zip Code:
^Arrival Date/Time:	___/___/_____ ___: ____	**Admission Date:**	___/___/_____ ___: ____ ☐ Not admitted, transferred out another acute care facility.

Race:

☐ American Indian or Alaska Native
☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American
☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐Other Pacific Islander

☐ White
☐ UTD

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

Cardiac Diagnosis:

O Confirmed AMI – STEMI
O Confirmed AMI – non-STEMI
O Confirmed AMI – STEMI/non-STEMI unspecified
O Coronary Artery Disease
O Unstable Angina
O Other

Pre-Hospital/Arrival

Pre-Hospital

^Means of transport to first facility:	O Air O Ambulance O Walk-in	EMS Agency name/number**:**	_____
		Run/Sequence number:	_____

Pre-Hospital Time Tracker

^EMS First Medical Contact:	___/___/_____ ___: ____	^Non-EMS First Medical Contact:	___/___/_____ ___: ____
^EMS Non-System Reason for Delay: OYes O No			
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

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:	___/___/_____ ___: ____
Mode of transport from outside facility	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: O Yes O No			
^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: ___/___/_____ ___:	
Arrival			
Symptom onset Date/Time: ___/___/_____ ___: ____			
Patient first evaluated:	O ED O Cath Lab O Other	If ED, Transfer out Date/Time: ___/___/_____ ___: ____	
^Patient Current Medications	O Dabigatran O Rivaroxaban O Apixaban O Warfarin		
^Aspirin within 24 hours of arrival?		O Yes O No O Contraindicated	
^Antithrombotic taken in 24hrs prior to arrival?		O Yes O No	
^Positive cardiac biomarkers in the first 24 hours?		O Yes O No	
^History of Smoking?		O Yes O No	
Hospitalization			
Reperfusion			
Reperfusion Candidate? O Yes O No			
If no, primary reason:	O No ST Elevation/LBBB O MI diagnosis unclear O Other	O Chest pain resolved O MI symptoms >12hrs	O ST elevation resolved O No chest pain
^Thrombolytics? O Yes O No	^If yes, Dose Start Date/Time:	___/___/_____ ___: ____	^Documented non-system reason or delay- Lytics? O Yes O No If yes, reason (check all that apply) ☐ Cardiac Arrest ☐ Intubation ☐ Patient refusal
^Primary PCI? O Yes O No			
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 (stable after successful full-dose lytic)	O PCI for STEMI (unstable, >12 hr from sx onset) O Rescue PCI for STEMI (after failed full-dose lytic)	O PCI for STEMI (stable, >12 hr from sx onset) O PCI for NSTEMI O Other
^Non-system reason for delay-PCI?	O Difficult vascular access O Cardiac arrest and/or need for intubation	O Patient delays in providing consent O Difficulty crossing the culprit lesion	O Other O None
Reperfusion Contraindications	^Reasons for not performing PCI	O Non-compressible vascular puncture(s) O Active bleeding on arrival or within 24 hours O Quality of life decision	O Spontaneous reperfusion (documented by cath only) O Patient/family refusal O DNR at time of treatment decision O Prior allergic reaction to IV contrast	O Other O Not performed O No reason documented O Thrombolytic Administered

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

Hospitalization		
^LVF Assessment _____%	Obtained:	**O** This Admission **O** W/in the last year **O** > 1 year ago **O** Planned After Discharge
^CABG During This Admission:	**O** Yes **O** No	
^LDL Cholesterol:	_____mg/dl	

Discharge	
Discharge Date/Time: ___/___/_____ ___: ____	
^Discharge Status:	1 - Home
	2 - Hospice-Home
	3 - Hospice-Healthcare 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)

^Comfort Measures Only		**O** Yes **O** No	
^Patient Referred to Cardiac Rehab?	**O** Yes	**O** No-Referral **O** No-Pt Reason/Preference	**O** No-Medical Reason **O** No-Health Care System Reason
^Smoking Cessation Counseling? **O** Yes **O** No			

^ACEI at discharge	**Prescribed**	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^ARB at discharge	**Prescribed**	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^Aspirin at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	**Dose:** Frequency:
	Contraindicated	**O** Yes **O** No
^Clopidogrel at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	Dose: Frequency:
	Contraindicated	**O** Yes **O** No
^Prasugrel at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	Dose: Frequency:
	Contraindicated	**O** Yes **O** No

^Ticagrelor at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	Dose: Frequency:
	Contraindicated	**O** Yes **O** No
^Ticlopidine at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	Dose: Frequency:
	Contraindicated	**O** Yes **O** No
^Anticoagulation at discharge	**Prescribed**	**O** Yes **O** No
	If yes,	**Class:** **Medication:** Dose: Frequency:
	Contraindicated	**O** Yes **O** No
^Beta Blocker at discharge	**Prescribed**	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^Statin at discharge	**Prescribed**	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
Optional Field-1		
Optional Field-2		
Optional Field-3		