

Facility Name _____ PFI Number
Sequence Number

I. Patient Information

Patient Name _____ (last) _____ (first) _____
 Medical Record Number
 Social Security Number - -
 Age in Years
 Date of Birth
 Sex Male Female Ethnicity Hispanic Non-Hispanic Race White Black Native American Asian Pacific Islander Other
 Residence Code (see instructions)
 Hospital Admission Date
 Primary payer Medicaid Transfer PFI

II. Procedural Information

Hospital That Performed Diagnostic Cath
 Hospital Name _____ PFI
 Primary Physician Performing Operation
 Name _____ License Number
 Date of Surgery
 Time at Start of Procedure : in military time
 Prior Surgery This Admission Yes No Date
 Cardiac Procedures This OR Visit
 SCAC Code (see instructions) 1 2 3 4
 CABG Information
 Total Conduits
 Arterial Conduits
 Distal Anastomoses
 Minimally Invasive No Yes
 Converted to Standard Incision
 Converted from off pump to on pump
 Entire procedure off pump
 IMA Grafting Never This OR Visit Prior to this OR Visit
 Within 24 hours Post-op
 Extubation
 Extubation Contraindicated
 Beta Blocker Use
 Beta Blocker Contraindicated

III. Pre-Op Surgical Risk Factors (answer all that apply)

Surgical Priority Elective Urgent Emergency
 Height cm
 Weight kg
 Ejection Fraction %
 Measure
 CCS Functional Class (see instructions)
 Creatinine mg/dl
 Vessels Diseased (check all that apply)
 LMT 50 - 69% 70 - 89% 90 - 100%
 Prox LAD or Major Diag 50 - 69% 70 - 100%
 Mid/Dist LAD or Major Diag 50 - 69% 70 - 100%
 RCA or PDA 50 - 69% 70 - 100%
 LCX or Large Marg 50 - 69% 70 - 100%

III. Pre-Op Surgical Risk Factors, continued (answer all that apply)

Valve Disease – This Section is Required for Valve Patients

	Aortic	Mitral	Tricuspid	Enter
Stenosis:	_	_	_	0 – None
Incompetence:	_	_	_	1 – Mild
				2 – Moderate
				3 – Severe

0 None of the pre-op risk factors listed below were present

Previous Open Heart Operations

- 1 One
- 2 Two
- 3 Three or more

Previous MI (most recent)

- 4 <6 hours
- 5 6-23 hours
- 6 |_| days
(use 21 for 21 or more)
- 7 Check here if Transmural MI

- 9 Cerebrovascular Disease
- 10 Peripheral Vascular Disease

Hemodynamic Instability at time of procedure

- 12 Unstable
- 13 Shock

- | | | |
|---|--|---|
| 18 <input type="checkbox"/> Congestive Heart Failure, Current | 27 <input type="checkbox"/> Renal Failure, dialysis | 39 <input type="checkbox"/> Any Previous Organ Transplant |
| 19 <input type="checkbox"/> Congestive Heart Failure, Past | 28 <input type="checkbox"/> Immune System Deficiency | 40 <input type="checkbox"/> Heart Transplant Candidate |
| 20 <input type="checkbox"/> Malignant Ventricular Arrhythmia | 30 <input type="checkbox"/> Emergency Transfer to OR after Dx Cath | 61 <input type="checkbox"/> Cardiomegaly |
| 21 <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | 31 <input type="checkbox"/> Emergency Transfer to OR after PCI | 62 <input type="checkbox"/> Active Endocarditis |
| 23 <input type="checkbox"/> Extensive Aortic Atherosclerosis | 32 <input type="checkbox"/> Previous PCI, this admission | |
| 24 <input type="checkbox"/> Diabetes requiring medication | 33 <input type="checkbox"/> PCI before this admission | |
| 25 <input type="checkbox"/> Hepatic Failure | 38 <input type="checkbox"/> Stent Thrombosis | |

IV. Major Events Following Operation (answer all that apply)

- | | |
|---|---|
| 0 <input type="checkbox"/> None | 5 <input type="checkbox"/> Bleeding Requiring Reoperation |
| 1 <input type="checkbox"/> Stroke (new neurological deficit) Intra-Op to 24 hrs | 8 <input type="checkbox"/> Sepsis or Endocarditis |
| 1A <input type="checkbox"/> Stroke (new neurological deficit) over 24 hrs | 9 <input type="checkbox"/> G-I Bleeding, Perforation or Infarction |
| 2 <input type="checkbox"/> Transmural MI (new Q waves) | 10 <input type="checkbox"/> Renal Failure |
| 4 <input type="checkbox"/> Deep Sternal Wound Infection (bone-related) | 13 <input type="checkbox"/> Respiratory Failure |
| | 14 <input type="checkbox"/> Unplanned Cardiac Reoperation or interventional procedure |

V. Discharge Information

Medications on Discharge

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Contraindicated |
| <input type="checkbox"/> Clopidogrel | |
| <input type="checkbox"/> Beta Blocker Use | <input type="checkbox"/> Contraindicated |
| <input type="checkbox"/> Lipid Lowering Medication | <input type="checkbox"/> Contraindicated |

Discharged Alive to:

- 11 Home
- 12 Hospice
- 13 Acute Care Facility
- 14 Skilled NH
- 15 Inpatient Physical Medicine & Rehab
- 19 Other (specify) _____

Died in:

- 2 Operating Room
- 3 Recovery Room
- 4 Critical Care Unit
- 5 Medical/Surgical Floor
- 6 In Transit to Other Facility
- 8 Elsewhere in Hospital (specify) _____

Hospital Discharge Date

_	_	_	_	_	_	_	_	_	_
m	d	y							

30 Day Status:

- 1 Live
- 2 Dead
- 9 Unknown

VI. Person Completing Report

Name _____ Referring Physician _____