Patient ID:		**Bold Question = Required**
DEMOGRAPHICS		***Demographics Tab***
Sex	○ Male ○ Female ○ Unknown	
Date of Birth:	_____/_____/_____	**Age:** _____
Zip Code:	_____ - _____	Homeless: ☐
Payment Source	☐ Medicare Title 18 ☐ Medicaid – Private/ HMO/ PPO/ Other ☐ Self Pay/ No Insurance ☐ Medicaid Title 19 ☐ Private/ HMO/ PPO/ Other ☐ Other/ Not Documented/ UTD ☐ Medicare – Private/ HMO/ PPO/ Other ☐ VA/ CHAMPVA/ Tricare	
RACE AND ETHNICITY		
Race (Select all that apply):	☐ American Indian/Alaska Native ☐ Asian [if Asian selected] ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander [if Native Hawaiian or Pacific Islander selected] ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ White ☐ UTD	
Hispanic Ethnicity:	○ Yes ○ No/UTD	
If Yes,	○ Mexican, Mexican American, Chicano/a ○ Cuban ○ Puerto Rican ○ Another Hispanic, Latino or Spanish Origin	
ADMIN		***Admin Tab***
Arrival Date/Time:	____/____/_____:____ ○ MM/DD/YYYY only ○ Unknown	**Admission Date:** _____/_____/_____
Discharge Date/Time:	____/_____/_____:_____ ☐ MM/DD/YYYY only	
Was patient declared Do Not Resuscitation (DNR) at any time during this admission?	○ Yes ○ No/ND	
Date/Time of DNR order	____/____/_____:____ ○ MM/DD/YYYY only ○ Unknown	
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	○ Inpatient Rehabilitation Facility (IRF) ○ Intermediate Care facility (ICF) ○ Long Term Care Hospital (LTCH) ○ Skilled Nursing Facility (SNF) ○ Other	
Was patient placed on Comfort Measures Only at any time during this admission?	○ Yes ○ No/ND	
Date of comfort measures only	____/____/_____ ○ Unknown	
ARRIVAL AND ADMISSION INFORMATION		***Admission Tab***
Means of Transport to your Facility:	○ Air ○ Ambulance ○ Walk-in ○ Transfer from another hospital ○ ND or Unknown	
MEDICAL HISTORY		

Past Medical History:	○ No Medical History ○ Atrial Flutter ○ Cerebrovascular Disease ☐ Stroke ☐ TIA ○ Congenital Heart Disease ○ Currently on Dialysis ○ Diabetes Mellitus ○ eCigarette (vaping) ○ Hypertension ○ Organ Transplant ○ Pregnancy ○ Prior MI ○ Pulmonary Embolism ○ Smoking ○ Atrial Fibrillation ○ Cancer ○ Chronic Kidney Disease ○ COVID-19 ○ DVT ○ Dyslipidemia ○ Heart Failure ○ Immune Disorders ☐ HIV ☐ Lupus ☐ Rheumatoid Arthritis ☐ Other Immune Disorder ○ Peripheral Artery Disease ○ Prior CABG ○ Prior PCI ○ Pulmonary Disease ☐ COPD ☐ Interstitial Lung Disease (ILD) ☐ Asthma ☐ Pulmonary Arterial Hypertension ☐ Other Pulmonary Disease
Influenza Vaccination	○ 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
COVID-19 Vaccination	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/ sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/ Not documented/ UTD
COVID-19 Vaccination Date	____/_____/_____ ○ Unknown
COVID-19 Vaccination Date Not Documented	☐
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND
DIAGNOSIS & EVALUATION	
COVID-19 Diagnosis	○ Yes, prior to admission ○ Yes, after discharge ○ Yes, during hospitalization ○ Unknown/ND
Method of diagnosis:	○ Clinical diagnosis using hospital specific criteria ○ RT-PCR test ○ IgM antibody test
Date of dx	_____/_____/_____ ☐ Unknown
Date of COVID-19 symptom onset?	_____/_____/_____ ☐ Unknown
Documented Symptoms	☐ Confusion or Altered Mental Status ☐ Fatigue ☐ Headache ☐ Myalgia ☐ Nausea, Vomiting, or Diarrhea ☐ Sore Throat ☐ Not Documented ☐ Cough ☐ Fever/ Chills ☐ Loss of Sense of Smell/ Taste ☐ Nasal Congestion ☐ Shortness of Breath ☐ Other: _____
Presence of interstitial infiltrates on initial Chest X-ray or CT	○ Yes ○ No ○ ND
During admission, was this patient enrolled in a clinical trial related to COVID-19?	○ Yes ○ No/ND
Was Influenza testing performed during this hospitalization?	○ Yes ○ No ○ ND

Influenza Rapid Ag Results	○ Positive ○ Negative ○ Not Done
Influenza PCR Results	○ Positive ○ Negative ○ Not Done
If Positive, Influenza Type	☐ Type A ☐ Type ☐ UTD

MEDICATION PRIOR TO ADMISSION

Medications prescribed or taking at time of admission:

Anti-hypertensive	○ Yes ○ No/ND
Anti-hypertensive Tx (Select all that apply)	☐ Ace Inhibitors ☐ ARB ☐ ARNI ☐ Beta Blockers ☐ CA++ Channel Blockers ☐ Diuretics ☐ MRA ☐ Other anti-hypertensive med
ACEI administered during hospitalization	○ Yes ○ No ○ ND
ARB administered during hospitalization	○ Yes ○ No ○ ND
ARNI administered during hospitalization	○ Yes ○ No ○ ND
Lipid Lowering Therapy	○ Yes ○ No/ND
Lipid lowering therapy (Select all that apply)	☐ Ezetimibe ☐ Statin ☐ PCSK 9 inhibitor ☐ Other lipid lowering med
Antiplatelet	○ Yes ○ No/ND
Antiplatelet Tx (Select all that apply)	☐ aspirin ☐ P2Y12 Inhibitors ☐ Other Antiplatelet
Anticoagulant	○ Yes ○ No/ND
Anticoagulant Tx (Select all that apply)	☐ Direct Thrombin Inhibitor ☐ Factor Xa Inhibitor ☐ warfarin ☐ Other Anticoagulant
Anti-hyperglycemic	○ Yes ○ No/ND
Anti-hyperglycemic Tx (select all that apply)	☐ DPP-4 Inhibitors ☐ SGLT2 inhibitor ☐ Other injectable/ subcutaneous agent ☐ GLP-1 receptor agonist ☐ Sulfonylurea ☐ Insulin ☐ Thiazolidinedione ☐ Metformin ☐ Other oral agents
Corticosteroid	○ Oral ○ Inhaled ○ None/ND
Immunosuppressive medications (other than steroids)	○ Yes ○ No/ND
Chemo or biological treatment for cancer	○ Yes ○ No/ND
Hydroxychloroquine	○ Yes ○ No/ND

HOSPITALIZATION ***Hospitalization Tab***

During this admission: If multiple events, record Date/Time of first episode.

Documentation of Presenting EKG	○ Yes ○ No/ND
Rhythm	○ Sinus ○ Atrial fibrillation ○ Atrial flutter ○ Other
QTC Value	_____ ms ○ Not Documented
EKG abnormalities	☐ Left Bundle Branch block ☐ Right Bundle Branch block ☐ ST-Segment Depression ☐ ST-Segment Elevation ☐ None of the above ☐ Not Documented

Sustained ventricular arrhythmias	○ Yes ○ No/ND
Date/Time of sustained ventricular arrythmia	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
Atrial Fibrillation	○ Yes ○ No/ND
Date/Time of A-Fib	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
Heart block requiring a temporary or permanent pacemaker	○ Yes ○ No/ND
Date/Time of HB intervention	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
Acute Myocardial Infarction (AMI):	○ STEMI ○ NSTEMI ○ No/ND
STEMI reperfusion	○ Primary PCI ○ Fibrinolytic therapy ○ No reperfusion therapy
NSTEMI type	○ Type 1 MI ○ Type 2 (demand-related) MI ○ ND
Date/time of AMI	____/____/____ ___;____ ○ MM/DD/YYYY only ○ Unknown
Percutaneous Coronary Intervention (PCI)	○ Yes ○ No/ND
Date/Time of PCI	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
LVEF assessment:	○ Yes ○ No/ND
Date of LVEF assessment	____/____/____ ○ Unknown
EF – Quantitative (%)	_____% ○ Not Documented
Is there documentation of an LVEF assessment within the last year?	○ Yes ○ No/ND
Last Known EF	_____% ○ Not Documented
Coronary Angiogram	○ Yes ○ No/ND
Angiogram type	○ Invasive (cath) ○ CTA ○ ND
Number of vessels with ≥ 50% stenosis	○ 0 ○ 2 ○ Left main CAD ○ 1 ○ ≥ 3 ○ Not Documented
Date/Time of cardiac angiogram	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
In-hospital Shock	○ Yes ○ No/ND
Shock type	○ Cardiogenic ○ Mixed ○ Distributive (eg. Sepsis) ○ Other/Unknown
Shock Management (select all that apply)	☐ Inotropes/Vasopressors ☐ Impella or other PVAD ☐ V-A ECMO ☐ IABP ☐ V-V ECMO ☐ Not treated for shock ☐ Not Documented
Date/Time of mechanical circulatory support	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
Date of Inotropes/Vasopressors	____/____/____ ____:____ ○ MM/DD/YYYY only ○ Unknown
New-onset heart failure	○ Yes ○ No/ND
Specify HF:	○ Systolic (HFrEF) ○ Diastolic (HFpEF)
Date of HF	____/____/____ ○ Unknown
Myocarditis	○ Yes ○ No/ND
Diagnostic test	☐ Cardiac biopsy ☐ CT ☐ MRI ☐ Clinical diagnosis

Date of Myocarditis	____/_____/_____ ○ Unknown
Deep Vein Thrombosis (DVT)	○ Yes ○ No/ND
Date of DVT diagnosis	____/_____/_____ ○ Unknown
Pulmonary Embolus (PE)	○ Yes ○ No/ND
Date of PE diagnosis	____/_____/_____ ○ Unknown
Intracardiac Thrombus	○ Yes ○ No/ND
Date of Intracardiac thrombus diagnosis	____/_____/_____ ○ Unknown
Acute Limb Ischemia	○ Yes ○ No/ND
Date of Acute Limb Ischemia	____/_____/_____ ○ Unknown
Clinical bleeding requiring transfusion	○ Yes ○ No/ND
Date of transfusion	____/_____/_____ ○ Unknown
New Hemodialysis or CRRT	○ Yes ○ No/ND
Date of New hemodialysis	____/_____/_____ ○ Unknown
Was hemodialysis or CRRT still required at discharge?	○ Yes ○ No/ND
Ischemic stroke / intracranial hemorrhage	○ Yes ○ No/ND
Initial NIH Stroke Scale	○ _____ ○ Not Documented
Imaging	○ CT ○ MRI ○ Not Documented
Imaging shows acute stroke?	○ Yes ○ No/ND
Stroke treatment	☐ Thrombolysis ☐ Thrombectomy ☐ None/ND
Stroke or intracranial hemorrhage type:	☐ Ischemic Stroke ☐ Intracerebral Hemorrhage ☐ Transient Ischemic Attack (TIA) ☐ Stroke not otherwise specified ☐ Subarachnoid Hemorrhage ☐ Cerebral venous sinus thrombosis ☐ Subdural / epidural Hemorrhage ☐ Not documented
Date of stroke diagnosis	____/_____/_____ ○ Unknown
Seizure	○ Yes ○ No/ND
Date of seizure	____/_____/_____ ○ Unknown
Cardiac Arrest (Code Blue, CPR)	○ Yes ○ No/ND
First documented pulseless rhythm	○ Asystole ○ Pulseless Electrical Activity (PEA) ○ Ventricular Fibrillation (VF) ○ Pulseless Ventricular Tachycardia (VT) ○ Unknown/ND
Date/Time of cardiac arrest	____/_____/_____ _____:____ ○ MM/DD/YYYY only ○ Unknown
Cause of death documented	○ Yes ○ No/ND
Cause of death:	○ AMI ○ Respiratory ○ Arrhythmia ○ Stroke ○ HF ○ Other
Date of death	____/_____/_____ ○ Unknown
PULMONARY / CRITICAL CARE	
Was this patient managed in an ICU	○ Yes ○ No/ND
Date Transferred to ICU	_____/_____/_____ ○ Unknown

Date Transferred out of ICU	_____/_____/_____	○ Unknown
During this hospitalization was the patient intubated or placed on mechanical ventilation?	○ Yes ○ No/ND	
Date mechanical ventilation initiated	_____/_____/_____	○ Unknown
Date mechanical ventilation terminated	_____/_____/_____	○ Unknown
Mechanical ventilation continued at discharge	☐	
Was prone position used during mechanical ventilation?	○ Yes ○ No/ND	

First blood gas obtained after intubation:

PH _____ ☐ PH ND	PaCO2 _____ mmHg ☐ PaCO2 ND	PaO2 _____ mmHg ☐ PaO2 ND
HCO3 _____ mEq/L ☐ HCO3 ND	SpO2 _____ % ☐ SpO2 ND	FiO2 _____ % ☐ FiO2 ND

Was V-V ECMO performed	○ Yes ○ No/ND		
Date V-V ECMO initiated	_____/_____/_____	○ Unknown	
Date V-V ECMO terminated	_____/_____/_____	○ Unknown	

VITALS (Admission)

Height	_____ ○ In ○ cm ☐ ND	**Weight (Admission)**	_____ ○ lbs ○ kgs ☐ ND

Temperature: _____ ☐ C ☐ F ☐ Temp ND	**Heart Rate:** _____ bpm ☐ HR ND	**Blood Pressure:** _____/_____ ☐ BP ND	**Respiratory Rate:** _____bpm ☐ RR ND	**SpO2:** _____ % ☐ SpO2 ND ○ Room air ○ Supplemental O2 ○ Unknown

ADMISSION LABS ***Admission Labs Tab***

Labs (Closest to Admission):	**Hemoglobin:**	_____	○ g/dL	○ g/L		○ Unavailable
	WBC	_____	○ K/uL	○ mcL		○ Unavailable
	Platelet:	_____	○ K/uL			○ Unavailable
	Absolute lymphocyte count:	_____	○ $X10^9$			○ Unavailable
	Serum Creatinine (SCr)	_____	○ mg/dL	○ µmol/L		○ Unavailable
	AST	_____	○ u/L			○ Unavailable
	ALT	_____	○ u/L			○ Unavailable
	Total Bilirubin	_____	○ mg/dL			○ Unavailable
	Bicarbonate	_____	○ mEq/1	○ mmol/L		○ Unavailable
	Troponin	_____	○ ng/mL	○ ug/L	○ ng/L	○ Unavailable
	NT-proBNP	_____	○ pg/mL	○ ng/L		○ Unavailable
	BNP	_____	○ pg/mL	○ pmol/L	○ ng/L	○ Unavailable
	Ferritin	_____	○ ng/mL			○ Unavailable
	CRP	_____	○ mg/L	○ ng/L	○ mg/dL	○ Unavailable
	IL6	_____	○ pg/mL	○ ng/mL		○ Unavailable
	D-dimer	_____	○ ng/mL	○ mg/L	○ ug/mL	○ Unavailable
	Procalcitonin	_____	○ µg/L	○ ng/mL		○ Unavailable

Hemoglobin A1C	_____	○ %		○ Unavailable
SERIAL LABS				***Serial Labs Tab***
Enter the date and the first reported lab value for the corresponding labs in the medical record, if available. Click "Add Instance" to enter lab values for subsequent days of the hospitalization. Serial Labs should be collected for each day of hospitalization.				
Select if serial labs were NOT performed on this patient:	☐			
Serial Labs (Repeat labs): **Date:**	_____/_____/_____			
Troponin	_____	○ ng/mL	○ ug/L	○ ng/L
NT-proBNP	_____	○ pg/mL	○ ng/L	
BNP	_____	○ pg/mL	○ pmol/L	○ ng/L
Ferritin	_____	○ ng/mL		
CRP	_____	○ mg/L	○ ng/L	○ mg/dL
Lymphocyte count	_____	○ $X10^9$		
Procalcitonin	_____	○ µg/L	○ ng/mL	
IL6	_____	○ pg/mL	○ ng/mL	
Serum Creatinine (SCr)	_____	○ mg/dL	○ µmol/L	
D-dimer	_____	○ ng/mL	○ mg/L	○ ug/mL
MEDICATIONS				***Medications Tab***
During this hospitalization, was the patient treated with any of the following medications? (Enter Date of first Administration)				
Corticosteroids during hospitalization?	○ Yes	○ No	○ NC	
Date: Corticosteroids	____/_____/_____		☐ Unknown	
Immunoglobulins during hospitalization?	○ Yes	○ No	○ NC	
Date: Immunoglobulins	____/_____/_____		☐ Unknown	
Convalescent serum during hospitalization?	○ Yes	○ No	○ NC	
Date: Convalescent serum	____/_____/_____		☐ Unknown	
Ritonavir/lopinavir during hospitalization?	○ Yes	○ No	○ NC	
Date: Ritonavir/lopinavir	____/_____/_____		☐ Unknown	
Hydroxychloroquine during hospitalization?	○ Yes	○ No	○ NC	
Date: Hydroxychloroquine	____/_____/_____		☐ Unknown	
Azithromycin during hospitalization?	○ Yes	○ No	○ NC	
Date: Azithromycin	____/_____/_____		☐ Unknown	
Remdesivir during hospitalization?	○ Yes	○ No	○ NC	
Date: Remdesivir	____/_____/_____		☐ Unknown	
Tocilizumab during hospitalization?	○ Yes	○ No	○ NC	
Date: Tocilizumab	____/_____/_____		☐ Unknown	
Other 1 (not listed):	_____			
Date: Other 1	____/_____/_____		☐ Unknown	
Other 2 (not listed):	_____			
Date: Other 2	____/_____/_____		☐ Unknown	

Other 3 (not listed):	_____
Date: Other 3	____/_____/_____ ☐ Unknown
ANTICOAGULATION	
During this hospitalization, was the patient treated with any of the following anticoagulants? (Enter Date of first administration)	
Sub-Q Unfractionated Heparin	○ Yes ○ No ○ NC
Date: Sub-Q UFH	____/_____/_____ ☐ Unknown
Parenteral Unfractionated Heparin	○ Yes ○ No ○ NC
Date: Parenteral UFH	____/_____/_____ ☐ Unknown
Sub-Q LMWH Low Dose	○ Yes ○ No ○ NC
Date: Sub-Q LMWH Low Dose	____/_____/_____ ☐ Unknown
Sub-Q LMWH Intermediate Dose	○ Yes ○ No ○ NC
Date: Sub-Q LMWH Intermediate Dose	____/_____/_____ ☐ Unknown
Sub-Q LMWH Full Therapeutic Dose	○ Yes ○ No ○ NC
Date: Sub-Q LMWH Full Therapeutic Dose	____/_____/_____ ☐ Unknown
Argatroban	○ Yes ○ No ○ NC
Date: Argatroban	____/_____/_____ ☐ Unknown
Bivalirudin	○ Yes ○ No ○ NC
Date: Bivalirudin	____/_____/_____ ☐ Unknown
DOAC	○ Yes ○ No ○ NC
Specify DOAC given	○ apixaban (Eliquis) ○ dabigatran (Pradaxa) ○ edoxaban (Savaysa) ○ rivaroxaban (Xarelto) ○ Not Documented
Date: DOAC	____/_____/_____ ☐ Unknown
Warfarin	○ Yes ○ No ○ NC
Date: Warfarin	____/_____/_____ ☐ Unknown
Anticoagulant at Discharge:	
Was the patient discharged on an anticoagulant	○ Yes ○ No ○ NC
If yes, select anticoagulant prescribed	○ Direct Thrombin Inhibitor ○ Factor Xa Inhibitor ○ warfarin ○ Other Anticoagulant _____
SOCIAL DETERMINANTS OF HEALTH	***Social Determinants of Health Tab***
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 that apply.	☐ Living Situation/ Housing ☐ Food ☐ Utilities ☐ Personal Safety ☐ Financial Strain ☐ Employment ☐ Education ☐ Mental Health ☐ Substance Use ☐ Transportation Barriers ☐ None