

New Jersey Cardiac Catheterization Data Registry, Version 2.0

(Please report data only for patients 16 years or older.)

A. ADMINISTRATIVE

1. Facility Code: _____ 2. Facility Name: _____
 3. Procedure Type (Choose only one):
 Diagnostic Cath. Only Coronary Intervention Only Diagnostic Cath. and Coronary Intervention

B. DEMOGRAPHICS

4. Last Name: _____ 5. First Name: _____ 6. MI: _____
 7. SSN: _____ - _____ - _____ 8. Medical Record No.: _____
 9. Date of Birth: _____ / _____ / _____ 10. Gender: Male Female
 11. Race (Choose only one):
 White Black Asian Native American/Alaska Native Hawaiian/Other Pacific Islander Other
 12. Hispanic or Latino Origin? Yes No 13. Patient Zip Code: _____

C. ADMISSION

14. Admission Date: _____ / _____ / _____
 15. Admission Status:
 Outpatient Referral ED Transfer–Acute Care Facility Transfer–Non-Acute Care Facility Other
 16. Inpatient Status: Yes No
 17. Insurance Payor:
 BC/BS HMO Medicare Tricare (CHAMPUS) Other
 Commercial Medicaid Self Pay Uninsured/Indigent

| ADMISSION/LAB MEDICATIONS (Administered on admission up to and including all cath. lab visits): | | | | | |
|---|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Medication | Yes | No | Medication | Yes | No |
| 18. Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | 25. Platelet Agg. Inhib. | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Beta Blocker | <input type="checkbox"/> | <input type="checkbox"/> | 26. Renal Adj. Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Coumadin | <input type="checkbox"/> | <input type="checkbox"/> | 27. Lipid Lowering Agents | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Glycoprotein IIb/IIIa Inhibitors | <input type="checkbox"/> | <input type="checkbox"/> | 28. Thrombin Inhibitors | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Heparin Low Molecular Weight | <input type="checkbox"/> | <input type="checkbox"/> | 29. Thrombolytics | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Heparin Unfract. | <input type="checkbox"/> | <input type="checkbox"/> | 30. Other | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. ACEI/ARB | <input type="checkbox"/> | <input type="checkbox"/> | → 31. If Other, Specify: _____ | | |

D. HISTORY AND RISK FACTORS

32. Height: _____ cm. 33. Weight: _____ kg.
 34. Previous MI (>7 days)? Yes No 35. CHF (Previous History)? Yes No
 36. Most recent EF: _____ % 37. EF Method: Not Done LVG Radionuclide Estimate Echo
 38. Diabetes: Yes No → 39. If Yes, Diabetes Control: None Insulin Oral Diet
 40. Renal Failure (Previous History)? Yes No → 41. If Yes, Dialysis? Yes No
 42. Cerebrovascular Disease? Yes No → 44. If Yes, When? ≤2 weeks >2 weeks
 43. Cerebrovascular Accident? Yes No 46. Chronic Lung Disease? Yes No
 45. Peripheral Vascular Disease? Yes No 48. Hypertension? Yes No
 47. Dyslipidemia? Yes No 50. Previous Diagnostic Cath.? Yes No
 49. Tobacco History? Never Current Former → 52. If Yes, Date of most recent: _____ / _____ / _____
 51. Previous PCI? Yes No → 54. If Yes, Date of most recent: _____ / _____ / _____
 53. Previous CABG? Yes No 56. Previous Cardiac Transplant? Yes No
 55. Previous Valve Surgery? Yes No

**New Jersey Cardiac Catheterization Data Registry
(Continued)**

E. CURRENT CLINICAL STATUS

57. CHF (Current Status)? Yes No
58. NYHA: I II III IV
59. Cardiogenic Shock? Yes No
60. Hemodynamically Stable? Yes No
61. Hypotension? Yes No
62. Last Creatinine: _____ mg/dl
63. Outcome of Non-Invasive Test: No Test Positive Negative Equivocal
64. Ventilator Support? Yes No
65. Defibrillation? Yes No
66. Admission Symptom (Sx) Presentation:
 No Sx/No Angina
 Atypical Chest Pain
 Stable Angina
 Unstable Angina
 Non-STEMI
 STEMI
67. If any symptom, Time Period Sx Onset to Admission:
 > 0° - ≤ 6 hrs
 > 6° - ≤ 12°
 > 12° - ≤ 24°
 > 24° - ≤ 48°
 > 48° - ≤ 72°
 > 72° - ≤ 7d
 Silent MI (No Time Period)

F. CATH LAB VISIT

68. Procedure Date: _____ / _____ / _____
69. Right Heart Cath? Yes No
70. Left Heart Cath? Yes No
71. Coronary Angiography? Yes No
72. Ventricular Angiography? Yes No
73. Other Angiography? Yes No
74. PCI? Yes No
75. Fluoro Time? _____ Minutes

HEMODYNAMIC SUPPORT:

76. IABP? Yes No
→ 77. If Yes, IABP Placement Timing: Before Lab Visit During Lab Visit After Lab Visit
78. Vasopressors/Inotropes: None Before Lab Visit During Lab Visit After Lab Visit
79. Other Clinical Support? Yes No

LV STATUS:

80. LV Function Assessed? Yes No
→ 81. If Yes, LV Wall Motion: Normal Abnormal
82. EF? _____ %
83. Ventilator Support (in Lab)? Yes No
84. Defibrillation (in Lab)? Yes No

G. DIAGNOSTIC CATH PROCEDURE (Skip this section if no diagnostic cath performed)

85. Operator License Number: _____
86. Operator Last Name: _____ 87. Operator First Name: _____
88. Cardiac Cath. Status: Elective Urgent Emergency

INDICATIONS:

89. Valvular Heart Disease? Yes No
90. Arrhythmia? Yes No
91. Other Cardiac Indications: None Congenital Heart Disease Heart Failure
 Cardiomyopathy Cardiomyopathy/Heart Failure Other

**New Jersey Cardiac Catheterization Data Registry
(Continued)**

G. DIAGNOSTIC CATH PROCEDURE, Continued

INDICATIONS, Continued:

| Coronary Anatomy (if assessed, enter percent): | | |
|--|--|---|
| | <u>Native Artery: Percent Stenosis</u> | <u>Grafts (Complete if Previous CABG=Yes): Percent Stenosis</u> |
| <u>Left Main:</u> | 92. _____ % | //////////////////// |
| <u>Prox LAD:</u> | 93. _____ % | 98. _____ % |
| <u>Mid/Distal LAD:</u> | 94. _____ % | 99. _____ % |
| <u>Circumflex:</u> | 95. _____ % | 100. _____ % |
| <u>RCA:</u> | 96. _____ % | 101. _____ % |
| <u>Ramus:</u> | 97. _____ % | 102. _____ % |

VALVE FINDINGS:

103. Mitral Insufficiency: None Grade 1 Grade 2 Grade 3 Grade 4 Not Assessed

104. Aortic Stenosis: Yes No Not Assessed

→ If Yes, 105. Calculated Valve Area: _____ cm²

106. Doppler Mean Gradient: _____ mmHg

107. Aortic Insufficiency: None Grade 1 Grade 2 Grade 3 Grade 4 Not Assessed

H. PCI PROCEDURE *(Skip this section if no PCI performed)*

108. Operator License Number: _____

109. Operator Last Name: _____ 110. Operator First Name: _____

111. PCI Status: Elective Urgent Emergency Salvage

INDICATIONS:

112. Ischemic symptoms compatible with AMI within 12 hours of onset? Yes No

113. ST segment elevation compatible with AMI? Yes No

114. Uninterpretable ECG? Yes No

115. % Stenosis of upstream left main artery? _____ %

116. Is left main artery unprotected? Yes No

117. Lesion ≥ 50%:

No Yes-De novo Yes-Restenosis Yes-De Novo/Restenosis Yes-Subacute Thrombosis

118. Acute PCI:

No Yes-Primary PCI for STEMI Yes-Rescue PCI

Yes-Facilitated PCI Yes-Non-STEMI/Unstable Angina

→ If Yes-Primary PCI for STEMI:

Symptom Onset: 119. Date: _____ / ____ / ____ 120. Time: _____ :

Date/Time of Arrival: 121. Date: _____ / ____ / ____ 122. Time: _____ :

123. Transfer in for Primary PCI: Yes No

→ If Yes, ED Presentation at Referring Facility:

124. Date: _____ / ____ / ____ 125. Time: _____ :

Reperfusion Date/Time: 126. Date: _____ / ____ / ____ 127. Time: _____ :

128. Transfer out for Emergency CABG: Yes No

→ If Yes, Call to Surgery Center: 129. Date: _____ / ____ / ____ 130. Time: _____ :

Left Original Hospital: 131. Date: _____ / ____ / ____ 132. Time: _____ :

Arrival at Receiving Hosp.: 133. Date: _____ / ____ / ____ 134. Time: _____ :

Arrival at OR: 135. Date: _____ / ____ / ____ 136. Time: _____ :

**New Jersey Cardiac Catheterization Data Registry
(Continued)**

I. LESIONS/DEVICES (Skip this section if no PCI performed. Provide detailed information for the first 3 lesions.)

| | | | |
|---|--|--|--|
| 137. Total Number of Lesions: _____ | | | |
| Lesion Counter: | 1 | 2 | 3 |
| Segment Number: | 138. | 161. | 184. |
| % Pre-Stenosis: | 139. _____% | 162. _____% | 185. _____% |
| % Post-Stenosis: | 140. _____% | 163. _____% | 186. _____% |
| Pre-Proc TIMI Flow: | 141. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete | 164. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete | 187. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete |
| Post-Proc TIMI Flow: | 142. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete | 165. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete | 188. 0 <input type="checkbox"/> No 2 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Slow 3 <input type="checkbox"/> Complete |
| Prev. Treated Lesion: | 143. <input type="checkbox"/> Yes <input type="checkbox"/> No | 166. <input type="checkbox"/> Yes <input type="checkbox"/> No | 189. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes: | Select Multiple: | 144. <input type="checkbox"/> Balloon 145. <input type="checkbox"/> DES or NonDES 146. <input type="checkbox"/> Radiation 147. <input type="checkbox"/> Other/Unknown | 167. <input type="checkbox"/> Balloon 168. <input type="checkbox"/> DES or NonDES 169. <input type="checkbox"/> Radiation 170. <input type="checkbox"/> Other/Unknown |
| | Prev. Treat Date: | 148. ____/____/____ | 171. ____/____/____ |
| Segment in Graft: | 149. <input type="checkbox"/> No <input type="checkbox"/> Yes-Vein <input type="checkbox"/> Yes-Artery | 172. <input type="checkbox"/> No <input type="checkbox"/> Yes-Vein <input type="checkbox"/> Yes-Artery | 195. <input type="checkbox"/> No <input type="checkbox"/> Yes-Vein <input type="checkbox"/> Yes-Artery |
| → If Yes Loc. In Graft: | 150. <input type="checkbox"/> Aortic <input type="checkbox"/> Body <input type="checkbox"/> Distal | 173. <input type="checkbox"/> Aortic <input type="checkbox"/> Body <input type="checkbox"/> Distal | 196. <input type="checkbox"/> Aortic <input type="checkbox"/> Body <input type="checkbox"/> Distal |
| Lesion Risk: | 151. <input type="checkbox"/> Non-High/Non-C <input type="checkbox"/> High/C | 174. <input type="checkbox"/> Non-High/Non-C <input type="checkbox"/> High/C | 197. <input type="checkbox"/> Non-High/Non-C <input type="checkbox"/> High/C |
| Lesion Length (mm): | 152. _____ mm | 175. _____ mm | 198. _____ mm |
| Bifurcation Lesion: | 153. <input type="checkbox"/> Yes <input type="checkbox"/> No | 176. <input type="checkbox"/> Yes <input type="checkbox"/> No | 199. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Intracoronary Devices (Note: For each lesion enter either "No Device Deployed" or one of the following): | 154. | 177. | 200. |
| | 0 <input type="checkbox"/> No Device Deployed 1 <input type="checkbox"/> Balloon Only 2 <input type="checkbox"/> Drug Eluting Stent Only 3 <input type="checkbox"/> Bare Metal Stent Only 4 <input type="checkbox"/> Rotational Atherectomy Only 5 <input type="checkbox"/> Thrombectomy Only 6 <input type="checkbox"/> Cutting Balloon Only 7 <input type="checkbox"/> Balloon and Drug Eluting Stent Only 8 <input type="checkbox"/> Balloon and Bare Metal Stent Only 9 <input type="checkbox"/> Other (Specify) 10 <input type="checkbox"/> Unsuccessful- Balloon Only 11 <input type="checkbox"/> Unsuccessful- Drug Eluting Stent Only 12 <input type="checkbox"/> Unsuccessful- Bare Metal Stent Only 13 <input type="checkbox"/> Unsuccessful - Balloon and Drug Eluting Stent Only 14 <input type="checkbox"/> Unsuccessful - Balloon and Bare Metal Stent Only 15 <input type="checkbox"/> Unsuccessful-Other (Specify) → 155. Specify: | 0 <input type="checkbox"/> No Device Deployed 1 <input type="checkbox"/> Balloon Only 2 <input type="checkbox"/> Drug Eluting Stent Only 3 <input type="checkbox"/> Bare Metal Stent Only 4 <input type="checkbox"/> Rotational Atherectomy Only 5 <input type="checkbox"/> Thrombectomy Only 6 <input type="checkbox"/> Cutting Balloon Only 7 <input type="checkbox"/> Balloon and Drug Eluting Stent Only 8 <input type="checkbox"/> Balloon and Bare Metal Stent Only 9 <input type="checkbox"/> Other (Specify) 10 <input type="checkbox"/> Unsuccessful- Balloon Only 11 <input type="checkbox"/> Unsuccessful- Drug Eluting Stent Only 12 <input type="checkbox"/> Unsuccessful- Bare Metal Stent Only 13 <input type="checkbox"/> Unsuccessful - Balloon and Drug Eluting Stent Only 14 <input type="checkbox"/> Unsuccessful - Balloon and Bare Metal Stent Only 15 <input type="checkbox"/> Unsuccessful-Other (Specify) → 178. Specify: | 0 <input type="checkbox"/> No Device Deployed 1 <input type="checkbox"/> Balloon Only 2 <input type="checkbox"/> Drug Eluting Stent Only 3 <input type="checkbox"/> Bare Metal Stent Only 4 <input type="checkbox"/> Rotational Atherectomy Only 5 <input type="checkbox"/> Thrombectomy Only 6 <input type="checkbox"/> Cutting Balloon Only 7 <input type="checkbox"/> Balloon and Drug Eluting Stent Only 8 <input type="checkbox"/> Balloon and Bare Metal Stent Only 9 <input type="checkbox"/> Other (Specify) 10 <input type="checkbox"/> Unsuccessful- Balloon Only 11 <input type="checkbox"/> Unsuccessful- Drug Eluting Stent Only 12 <input type="checkbox"/> Unsuccessful- Bare Metal Stent Only 13 <input type="checkbox"/> Unsuccessful - Balloon and Drug Eluting Stent Only 14 <input type="checkbox"/> Unsuccessful - Balloon and Bare Metal Stent Only 15 <input type="checkbox"/> Unsuccessful-Other (Specify) → 201. Specify: |
| No Reflow Phenom | 156. <input type="checkbox"/> Yes <input type="checkbox"/> No | 179. <input type="checkbox"/> Yes <input type="checkbox"/> No | 202. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dissection | 157. <input type="checkbox"/> Yes <input type="checkbox"/> No | 180. <input type="checkbox"/> Yes <input type="checkbox"/> No | 203. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acute Closure | 158. <input type="checkbox"/> Yes <input type="checkbox"/> No | 181. <input type="checkbox"/> Yes <input type="checkbox"/> No | 204. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| → If Yes: Successful Reopening | 159. <input type="checkbox"/> Yes <input type="checkbox"/> No | 182. <input type="checkbox"/> Yes <input type="checkbox"/> No | 205. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Perforation | 160. <input type="checkbox"/> Yes <input type="checkbox"/> No | 183. <input type="checkbox"/> Yes <input type="checkbox"/> No | 206. <input type="checkbox"/> Yes <input type="checkbox"/> No |

**New Jersey Cardiac Catheterization Data Registry
(Continued)**

J. ADVERSE OUTCOMES PRIOR TO DISCHARGE (Complete this section for each Admission/Discharge)

GENERAL COMPLICATIONS:

- 207. Periprocedural MI Yes No
- 208. Cardiogenic Shock Yes No
- 209. CHF Yes No
- 210. CVA/Stroke Yes No
- 211. Tamponade Yes No
- 212. Thrombocytopenia Yes No
- 213. Contrast Reaction Yes No
- 214. Renal Failure Yes No
- 215. Emergency PCI Yes No
- 216. TIA Yes No
- 217. Sepsis Yes No
- 218. Arrhythmia Yes No
- 219. Ventilator Support Yes No

VASCULAR/BLEEDING COMPLICATIONS:

- 220. Bleeding at Percutaneous Entry Site Yes No
- 221. Retroperitoneal Bleeding Yes No
- 222. Gastrointestinal Bleeding Yes No
- 223. Genito-Urinary Bleeding Yes No
- 224. Bleeding - Other/Unknown Cause Yes No
- 225. Access Site Occlusion Yes No
- 226. Peripheral Embolization Yes No
- 227. Dissection Yes No
- 228. Pseudoaneurysm Yes No
- 229. If Yes, Treatment:
 None Pressure Fibrin Injection Surgery
- 230. AV Fistula Yes No

K. DISCHARGE (Complete this section for each Admission/Discharge)

231. CABG Status - During This Admission:

- No CABG Elective Urgent Emergency Salvage Transferred for CABG

→ If Yes, 232. CAB Date: _____ / _____ / _____

233. Blood products transfused after lab visit: Yes No

234. Discharge Date: _____ / _____ / _____

235. Discharge Status: Alive Dead

236. If Dead, Date of Death: _____ / _____ / _____

237. If Dead, Primary Cause of Death:

- Cardiac Neurologic Renal Vascular Infection
 Pulmonary Valvular Unknown Other

238. If Dead, Location of Death:

- Died in Cath Lab Died in Hospital Performing Procedure, but not in Cath Lab
 Died in Transit to Cardiac Surgery Center Died at Cardiac Surgery Center

239. If Alive, Discharge Location:

- Not Discharged Home Other Acute Care Rehab/Subacute Care
 Nursing Home Unknown Other

IF ALIVE AT DISCHARGE, MEDICATIONS (Prescribed at Discharge):

| | |
|--|--|
| <p>Medication</p> <p>240. Aspirin: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>241. Beta Blocker: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>242. Coumadin: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Medication</p> <p>243. Platelet Agg. Inhib.: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>244. Lipid-Lowering Agents: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>245. ACEI/ARB: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

246. Reserved 1:

247. Reserved 2:

248. Reserved 3: