August 2021

FORM SELECTION **Legend: Elements in bold are required**

HF	**Patient ID:**

DEMOGRAPHICS TAB

Demographics

Sex	○ Male ○ Female ○ Unknown
Patient Gender Identify	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other. _____ ○ Did not disclose.
Patient-Identified Sexual Orientation	○ Straight or heterosexual ○ Lesbian or gay ○ Queer, pansexual, and/or questioning ○ Something else; please specify. _____. ○ Don't know ○ Declined to answer
Date of Birth	___/___/_____ (MM/DD/YYYY) **Patient Postal Code** _____ - _____
Payment Source	❑ Medicare Title 18 ❑ Medicaid Title 19 ❑ Medicare – Private/HMO/PPO/Other ❑ Medicaid – Private/HMO/PPO/Other ❑ Private/HMO/PPO/Other ❑ VA/CHAMPVA/Tricare ❑ Self-pay/No Insurance ❑ Other/Not Documented/UTD
External Tracking ID	_____

Race and Ethnicity

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	❍ Yes	❍ No/UTD
Select Hispanic Origin Group(s):	❑ Mexican, Mexican American, Chicano/a ❑ Cuban ❑ Puerto Rican ❑ Another Hispanic, Latino, or Spanish Origin	

ADMISSIONS TAB

Arrival and Admission

Internal Tracking ID	_____	Physician/Provider NPI	_____
Arrival Date/Time	___/___/_____ ___: ___	**Admission Date**	___/___/_____
Transferred in (from another ED?)	❍ Yes	❍ No	
Point of Origin for Admission or Visit	❍ 1. Non-Healthcare Facility Point of Origin ❍ 2. Clinic ❍ 4. Transfer from a Hospital (Different Facility)	❍ 6. Transfer from another Health Care Facility ❍ 7. Emergency Room ❍ 9. Information not available	

	❍ 5. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	❍ F. Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
Discharge Date/Time	___/___/_____ ___: ____	

Medical History

Medical History (Select all that apply):

- ❑ Anemia
- ❑ Atrial Fib (chronic or recurrent)
- ❑ Atrial Flutter (chronic or recurrent)
- ❑ CAD
- ❑ CardioMEMs (implantable hemodynamic monitor)
- ❑ COPD or Asthma
- ❑ CRT-D (cardiac resynchronization therapy with ICD)
- ❑ CRT-P (cardiac resynchronization therapy-pacing only)
- ❑ CVA/TIA
- ❑ Depression
- ❑ Diabetes
- ❑ Dialysis (chronic)
- ❑ Emerging Infectious Disease
  - ❍ **MERS**
  - ❍ **SARS-COV-1**
  - ❍ **SARS-COV-2 (COVID-19)**
  - ❍ **Other infectious respiratory pathogen**
- ❑ Familial hypercholesterolemia
- ❑ Heart failure
- ❑ Heart Transplant
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ ICD only
- ❑ Kidney Transplant
- ❑ Left Ventricular Assist Device
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Prior CABG
- ❑ Prior MI
- ❑ Prior PCI
- ❑ Renal insufficiency - chronic (SCr>2.0)
- ❑ Sleep-Disordered Breathing
- ❑ TAVR
- ❑ TMVR
- ❑ Tricuspid Valve procedure
- ❑ Valvular Heart Disease
- ❑ Ventricular assist device

❑ No Medical History

Diabetes Type:	❍ Type 1 ❍ Type 2 ❍ ND
Diabetes Duration:	❍ <5 years ❍ 5 - <10 years ❍ 10 - <20 years ❍ >=20 years ❍ Unknown
Sleep-Disordered Breathing Type:	❑ Obstructive ❑ Central ❑ Mixed ❑ Unknown/Not Documented
Equipment used at home:	❑ O2 ❑ CPAP ❑ Adaptive Servo-Ventilation ❑ None ❑ Unknown/Not Documented

History of cigarette smoking? (In the past 12 months)	❍ Yes	❍ No
History of vaping or e-cigarette use in the past 12 months?	❍ Yes	❍ No/ND

Heart Failure History Etiology: Check if history of:	❑ Ischemic/CAD		❑ Non-Ischemic ❑ Alcohol/Other Drug ❑ Chemotherapy ❑ Familial ❑ Hypertensive ❑ Postpartum ❑ Viral ❑ Other Etiology ❑ Unknown Etiology		
Known history of HF prior to this admission?	❍ Yes		❍ No		
# of hospital admissions in past 6 mo. for HF:	❍ 0	❍ 1	❍ 2	❍ >2	❍ Unknown

❑ Patient Listed for Transplant

DIAGNOSIS — *Admission Tab*

Heart Failure Diagnosis	❍ Heart Failure, primary diagnosis, with CAD ❍ Heart Failure, primary diagnosis, no CAD ❍ Heart Failure, secondary diagnosis		
Atrial Fibrillation (At presentation or during hospitalization)	❍ Yes	❍ No	❑ Documented New Onset?
Atrial Flutter (At presentation or during hospitalization)	❍ Yes	❍ No	❑ Documented New Onset?
New Diagnosis of Diabetes	❍ Yes	❍ No	❍ Not Documented
Basis for Diagnosis	❑ HbA1c ❑ Oral Glucose Tolerance		❑ Fasting Blood Sugar ❑ Test Other
Characterization of HF at admission or when first recognized	❍ Acute Pulmonary Edema ❍ Dizziness/Syncope ❍ Dyspnea ❍ ICD Shock/Sustained Ventricular Arrhythmia		❍ Pulmonary Congestion ❍ Volume overload/Weight Gain ❍ Worsening fatigue ❍ Other
Other Conditions Contributing to HF Exacerbation *Select all that apply*	❑ Arrhythmia ❑ Pneumonia/respiratory process ❑ Noncompliance - medication		❑ Worsening Renal Failure ❑ Ischemia/ACS ❑ Uncontrolled HTN ❑ Noncompliance – Dietary ❑ Other
Active bacterial or viral infection at admission or during hospitalization	❑ None/ND ❑ Bacterial infection ❑ Emerging Infectious Disease ❑ SARS-COV-1 ❑ SARS-COV-2 (COVID-19) ❑ MERS ❑ Other infectious respiratory pathogen ❑ Influenza ❑ Seasonal Cold ❑ Other Viral Infection		

MEDICATIONS AT ADMISSION — *Admission Tab*

Medications Used Prior to Admission: *[Select all that apply]*

❑ Patient on no meds prior to admission ❑ ACE Inhibitor ❑ Aldosterone Antagonist ❑ Angiotensin receptor blocker (ARB) ❑ Angiotensin Receptor Neprilysin Inhibitor (ARNI) ❑ Antiarrhythmic ❑ Anticoagulation Therapy ❍ Warfarin ❍ Direct Thrombin Inhibitor ❍ Factor Xa Inhibitor ❍ Other ❑ Antiplatelet agent (excluding aspirin) ❑ Aspirin	❑ Beta-Blocker ❑ Ca channel blocker ❑ Anti-hyperglycemic medications: ❑ DPP-4 Inhibitors ❑ GLP-1 receptor agonist ❑ Insulin ❑ Metformin ❑ Sulfonylurea ❑ Thiazolidinedione ❑ Other Oral Agents ❑ Other injectable/subcutaneous agents	❑ Digoxin ❑ Diuretic ❍ Thiazide/Thiazide-like ❍ Loop ❑ Hydralazine ❑ Ivabradine ❑ Lipid lowering agent (Any) ❍ Statin ❍ Other Lipid lowering agent ❑ Nitrate ❑ Omega-3 fatty acid supplement ❑ Renin Inhibitor ❑ SGLT2 Inhibitor ❑ Vericiguat ❑ Other medications prior to admission

Symptoms (Closest to Admission) *Select all that apply*	❍ Chest Pain ❍ Orthopnea ❍ Palpitations	❍ Dyspnea at rest ❍ Fatigue ❍ PND	❍ Dyspnea on Exertion ❍ Decreased appetite/early satiety ❍ Dizziness/lightheadedness/syncope

EXAMS/LABS AT ADMISSION — *Admission Tab*

Height	_____ ❍ inches ❍ cm	❍ Height ND
Weight	_____ ❍Lbs. ❍Kgs.	❍ Weight ND

Waist Circumference	_____ ❍ inches ❍ cm						❍ Waist Circumference ND
BMI	_____ (Automatically Calculated)						
Systolic	_____						
Diastolic	_____						
❍ BP ND							
Respiratory Rate (breaths per minute)	_____						
JVP (cm):	❍ Yes	❍ No	❍ Unknown	JVP Value _____			
Rales:	❍ Yes	❍ No	❍ Unknown	Rales Value _____	❍ <1/3	❍ ≥1/3	❍ N/A
Lower Extremity Edema	❍ Yes	❍ No	❍ Unknown	Lower Extremity Value	❍ Trace ❍ 1+ ❍ 2+ ❍ 3+ ❍ 4+ ❍ N/A		
Lipids	TC: _____ mg/dL		HDL: _____ mg/dL	LDL: _____ mg/dL	TG: _____ mg/dL		❑ Lipids Not Available

Labs (Closet to Admission)					
Sodium (Na+)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Not Available
Hgb	_____	❍ g/dL	❍ g/L		❑ Not Available
Albumin	_____	❍ g/dL	❍ g/L		❑ Not Available
BNP	_____	❍ pg/mL	❍ pmol/L	❍ ng/L	❑ Not Available
NT-proBNP	_____	❍ pg/mL	❍ ng/L		❑ Not Available
Serum Creatinine	_____	❍ mg/dL	❍ µmol/L		❑ Not Available
BUN	_____	❍ mg/dL	❍ µmol/L		❑ Not Available
Troponin (Peak)	_____ ❍ng/mL ❍ug/L	❍ T ❍ I ❍ hs-I ❍ hs-T	❍ Normal ❍ Abnormal		❑ Not Available
Potassium (K+)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Not Available
Ferritin (ng/mL)	_____				
HbA1C	_____ %		❑ Not Available		
Fasting Blood Glucose (mg/dL)	_____		❑ Not Available		
EKG QRS Duration (ms)	_____		❑ Not Available		
EKG QRS Morphology	❍ Normal ❍ LBBB	❍ RBBB ❍ NS-IVCD	❍ Paced ❍ Not Available		

CLINICAL CODES			***Clinical Codes Tab***
ICD-10-CM Principal Diagnosis Code	_____		
ICD-10-CM Other Diagnoses Codes	1.	2.	3.
	4.	5.	6.
	7.	8.	9
	10.	11.	12.
ICD-10-PCS Principal Procedure Code	_____	Date: __/__/_____	❍ Date UTD
ICD-10-PCS Other Principal Procedure Codes	1.	Date: __/__/_____	❍ Date UTD

	2.	Date: __/__/_____	❍ Date UTD
	3.	Date: __/__/_____	❍ Date UTD
	4.	Date: __/__/_____	❍ Date UTD
	5.	Date: __/__/_____	❍ Date UTD

IN-HOSPITAL *In-Hospital Tab*

In-Hospital Care

Procedures

- ❑ No Procedures
- ❑ Cardiac Cath/Coronary Angiography
- ❑ CardioMEMs (implantable hemodynamic monitor)
- ❑ Coronary Artery Bypass Graft
- ❑ CRT-P (cardiac resynchronization therapy-pacing only)
- ❑ Dialysis or Ultrafiltration unspecified
- ❑ ICD only
- ❑ Mechanical Ventilation
- ❑ PCI
- ❑ Right Cardiac Catheterization
- ❑ TMVR
- ❑ Tricuspid Valve Procedure
- ❑ Atrial Fibrillation Ablation or Surgery
- ❑ Cardiac Valve Surgery
- ❑ Cardioversion
- ❑ CRT-D (cardiac resynchronization therapy with ICD
- ❑ Dialysis
- ❑ Intra-aortic Balloon Pump
- ❑ Left Ventricular Assist Device
- ❑ Pacemaker
- ❑ PCI with stent
- ❑ Stress Testing
- ❑ TAVR
- ❑ Transplant (Heart)
- ❑ Ultrafiltration

EF - Quantitative	_____ %	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
EF - Qualitative	❍ Not Applicable ❍ Normal or mild dysfunction ❍ Qualitative moderate/severe dysfunction ❍ Performed/results not available ❍ Planned after discharge ❍ Not performed	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
Mitral Valve Regurgitation (MR) on echocardiogram	❍ Not applicable ❍ None ❍ Trace/trivial ❍ 1+ or Mild ❍ 2+ or Moderate ❍ 3+ or Moderate to Severe ❍ 4+ or Severe		
Documented LVSD?	❍ Yes		❍ No
LVF Assessment?	❍ Yes	❍ No	❍ Not done, Reason Documented
Oral Medications during hospitalization *Select all that apply*	❑ None ❑ ARNI ❑ ARB	❑ Aldosterone Antagonist ❑ Hydralazine Nitrate	❑ ACE Inhibitor ❑ Beta Blocker ❑ SGLT2 Inhibitor
IV Iron	❑ Yes	❑ No	❑ Not documented
Parenteral Therapies during hospitalization *Select all that apply*	❑ None ❑ Dopamine ❑ Dobutamine ❑ Iron	❑ Loop Diuretics ❍ Intermittent Bolus ❍ Continuous Infusion ❑ Milrinone ❑ Nesiritide Nitroglycerine ❑ Other IV Vasodilator ❑ Vasopressin antagonist	
Was the patient ambulating at the end of hospital day 2?	❍ Yes	❍ No	❍ Not Documented
Was DVT prophylaxis initiated by the end of hospital day 2?	❍ Yes	❍ No/Not Documented	❍ Contraindicated
DVT prophylaxis type	❑ Low dose unfractionated heparin (LDUH) ❑ Low molecular weight heparin (LMWH) ❑ Warfarin ❑ Other	❑ Factor Xa Inhibitor ❑ Direct thrombin inhibitor ❑ Venous foot pumps (VFP) ❑ Intermittent pneumatic compression devices (IPC)	

Was DVT or PE (pulmonary embolus) documented?	❍ Yes	❍ No/Not Documented

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 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 or if medically contraindicated ❍ Vaccine not available ❍ None of the above/Not Documented/UTD
COVID-19 Date	_____/_____/_____ ❑ Unknown
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND
Pneumococcal Vaccination	❍ Pneumococcal vaccine was given during this hospitalization ❍ Pneumococcal vaccine was received in the past, not during this hospitalization ❍ Documentation of patient's refusal of pneumococcal vaccine ❍ Allergy/sensitivity or if medically contraindicated to pneumococcal vaccine ❍ None of the above/Not Documented/UTD

DISCHARGE INFORMATION ***Discharge Tab***

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:	❍ Skilled Nursing Facility (SNF) ❍ Inpatient Rehabilitation Facility (IRF) ❍ Long Term Care Hospital (LTCH)	❍ Intermediate Care Facility (ICF) ❍ Other
Skilled Nursing Facility	_____ ❑ ND	

If Home, special discharge circumstances:	❍ Home Health Care ❍ Homeless	❍ International ❍ Prison/Incarcerated	❍ None/UTD
Primary Cause of Death	❍ Cardiovascular	❍ Non-Cardiovascular	❍ Unknown
If Cardiovascular:	❍ Acute Coronary Syndrome	❍ Worsening Heart Failure	❍ Sudden Death ❍ Other
When is the earliest physician/APN/PA documentation of comfort measures only?		❍ Day 0 or 1 ❍ Day 2 or after	❍ Timing unclear ❍ Not Documented
Symptoms (closest to discharge)	❍ Worse ❍ Unchanged	❍ Better, Symptomatic ❍ Better, Asymptomatic	❍ Unable to determine

Vital Signs (closest to Discharge)	Weight	_____ ❍ Lbs. ❍ Kgs.					❍ Not Documented
	Heart Rate (bpm)	_____					❍ Not Documented
	Systolic						❍ Not Documented
	Diastolic						
Exam (Closest to Discharge)	JVP:	❍ Yes	❍ No	❍ Unknown	If Yes, _____ cm		
	Rales:	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ <1/3	❍ ≥1/3	❍ N/A
	Lower Extremity Edema	❍ Yes ❍ No	❍ Unknown	If Yes,	❍ Trace ❍ 1+	❍ 2+ ❍ 3+	❍ 4+ ❍ N/A
	Sodium (Na+)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable	

Labs (Closest to Discharge)	BNP	_____	❍ pg/mL	❍ pmol/L	❍ ng/L	❑ Unavailable
	Serum Creatinine	_____		❍ mg/dL	❍ µmol/L	❑ Unavailable
	BUN	_____		❍ mg/dL	❍ µmol/L	❑ Unavailable
	eGFR (mL/min)					
	NT-proBNP (pg/mL)	_____			❑ Not Documented	
	Potassium (K+)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Unavailable
	Urinary Albumin (mg/dL)					
	Urinary Creatinine (mg/dL)					
	Urinary Albumin-to-Creatinine Ratio (UACR) (mg/g)					
	Ferritin (mg/mL)	_____	❑ Unavailable			

DISCHARGE MEDICATIONS	***Discharge Tab***		
ACE Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ACE Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ACEI:	❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other ❑ Patient Reason ❑ System Reason		
ARB Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARB Medication/ Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ARB:	❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other ❑ Patient Reason ❑ System Reason		
ARNI Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARNI Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	❑ ACE inhibitor use within the prior 36 hours ❑ Allergy ❑ Hyperkalemia ❑ Hypotension ❑ Other medical reasons ❑ Patient Reason ❑ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women ❑ System Reason		
Reasons for not switching to ARNI at discharge:	❍ Yes ❍ No	❍ ARNI was prescribed at discharge	

If Yes,	❍ New Onset Heart Failure ❍ Not previously tolerating ACEI/ARB	❍ NYHA Class I ❍ NYHA Class IV	
Beta Blocker Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Beta Blocker Class	❍ Evidence-Based Beta Blocker ❍ Non-Evidence-Based Beta Blocker ❍ Unknown Class		
Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	❑ Asthma ❑ Fluid Overload ❑ Low Blood Pressure ❑ Patient recently treated with an intravenous positive inotropic agent ❑ Patient Reason ❑ System Reason		
Beta Blocker **Medication**/Dosage/Frequency	**Medication**:	Dosage:	Frequency:
SGLT2 Inhibitor Prescribed?	❍ Yes ❍ No ❍ NC		
	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:	❑ Patient currently on dialysis ❑ Ketoacidosis ❑ Known hypersensitivity to the medication ❑ Type I diabetes (not approved for use in patients with Type I diabetes due to increased risk of ketoacidosis) ❑ Patient Reason ❑ System Reason ❑ Other		
Aldosterone Antagonist Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Aldosterone Antagonist Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Was there a dose increase since prior to admission?	❍ Yes ❍ No/ND		
Potassium ordered or planned after discharge?	❍ Yes ❍ No/ND		
Renal function test scheduled	❍ Yes ❍ No/ND		
Contraindications or Other Documented Reason(s) for Not Providing Aldosterone Antagonist at Discharge	❑ Allergy due to aldosterone receptor antagonist ❑ Hyperkalemia ❑ Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women. ❑ Other medical reasons ❑ Other contraindications ❑ Patient Reason ❑ System Reason		
Anticoagulation Therapy Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Anticoagulation Therapy Class	❑ Warfarin ❑ Direct Thrombin Inhibitor	❑ Factor Xa Inhibitor ❑ Other	
	Medication:	Dosage:	Frequency:
If Yes, Contraindication(s):	❑ Contraindicated ❑ Other ❑ Intolerance ❑ Not Eligible ❑ Allergy to or complication r/t anticoagulation therapy (hx or current) ❑ Patient/Family Refused ❑ Risk for bleeding or discontinued due to bleeding		

	❑ Serious side effect to medication ❑ Terminal illness/Comfort Measures Only		
Hydralazine Nitrate Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	❑ Contraindicated ❑ Other ❑ Intolerance ❑ Not Eligible ❑ Medical Reason ❑ Patient Reason ❑ System Reason		
Anti-hyperglycemic Prescribed?	❍ Yes ❍ No ❍ NC		
Antihyperglycemic Class/Medication	Class:	Medication:	
	Class:	Medication:	
	Class:	Medication:	
ASA Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ASA Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Other Antiplatelets Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Other Antiplatelets Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Clopidogrel Prescribed?	❍ Yes ❍ No ❍ NC		
Clopidogrel Dosage/Frequency	Dosage:	Frequency:	
Ivabradine Prescribed?	❍ Yes ❍ No ❍ NC		
Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:	❑ Contraindicated ❑ Intolerance ❑ Allergy to Ivabradine ❑ Not Eligible ❑ NYHA class I or IV ❑ New Onset of HF ❑ Not in sinus rhythm ❑ Patient 100% atrial or ventricular paced	❑ Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated ❑ Other Medical Reasons ❑ Patient Reasons ❑ System Reasons	
Lipid Lowering Medication Prescribed?	❍ Yes ❍ No ❍ NC		
Lipid Lowering Class/Medication/Dosage/Frequency	Class:	Medication:	Dosage: Frequency:
	Class:	Medication:	Dosage: Frequency:
	Class:	Medication:	Dosage: Frequency:
Omega-3 Prescribed?	❍ Yes ❍ No ❍ NC		
Other Medications			
❑ Antiarrhythmic (Discharge) ❑ Amiodarone ❑ Dofetilide ❑ Sotalol ❑ Other antiarrhythmics	❑ Ca Channel Blocker (Discharge) ❑ Digoxin (Discharge) ❑ Diuretic (Discharge) ❑ Loop Diuretic	❑ Nitrate (Discharge) ❑ Ranolazine ❑ Renin Inhibitor (Discharge) ❑ Vericiguat ❑ Other Anti-Hypertensive	

	❑ Thiazide Diuretic	❑ Other medications at discharge

OTHER THERAPIES			*Discharge Tab*
ICD Counseling?	❍ Yes	❍ No	
Reason for not counseling	❍ Yes	❍ No	
Documented Medical Reason(s) for Not Counseling?	❑ ICD or CRT-D device in patient ❑ Multiple or significant comorbidities	❑ Limited Life Expectancy ❑ other reasons not eligible for ICD (e.g. EF>35%, new onset HF) ❑ Other reasons for not counseling	
ICD Placed or Prescribed?	❍ Yes	❍ No	
Reason(s) for Not Placing or Prescribing?	❍ Yes	❍ No	
Documented Reason(s) for Not Placing or Prescribing ICD Therapy?	❑ Contraindications ❑ Not receiving optimal medical therapy ❑ Patient Reason ❑ System Reason	❑ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset HF	
CRT-D Placed or Prescribed?		❍ Yes	❍ No
CRT-P Placed or Prescribed?		❍ Yes	❍ No
Reason for not Placing or Prescribing?		❍ Yes	❍ No
Documented Reason(s) for Not Placing or Prescribing CRT Therapy?	❑ Contraindications ❑ Not receiving optimal medical therapy ❑ Not NYHA functional Class III or ambulatory Class IV ❑ Patient Reason	❑ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF ❑ System Reason	

RISK INTERVENTIONS			*Discharge Tab*
Smoking Cessation Counseling Given	❍ Yes	❍ No	
Smoking Cessation Therapies Prescribed (select all that apply)	❑ Treatment Not Specified ❑ Counseling Only ❑ Over the Counter Nicotine Replacement Therapy	❑ Prescription Medications ❑ Other	

DISCHARGE INSTRUCTIONS					*Discharge Tab*
Activity Level	❍ Yes	❍ No	Diet (Salt restricted)	❍ Yes	❍ No
Follow-up	❍ Yes	❍ No	Medications	❍ Yes	❍ No
Symptoms Worsening	❍ Yes	❍ No	Weight Monitoring	❍ Yes	❍ No
Follow-up Visit Scheduled	❍ Yes	❍ No	**Date/Time of first follow-up visit:**	___/___/_____ ___:____	
Location of first follow-up visit:			❍ Office Visit ❍ Home Health Visit	❍ Telehealth ❍ Not Documented	
Medical or Patient Reason for no follow-up appointment being scheduled?			❍ Yes	❍ No	
Follow-up Phone Call Scheduled	❍ Yes	❍ No	Date/Time of first follow-up phone call:	___/___/_____	
Follow-up appointment scheduled for diabetes management?	❍ Yes	❍ No	Date of diabetes management follow-up visit:	___/___/_____	

OTHER RISK INTERVENTIONS				*Discharge Tab*
TLC (Therapeutic Lifestyle Change) Diet	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Obesity Weight Management	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Activity Level/Recommendation	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referred to Outpatient Cardiac Rehab Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Anticoagulation Therapy Education	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Was Diabetes Teaching provided?	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable

PT/INR Planned Follow-Up	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referral to Sleep Study	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Referral to Outpatient HF Management Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Outpatient HF Management Program Type(s):	❑Telemanagement		❑ Home Visit	❑ Clinic-based
Referral to AHA My HF Guide/Heart Failure Interactive Workbook	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Provision of at least 60 minutes of Heart Failure Education by a qualified educator	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advance Directive Executed	❍ Yes		❍ No	

POST DISCHARGE TRANSITION			***Discharge Tab***
Care Transition Record Transmitted	❍ By the seventh post-discharge day ❍ Exists, but not transmitted by the seventh post-discharge day ❍ No Care Transition Record/UTD		
Care Transition Record Transmitted Includes	❑ All were included *(Check all yes)*		
	Discharge Medications	❍ Yes	❍ No
	Follow-up Treatment(s) and Service(s) Needed	❍ Yes	❍ No
	Procedures Performed During Hospitalization	❍ Yes	❍ No
	Reason for Hospitalization	❍ Yes	❍ No
	Treatment(s)/Service(s) Provided	❍ Yes	❍ No

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):	❑ None ❑ Education ❑ Employment ❑ Financial Strain ❑ Food ❑ Living Situation/Housing	❑ Mental Health ❑ Personal Safety ❑ Substance Abuse ❑ Transportation Barriers ❑ Utilities

ADMIN/ACHF		***Admin/ACHF Tab***
Race (TJC)	❍ American Indian or Alaskan Native ❍ Black of African American ❍ White ❍ Asian (2020)/Asian or Pacific Islander (2021) ❍ Native Hawaiian or Pacific Islander ❍ UTD	
What is the patient's source of payment for this episode of care?	❍ Medicare	❍ Non-Medicare
Was this Case Sampled?	❍ Yes	❍ 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)?	❍ Yes	❍ No
Registry used concurrently, retrospectively, or combination	❍ Concurrently ❍ Retrospectively ❍ Combination	
Standardized order sets used?	❍ Yes	❍ No
Patient adherence contract/compact used?	❍ Yes	❍ No
Discharge checklist used?	❍ Yes	❍ No