



The Society of Thoracic Surgeons

Adult Cardiac Surgery Database

Data Collection Form Version 2.9

February 13, 2017

A. Administrative		
Participant ID:	Record ID: (software generated)	STS Cost Link:
Patient ID: (software generated)		
Patient participating in STS-related clinical trial:		
<input type="checkbox"/> None <input type="checkbox"/> Trial 1 <input type="checkbox"/> Trial 2 <input type="checkbox"/> Trial 3 <input type="checkbox"/> Trial 4 <input type="checkbox"/> Trial 5 <input type="checkbox"/> Trial 6 (If not "None" →) Clinical trial patient ID: _____		

B. Demographics		
Patient Last Name:	Patient First Name:	Patient Middle Name:
Date of Birth: ____/____/____ (mm/dd/yyyy)	Patient Age: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
National Identification (Social Security) Number Known: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused (If Yes →)		National ID Number: _____
Medical Record Number:		
Street Address:	City:	
Region:	ZIP Code:	Country:
Is This Patient's Permanent Address: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is the Patient's Race Documented? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pt. Declined to Disclose		
(If Yes →) Race : (Select all that apply→)		
White:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Am Indian/Alaskan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Black/African American:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hawaiian/Pacific Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No
Asian:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No
Hispanic, Latino or Spanish Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Documented		

C. Hospitalization		
Hospital Name: _____ (If Not Missing →)	Hospital ZIP Code: _____	Hospital Region: _____
Hospital National Provider Identifier: _____	Hospital CMS Certification Number: _____	
Primary Payor: (Choose one)	(If Primary Payor <None/Self ↓) Secondary Payor: (Choose one)	
<input type="checkbox"/> None/Self	<input type="checkbox"/> None	
<input type="checkbox"/> Medicare (includes commercially managed options)	<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medicaid (includes commercially managed options)	<input type="checkbox"/> Medicaid	
<input type="checkbox"/> Military Health	<input type="checkbox"/> Military Health	
<input type="checkbox"/> Indian Health Service	<input type="checkbox"/> Indian Health Service	
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Correctional Facility	
<input type="checkbox"/> State Specific Plan	<input type="checkbox"/> State Specific Plan	
<input type="checkbox"/> Other Government Insurance	<input type="checkbox"/> Other Government Insurance	
<input type="checkbox"/> Commercial Health Insurance	<input type="checkbox"/> Commercial Health Insurance	
<input type="checkbox"/> Health Maintenance Organization	<input type="checkbox"/> Health Maintenance Organization	
<input type="checkbox"/> Non -U.S. Plan	<input type="checkbox"/> Non -U.S. Plan	
<input type="checkbox"/> Charitable care/ Foundation Funding	<input type="checkbox"/> Charitable care/ Foundation Funding	
(if Medicare →) Primary Payor Medicare Fee for Service: <input type="checkbox"/> Yes <input type="checkbox"/> No	(if Medicare →) Secondary Payor Medicare Fee for Service: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Admit Date: ____/____/____ (mm/dd/yyyy)	Date of Surgery: ____/____/____ (mm/dd/yyyy)	
Admit Source: <input type="checkbox"/> Elective Admission <input type="checkbox"/> Emergency Department <input type="checkbox"/> Transfer in from another hospital/acute care facility <input type="checkbox"/> Other		
(If Transfer →) Other Hospital Performs Cardiac Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		

D. Risk Factors		
"Unknown" should only be selected if Patient / Family unable to provide history		
Height (cm): _____	Weight (kg): _____	
Family History of Premature Coronary Artery Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) Diabetes-Control: <input type="checkbox"/> None <input type="checkbox"/> Diet only <input type="checkbox"/> Oral <input type="checkbox"/> Insulin <input type="checkbox"/> Other SubQ <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Dyslipidemia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Endocarditis: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Endocarditis Type: <input type="checkbox"/> Treated <input type="checkbox"/> Active		

(If Endocarditis Yes→)	Endocarditis Culture: <input type="checkbox"/> Culture negative <input type="checkbox"/> Strep species <input type="checkbox"/> MRSA <input type="checkbox"/> MSSA <input type="checkbox"/> Coagulase negative staph <input type="checkbox"/> Enterococcus species <input type="checkbox"/> Gram negative species <input type="checkbox"/> Polymicrobial <input type="checkbox"/> Mycobacterium (chimera) <input type="checkbox"/> Fungal <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Tobacco use:	<input type="checkbox"/> Never smoker <input type="checkbox"/> Smoker, current status (frequency) unknown <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Smoking status unknown			
Lung Disease: <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Lung disease documented, severity unknown <input type="checkbox"/> Unknown (If Mild, Moderate or Severe→) Type: <input type="checkbox"/> Obstructive <input type="checkbox"/> Reactive <input type="checkbox"/> Interstitial Fibrosis <input type="checkbox"/> Restrictive <input type="checkbox"/> Other <input type="checkbox"/> Multiple <input type="checkbox"/> Not Documented			
Pulmonary Function Test Done: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes →) FEV1 % Predicted: _____ DLCO Test Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) DLCO % Predicted: _____ Room Air ABG Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Carbon Dioxide Level: _____ Oxygen Level : _____			
Home Oxygen: <input type="checkbox"/> Yes, PRN <input type="checkbox"/> Yes, oxygen dependent <input type="checkbox"/> No <input type="checkbox"/> Unknown	Inhaled Medication or Oral Bronchodilator Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Sleep Apnea: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pneumonia: <input type="checkbox"/> Recent <input type="checkbox"/> Remote <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Illicit Drug Use: <input type="checkbox"/> Recent <input type="checkbox"/> Remote <input type="checkbox"/> No <input type="checkbox"/> Unknown	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Alcohol Use: <input type="checkbox"/> <=1 drink/week <input type="checkbox"/> 2- 7 drinks/week <input type="checkbox"/> >=8 drinks/week <input type="checkbox"/> None <input type="checkbox"/> Unknown				
Liver Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →)	Child –Pugh Class <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Unknown Listed for liver transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No Status post liver transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Immunocompromise Present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mediastinal Radiation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Cancer Within 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Peripheral Artery Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Thoracic Aorta Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Syncope: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Unresponsive State: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest wall Deformity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Cerebrovascular Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(If Yes→) Prior CVA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) Prior CVA-When: <input type="checkbox"/> <= 30 days <input type="checkbox"/> > 30 days CVD TIA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown CVD Carotid stenosis: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> None <input type="checkbox"/> Not Documented (If “Right” or “Both” →) Severity of stenosis on the right carotid artery: <input type="checkbox"/> 50-79% <input type="checkbox"/> 80 – 99% <input type="checkbox"/> 100% <input type="checkbox"/> Not documented (If “Left” or “Both” →) Severity of stenosis on the left carotid artery: <input type="checkbox"/> 50-79% <input type="checkbox"/> 80 – 99% <input type="checkbox"/> 100% <input type="checkbox"/> Not documented History of previous carotid artery surgery and/or stenting: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Enter available lab results below. Not all tests are expected or appropriate for all patients. Data Quality Report will flag missing Creatinine or if both Hemoglobin & Hematocrit are missing. if Liver disease is present, Creatinine, Bilirubin and INR are expected				
WBC Count: _____	Hemoglobin: _____	Hematocrit: _____	Platelet Count: _____	
Last Creatinine Level: _____	Total Albumin: _____	Total Bilirubin: _____	A1c Level: _____	
HIT Antibodies <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	INR: _____	MELD Score: _____ (System Calculation)	BNP _____	
Five Meter Walk Test Done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Non-ambulatory patient				
(If Yes →)	Time 1: _____ (seconds)	Time 2: _____ (seconds)	Time 3 : _____ (seconds)	
Six Minute Walk test done: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)	Total Distance : _____ feet			

E. Previous Cardiac Interventions					
Previous Cardiac Interventions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
(If Yes →)	Previous coronary artery bypass (CAB): <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Previous valve procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No If PrValve Yes, Enter at least one previous valve procedure and up to 5 ↓				
	#1	#2	#3	#4	#5
No additional valve procedure(s)					
Aortic valve balloon valvotomy/valvuloplasty					
Aortic valve repair, surgical					
Aortic valve replacement, surgical					
Aortic valve replacement, transcatheter					
Mitral valve balloon valvotomy/valvuloplasty					
Mitral valve commissurotomy, surgical					
Mitral valve repair, percutaneous					
Mitral valve repair, surgical					
Mitral valve replacement, surgical					
Mitral valve replacement, transcatheter					
Tricuspid valve balloon valvotomy/valvuloplasty					
Tricuspid valve repair, percutaneous					
Tricuspid valve repair, surgical					
Tricuspid valve replacement, surgical					
Tricuspid valve replacement, transcatheter					
Tricuspid valvectomy					
Pulmonary valve balloon valvotomy/valvuloplasty					
Pulmonary valve repair, surgical					
Pulmonary valve replacement, surgical					

Pulmonary valve replacement, transcatheter						
Pulmonary valvectomy						
Other valve procedure						
Previous PCI: <input type="checkbox"/> Yes <input type="checkbox"/> No						
(If Yes →) PCI Performed Within This Episode Of Care: <input type="checkbox"/> Yes, at this facility <input type="checkbox"/> Yes, at some other acute care facility <input type="checkbox"/> No (If "Yes, at this facility" or "Yes, at some other acute care facility" ↓)						
Indication for Surgery: <input type="checkbox"/> PCI Complication <input type="checkbox"/> PCI Failure without Clinical Deterioration						
<input type="checkbox"/> PCI Failure with Clinical Deterioration <input type="checkbox"/> PCI/Surgery Staged (not STEMI)						
<input type="checkbox"/> PCI for STEMI, multivessel disease <input type="checkbox"/> Other						
PCI Stent: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Stent Type: <input type="checkbox"/> Bare metal <input type="checkbox"/> Drug-eluting <input type="checkbox"/> Bioresorbable <input type="checkbox"/> Multiple						
<input type="checkbox"/> Unknown						
PCI Interval: <input type="checkbox"/> ≤ 6 Hours <input type="checkbox"/> > 6 Hours						
Other Previous Cardiac Interventions: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter at least one previous other cardiac procedure and up to 7 ↓)						
	#1	#2	#3	#4	#5	#6
No additional interventions						
Ablation, catheter, atrial fibrillation						
Ablation, catheter, other or unknown						
Ablation, catheter, ventricular						
Ablation, surgical, atrial fibrillation						
Ablation, surgical, other or unknown						
Aneurysmectomy, LV						
Aortic procedure, arch						
Aortic procedure, ascending						
Aortic procedure, descending						
Aortic procedure, root						
Aortic procedure, thoracoabdominal						
Aortic Procedure, TEVAR						
Aortic root procedure, valve sparing						
Atrial appendage obliteration, Left, surgical						
Atrial appendage obliteration, Left, transcatheter						
Cardiac Tumor						
Cardioversion(s)						
Closure device, atrial septal defect						
Closure device, ventricular septal defect						
Congenital cardiac repair, surgical						
ECMO						
Implantable Cardioverter Defibrillator (ICD) with or without pacemaker						
Pacemaker						
Pericardial window/Pericardiocentesis						
Pericardiectomy						
Pulmonary Thromboembolectomy						
Total Artificial Heart (TAH)						
Transmyocardial Laser Revascularization (TMR)						
Transplant heart & lung						
Transplant, heart						
Transplant, lung(s)						
Ventricular Assist Device (VAD), BiVAD						
Ventricular Assist Device (VAD), left						
Ventricular Assist Device (VAD), right						
Other Cardiac Intervention (not listed)						

F. Preoperative Cardiac Status						
Prior Myocardial Infarction: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓)						
MI When: <input type="checkbox"/> ≤6 Hrs. <input type="checkbox"/> >6 Hrs. but <24 Hrs. <input type="checkbox"/> 1 to 7 Days <input type="checkbox"/> 8 to 21 Days <input type="checkbox"/> >21 Days						
Cardiac Presentation/Symptoms: (Choose <u>one</u> from the list below for each column↓)						
	At time of this admission:			At time of surgery:		
No Symptoms						
Stable Angina						
Unstable Angina						
Non-ST Elevation MI (Non-STEMI)						
ST Elevation MI (STEMI)						
Angina Equivalent						
Other						
Heart Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes→) Timing: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Both Type: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Both <input type="checkbox"/> Unavailable						
Classification-NYHA: <input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV <input type="checkbox"/> Not Documented						
Cardiogenic Shock : <input type="checkbox"/> Yes, at the time of the procedure <input type="checkbox"/> Yes, not at the time of the procedure but within prior 24 hours <input type="checkbox"/> No						
Resuscitation: <input type="checkbox"/> Yes - Within 1 hour of the start of the procedure <input type="checkbox"/> Yes - More than 1 hour but less than 24 hours of the start of the procedure <input type="checkbox"/> No						
Arrhythmia: <input type="checkbox"/> Yes <input type="checkbox"/> No						
(If Arrhythmia = Yes →) Permanently Paced Rhythm: <input type="checkbox"/> Yes <input type="checkbox"/> No						
(If Yes , choose one response below for each rhythm →)	VTach/VFib	Sick Sinus	AFlutter	AFibrillation	Second Degree Heart Block	Third Degree Heart Block
None						
Remote (> 30 days preop)						
Recent (≤ 30 days preop)						
(If AFibrillation not 'None' →)	Atrial Fibrillation Type: <input type="checkbox"/> Paroxysmal <input type="checkbox"/> Persistent <input type="checkbox"/> Longstanding Persistent <input type="checkbox"/> Permanent					

G. Preoperative Medications			
Medication		Timeframe	Administration
ACE or ARB		Within 48 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown
Amiodarone		Prior to surgery	<input type="checkbox"/> Yes, on home therapy <input type="checkbox"/> Yes, therapy started this admission <input type="checkbox"/> No <input type="checkbox"/> Unknown
Antianginal	Beta Blocker	Within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Beta Blocker	On therapy for ≥ 2 weeks prior to surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown
	Calcium Channel Blocker	On therapy for ≥ 2 weeks prior to surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown
	Long-acting Nitrate	On therapy for ≥ 2 weeks prior to surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown
	Nitrates, intravenous	Within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Antianginal	On therapy for ≥ 2 weeks prior to surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown
Antiplatelet	ADP Inhibitor (includes P2Y12)	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown (If Yes→)ADP Inhibitors Discontinuation: _____ (# days prior to surgery)
	Aspirin	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown (If Yes→) Aspirin Discontinuation: _____ (# days prior to surgery) Aspirin one time dose: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Glycoprotein IIb/IIIa	Within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Anticoagulants (Intravenous/ SubQ)	Within 48 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Medication: <input type="checkbox"/> Heparin (Unfractionated) <input type="checkbox"/> Heparin (Low Molecular) <input type="checkbox"/> Both <input type="checkbox"/> Other
Anticoagulant	Warfarin (Coumadin)	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes→) Coumadin Discontinuation: _____ (# days prior to surgery)
	Factor Xa inhibitors	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes→)Factor Xa Discontinuation: _____ (# days prior to surgery)
	Novel Oral Anticoagulant	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes→) NOAC Discontinuation: _____ (# days prior to surgery)
	Thrombin Inhibitors	Within 5 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes→) Thrombin Inhibitor Discontinuation: _____ (# days prior to surgery)
	Thrombolytics	Within 48 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inotropic, intravenous		Within 48 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lipid lowering		Within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown (If Yes→)Medication Type : <input type="checkbox"/> Statin <input type="checkbox"/> Statin + Other <input type="checkbox"/> Non-statin/Other
Steroids		Within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Unknown

H. Hemodynamics/Cath/Echo

Cardiac Catheterization Performed : <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Cardiac Catheterization Date: ____/____/____					
Coronary Anatomy/Disease known: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes↓)					
Dominance: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Co-dominant <input type="checkbox"/> Not Documented Source(s) used to quantify stenosis : <input type="checkbox"/> Angiogram <input type="checkbox"/> CT <input type="checkbox"/> IVUS <input type="checkbox"/> Progress/OP Note <input type="checkbox"/> Other <input type="checkbox"/> Multiple Number Diseased Vessels (If one, two or three vessel disease ↓) <input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three					
Each Column with a “yes” response below must have documentation on at least one vessel					
Coronary	Native Artery % Stenosis Known: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes↓)	Graft(s) Graft(s) Present: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes↓)	Stent(s) Stent(s) Present: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes↓)	Fractional Flow Reserve (FFR) performed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes↓)	Instantaneous wave-free ratio (iFR) performed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes↓)
Left Main	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Proximal LAD	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Mid LAD	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Distal LAD	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Diagonal 1	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Diagonal 2	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Diagonal 3	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Circumflex	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Obtuse Marginal 1	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Obtuse Marginal 2	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Obtuse Marginal 3	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Ramus	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
RCA	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Acute Marginal (AM)	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____

Posterior Descending (PDA)	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____
Posterolateral (PLB)	_____ %	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> 100% occlusion <input type="checkbox"/> Not Documented	<input type="checkbox"/> Patent <input type="checkbox"/> Stenosis >=50% <input type="checkbox"/> Not Documented	_____	_____

Syntax Score Known: ☐ Yes ☐ No (If Yes→) Syntax Score: _____

Stress Test: ☐ Yes ☐ No (If Yes →) Result: ☐ Negative (Normal) ☐ Positive (Abnormal) ☐ Not Documented

Ejection Fraction Done: ☐ Yes ☐ No (If Yes→) Ejection Fraction: _____ (%)

Dimensions Available: ☐ Yes ☐ No (If Yes→) LV End-Systolic Dimension: _____ (mm) LV End-Diastolic Dimension: _____ (mm)

PA Systolic Pressure Measured: ☐ Yes ☐ No (If Yes→) PA Systolic Pressure: _____ mmHg

Aortic Valve

Aortic Insufficiency: ☐ None ☐ Trivial/Trace ☐ Mild ☐ Moderate ☐ Severe ☐ Not Documented (If not "None" ↓)

Eccentric Jet: ☐ Yes ☐ No ☐ Not Documented

Aortic Valve Disease: ☐ Yes ☐ No

(If Yes ↓→)

Aortic Stenosis: ☐ Yes ☐ No (If Yes→) Hemodynamic/Echo data available: ☐ Yes ☐ No (If Yes ↓)

Smallest Aortic Valve Area: _____ cm²

Highest Mean Gradient: _____ mmHg Maximum Aortic jet velocity (V_{max}): _____ m/s

AV Disease Etiology Choose PRIMARY Etiology (one):

<input type="checkbox"/> Bicuspid valve disease	<input type="checkbox"/> Primary Aortic Disease, Hypertensive Aneurysm
<input type="checkbox"/> Congenital (other than bicuspid)	<input type="checkbox"/> Primary Aortic Disease, Idiopathic Root Dilatation
<input type="checkbox"/> Degenerative- Calcified	<input type="checkbox"/> Primary Aortic Disease, Inflammatory
<input type="checkbox"/> Degenerative- Leaflet prolapse with or without annular dilation	<input type="checkbox"/> Primary Aortic Disease, Loeys-Dietz Syndrome
<input type="checkbox"/> Degenerative- Pure annular dilatation without leaflet prolapse	<input type="checkbox"/> Primary Aortic Disease, Marfan Syndrome
<input type="checkbox"/> Degenerative- Commissural rupture	<input type="checkbox"/> Primary Aortic Disease, Other Connective tissue disorder
<input type="checkbox"/> Degenerative- Extensive fenestration	<input type="checkbox"/> Reoperation-Failure of previous AV repair or replacement
<input type="checkbox"/> Degenerative- Leaflet perforation/hole	<input type="checkbox"/> Rheumatic
<input type="checkbox"/> Endocarditis with root abscess	<input type="checkbox"/> Supravalvular Aortic Stenosis
<input type="checkbox"/> Endocarditis without root abscess	<input type="checkbox"/> Trauma
<input type="checkbox"/> LV Outflow Tract Pathology, HOCM	<input type="checkbox"/> Tumor, Carcinoid
<input type="checkbox"/> LV Outflow Tract Pathology, Sub-aortic membrane	<input type="checkbox"/> Tumor, Myxoma
<input type="checkbox"/> LV Outflow Tract Pathology, Sub-aortic Tunnel	<input type="checkbox"/> Tumor, Papillary Fibroelastoma
<input type="checkbox"/> LV Outflow Tract Pathology, Other	<input type="checkbox"/> Tumor, Other
<input type="checkbox"/> Primary Aortic Disease, Aortic Dissection	<input type="checkbox"/> Mixed Etiology
<input type="checkbox"/> Primary Aortic Disease, Atherosclerotic Aneurysm	<input type="checkbox"/> Not Documented
<input type="checkbox"/> Primary Aortic Disease, Ehler-Danlos Syndrome	

(If Bicuspid valve disease→) Sievers Class: ☐ 0 No raphe ☐ 1 one raphe ☐ 2 two raphe ☐ Not Documented

Mitral Valve

Mitral Insufficiency: ☐ None ☐ Trivial/Trace ☐ Mild ☐ Moderate ☐ Severe ☐ Not Documented

(If not "None" ↓)

Eccentric Jet: ☐ Yes ☐ No ☐ Not Documented

Mitral Valve Disease: ☐ Yes ☐ No

(If Yes ↓→)

Mitral Stenosis: ☐ Yes ☐ No (If Yes→) Hemodynamic/ Echo data available: ☐ Yes ☐ No (If Yes ↓)

Smallest Valve Area: _____ cm² Highest Mean Gradient: _____ mmHg

MV Disease Etiology Choose PRIMARY Etiology (one):

<input type="checkbox"/> Myxomatous degeneration/prolapse	<input type="checkbox"/> Tumor, Papillary fibroelastoma
<input type="checkbox"/> Rheumatic	<input type="checkbox"/> Tumor, Other
<input type="checkbox"/> Ischemic- acute, post infarction (MI ≤ 21 days)	<input type="checkbox"/> Carcinoid
<input type="checkbox"/> Ischemic- chronic (MI > 21 days)	<input type="checkbox"/> Trauma
<input type="checkbox"/> Non-ischemic Cardiomyopathy	<input type="checkbox"/> Congenital
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Pure annular dilatation
<input type="checkbox"/> Hypertrophic Obstructive Cardiomyopathy (HOCM)	<input type="checkbox"/> Reoperation-Failure of previous MV repair or replacement
<input type="checkbox"/> Tumor, Carcinoid	<input type="checkbox"/> Mixed Etiology
<input type="checkbox"/> Tumor, Myxoma	<input type="checkbox"/> Not Documented

MV Lesion Choose PRIMARY Lesion (one):

<input type="checkbox"/> Leaflet prolapse, posterior	<input type="checkbox"/> Papillary muscle elongation
<input type="checkbox"/> Leaflet prolapse, bileaflet	<input type="checkbox"/> Papillary muscle rupture
<input type="checkbox"/> Leaflet prolapse, anterior	<input type="checkbox"/> Leaflet thickening
<input type="checkbox"/> Leaflet prolapse, unspecified	<input type="checkbox"/> Leaflet retraction
<input type="checkbox"/> Elongated/ruptured chord(s)/Flail	<input type="checkbox"/> Chordal tethering
<input type="checkbox"/> Annular dilatation	<input type="checkbox"/> Chordal thickening/retraction/fusion

I. Operative			
Surgeon: _____		Surgeon NPI: _____	
Taxpayer Identification Number: _____			
Indicate whether the STS Risk Calculator score was discussed with the patient/family prior to surgery. <input type="checkbox"/> Yes, STS risk calculator score was calculated and discussed with the patient/family prior to surgery as documented in the medical record <input type="checkbox"/> No, STS risk calculator score was available for scheduled procedure but not discussed with the patient/family prior to surgery or the discussion was not documented <input type="checkbox"/> NA, Not applicable (emergent or salvage case, or no risk model available for this procedure)			
Incidence: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> First cardiovascular surgery <input type="checkbox"/> First re-op cardiovascular surgery <input type="checkbox"/> Second re-op cardiovascular surgery </div> <div> <input type="checkbox"/> Third re-op cardiovascular surgery <input type="checkbox"/> Fourth or more re-op cardiovascular surgery <input type="checkbox"/> NA- not a cardiovascular surgery </div> </div>			
Status: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Elective </div> <div> <input type="checkbox"/> Urgent </div> <div> <input type="checkbox"/> Emergent </div> <div> <input type="checkbox"/> Emergent Salvage </div> </div> <p>(If Urgent or Emergent choose the most pressing reason↓)</p> <p>Urgent / Emergent reason:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> AMI <input type="checkbox"/> Anatomy <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Aortic Dissection <input type="checkbox"/> CHF <input type="checkbox"/> Device Failure <input type="checkbox"/> Diagnostic/Interventional Procedure Complication <input type="checkbox"/> Endocarditis <input type="checkbox"/> Failed Transcatheter Valve Therapy , acute annular disruption <input type="checkbox"/> Failed Transcatheter Valve Therapy , acute device malposition <input type="checkbox"/> Failed Transcatheter Valve Therapy , subacute device dysfunction <input type="checkbox"/> IABP <input type="checkbox"/> Infected Device <input type="checkbox"/> Intracardiac mass or thrombus <input type="checkbox"/> Ongoing Ischemia </div> <div> <input type="checkbox"/> PCI Incomplete without clinical deterioration <input type="checkbox"/> PCI or attempted PCI with Clinical Deterioration <input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Rest Angina <input type="checkbox"/> Shock, Circulatory Support <input type="checkbox"/> Shock, No Circulatory Support <input type="checkbox"/> Syncope <input type="checkbox"/> Transplant <input type="checkbox"/> Trauma <input type="checkbox"/> USA <input type="checkbox"/> Valve Dysfunction <input type="checkbox"/> Worsening CP <input type="checkbox"/> Other </div> </div>			
Was case previously attempted during this admission, but canceled: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Date of previous case: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy) Timing of previous case: <input type="checkbox"/> Prior to induction of anesthesia <input type="checkbox"/> After induction, prior to incision <input type="checkbox"/> After incision made Reason previous case was canceled: <input type="checkbox"/> Anesthesiology event <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Equipment/supply issue <input type="checkbox"/> Access Issue <input type="checkbox"/> Unanticipated tumor <input type="checkbox"/> Donor Organ Unacceptable <input type="checkbox"/> Abnormal Labs <input type="checkbox"/> Other Planned previous procedure: CABG <input type="checkbox"/> Yes <input type="checkbox"/> No Valve, Surgical <input type="checkbox"/> Yes <input type="checkbox"/> No Mechanical Assist Device <input type="checkbox"/> Yes <input type="checkbox"/> No Valve, Transcatheter <input type="checkbox"/> Yes <input type="checkbox"/> No			

Other Non-cardiac		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Cardiac		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the current procedure canceled: <input type="checkbox"/> Yes <input type="checkbox"/> No					
(If Yes→) Canceled Timing: <input type="checkbox"/> Prior to induction of anesthesia <input type="checkbox"/> After induction, prior to incision <input type="checkbox"/> After incision made					
Canceled Reason: <input type="checkbox"/> Anesthesiology event <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Equipment/supply issue <input type="checkbox"/> Access Issue <input type="checkbox"/> Unanticipated tumor <input type="checkbox"/> Donor Organ Unacceptable <input type="checkbox"/> Abnormal Labs <input type="checkbox"/> Other					
Planned procedure:		CABG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valve, Surgical	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mechanical Assist Device	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valve, Transcatheter	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other Non-cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No
Initial Operative Approach: <input type="checkbox"/> Full conventional sternotomy <input type="checkbox"/> Left Thoracotomy <input type="checkbox"/> Thoracoabdominal Incision <input type="checkbox"/> Partial sternotomy <input type="checkbox"/> Right Thoracotomy <input type="checkbox"/> Percutaneous <input type="checkbox"/> Transverse sternotomy <input type="checkbox"/> Bilateral Thoracotomy <input type="checkbox"/> Port Access <input type="checkbox"/> Right or left parasternal incision <input type="checkbox"/> Limited (mini) Thoracotomy , right <input type="checkbox"/> Other <input type="checkbox"/> Sub-xiphoid <input type="checkbox"/> Limited (mini) Thoracotomy , left <input type="checkbox"/> None (canceled case) <input type="checkbox"/> Sub-Costal <input type="checkbox"/> Limited (mini) Thoracotomy , bilateral					
Approach converted during procedure: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned <input type="checkbox"/> No					
Robot Used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) <input type="checkbox"/> Used for entire operation <input type="checkbox"/> Used for part of the operation					
Coronary Artery Bypass: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No (If “Yes” complete Section J)					
Valve Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No (If “Yes” complete Section K) (If Yes →) Did the surgeon provide input for valve surgery data abstraction? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Aorta procedure Performed: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No (If “Yes” complete Section M 2) (If Yes →) Did the surgeon provide input for aortic surgery data abstraction? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other Cardiac Procedure: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No (If “Yes” complete Section M)					
Other Cardiac Procedure, AFib: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) (Complete Section M 1) (If Yes →) Did the surgeon provide input for AFib data abstraction? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other Non-Cardiac Procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If “Yes” complete Section N)					
Enter up to 10 CPT-1 Codes pertaining to the surgery for which the data collection form was initiated:					
1. _____		2. _____		3. _____	
4. _____		5. _____		6. _____	
7. _____		8. _____		9. _____	
10. _____		11. _____		12. _____	
OR Entry Date And Time: ____/____/____ : ____ mm/dd/yyyy hh:mm - 24 hr clock)					
OR Exit Date And Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
General Anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No (If General Anesthesia No→) Procedural Sedation : <input type="checkbox"/> Yes <input type="checkbox"/> No					
(If General Anesthesia Yes →) Intubation: <input type="checkbox"/> Yes, prior to entering OR for this procedure <input type="checkbox"/> Yes, in OR for this procedure <input type="checkbox"/> No (If Intubation Yes →) Intubation Date and Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
Initial Extubation Date and Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
Skin Incision Start Date and Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
Skin Incision Stop Date and Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
Anesthesia End Date and Time: ____/____/____ : ____ (mm/dd/yyyy hh:mm - 24 hr clock)					
Appropriate Antibiotic Selection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exclusion		Appropriate Antibiotic Administration Timing: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exclusion		Appropriate Antibiotic Discontinuation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exclusion	
Additional intraoperative prophylactic antibiotic dose given : <input type="checkbox"/> Yes <input type="checkbox"/> No					
Temperature Measured: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Lowest Temperature (° C): _____ Temperature Source: <input type="checkbox"/> Esophageal <input type="checkbox"/> CPB venous return <input type="checkbox"/> Bladder <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Tympanic <input type="checkbox"/> Rectal <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
Lowest Intra-op Hemoglobin : _____		Lowest Intra-op Hematocrit : _____		Highest Intra-op Glucose: _____	
CPB Utilization: <input type="checkbox"/> None <input type="checkbox"/> Combination (If Combination→) Combination Plan: <input type="checkbox"/> Planned <input type="checkbox"/> Unplanned (If Unplanned↓) Unplanned Reason: <input type="checkbox"/> Exposure/visualization <input type="checkbox"/> Bleeding <input type="checkbox"/> Inadequate size/ diffuse disease of distal vessel <input type="checkbox"/> Hemodynamic instability(hypotension/arrhythmias) <input type="checkbox"/> Conduit quality and/or trauma <input type="checkbox"/> Other					
<input type="checkbox"/> Full (If “Combination” or “Full”↓) Arterial Cannulation Insertion Site: (Select all that apply↓) Aortic <input type="checkbox"/> Yes <input type="checkbox"/> No Axillary <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No Femoral <input type="checkbox"/> Yes <input type="checkbox"/> No Innominate <input type="checkbox"/> Yes <input type="checkbox"/> No Venous Cannulation Insertion Site: (Select all that apply↓) Femoral <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary Vein <input type="checkbox"/> Yes <input type="checkbox"/> No Jugular <input type="checkbox"/> Yes <input type="checkbox"/> No Caval/Bicaval <input type="checkbox"/> Yes <input type="checkbox"/> No Rt. Atrial <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No Lt. Atrial <input type="checkbox"/> Yes <input type="checkbox"/> No					

Cardiopulmonary Bypass Time (minutes): _____	
Circulatory Arrest: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Circulatory Arrest Without Cerebral Perfusion Time: _____ (min)	
Circulatory Arrest With Cerebral Perfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If Yes →)	Cerebral Perfusion Time: _____ (min)
Cerebral Perfusion Type: <input type="checkbox"/> Antegrade <input type="checkbox"/> Retrograde <input type="checkbox"/> Both antegrade and retrograde	
Total Circulatory Arrest Time: _____ (System Calculation)	
Aortic Occlusion:	<input type="checkbox"/> None – beating heart <input type="checkbox"/> Aortic Cross clamp
	<input type="checkbox"/> None – fibrillating heart <input type="checkbox"/> Balloon Occlusion
(If “Aortic cross clamp” or “Balloon occlusion” →): Cross Clamp Time: _____ (min)	
Cardioplegia Delivery:	<input type="checkbox"/> None <input type="checkbox"/> Antegrade <input type="checkbox"/> Retrograde <input type="checkbox"/> Both
(If “Antegrade”, “Retrograde” or “Both” →) Type of cardioplegia used: <input type="checkbox"/> Blood <input type="checkbox"/> Crystalloid <input type="checkbox"/> Both <input type="checkbox"/> Other	
Cerebral Oximetry Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diffuse Aortic Calcification (Porcelain Aorta) : <input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment of Ascending Aorta/Arch for atheroma/plaque: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Reported (If Yes ↓)	
Assessment method:	<input type="checkbox"/> TEE <input type="checkbox"/> Epi-aortic ultrasound <input type="checkbox"/> CT scan <input type="checkbox"/> Other diagnostic modality
Assessment of Aorta Plaque:	<input type="checkbox"/> Normal Aorta/No or minimal plaque <input type="checkbox"/> Extensive intimal thickening
	<input type="checkbox"/> Protruding Atheroma < 5 mm <input type="checkbox"/> Protruding Atheroma ≥ 5 mm
	<input type="checkbox"/> Mobile plaques <input type="checkbox"/> Not documented
Aortic Condition Altered Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intraop Blood Products Refused: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If No →)	Intraop Blood Products: <input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes →)	Red Blood Cell Units: _____ Platelet Units: _____
	Fresh Frozen Plasma Units: _____ Cryoprecipitate Units: _____
Intraop Clotting Factors : <input type="checkbox"/> Yes, Factor VIIa <input type="checkbox"/> Yes, FEIBA <input type="checkbox"/> Yes, Composite <input type="checkbox"/> No Intraop Prothrombin Complex concentrate: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intraop Antifibrinolytic Medications:	Epsilon Amino-Caproic Acid: <input type="checkbox"/> Yes <input type="checkbox"/> No Tranexamic Acid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Intraoperative TEE Performed post procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Highest level aortic insufficiency found:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Mean Aortic Gradient: _____	
Aortic Paravalvular leak:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Highest level Mitral insufficiency found:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Mean Mitral Gradient: _____	
Mitral Paravalvular leak:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Highest level Tricuspid insufficiency found:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Mean Tricuspid Gradient: _____	
Tricuspid Paravalvular leak:	
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented	
Ejection Fraction Measured post procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Ejection Fraction: _____	
Surgery followed by a planned PCI: <input type="checkbox"/> Yes <input type="checkbox"/> No	

J. Coronary Bypass													
(If Coronary Artery Bypass = Yes ↓)													
Internal Mammary Artery (arteries) used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes →) Total Number of Distal Anastomoses with IMA conduits: _____													
(If no →)	Reason for no IMA <input type="checkbox"/> Subclavian stenosis <input type="checkbox"/> Previous mediastinal radiation <input type="checkbox"/> No (bypassable) LAD disease												
	<input type="checkbox"/> Previous cardiac or thoracic surgery <input type="checkbox"/> Emergent or salvage procedure <input type="checkbox"/> Other												
(If yes →)	Left IMA: <input type="checkbox"/> Yes, pedicle <input type="checkbox"/> Yes, skeletonized <input type="checkbox"/> No												
(If not no →)	LIMA Harvest technique: <input type="checkbox"/> Direct Vision (open) <input type="checkbox"/> Thoracoscopy <input type="checkbox"/> Combination <input type="checkbox"/> Robotic Assist												
	Right IMA: <input type="checkbox"/> Yes, pedicle <input type="checkbox"/> Yes, skeletonized <input type="checkbox"/> No												
(If not no →)	RIMA Harvest technique: <input type="checkbox"/> Direct Vision (open) <input type="checkbox"/> Thoracoscopy <input type="checkbox"/> Combination <input type="checkbox"/> Robotic Assist												
Radial Artery (arteries) used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes →) Total Number of Distal Anastomoses with radial artery conduits: _____													
(If yes →)	Radial Artery Harvest Technique: <input type="checkbox"/> Endoscopic <input type="checkbox"/> Direct Vision (open) <input type="checkbox"/> Both												
	Radial Artery Harvest and Prep Time: _____ (minutes)												
Venous Conduit(s) used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes →) Total Number of Distal Anastomoses with venous conduits: _____													
(If yes →)	Vein Harvest Technique: <input type="checkbox"/> Endoscopic <input type="checkbox"/> Direct Vision (open) <input type="checkbox"/> Both <input type="checkbox"/> Cryopreserved												
	Vein Harvest and Prep Time: _____ (minutes)												
Number of Distal Anastomoses : with other arterial conduits: _____ with arterial- venous composite conduits: _____													
with venous -arterial composite conduits: _____ with arterial- arterial composite conduits: _____													
(Note: the total number of distals above should equal the number of columns in the CABG Grid)													
Proximal Technique: <input type="checkbox"/> Single Cross Clamp <input type="checkbox"/> Partial Occlusion Clamp <input type="checkbox"/> Anastomotic Assist Device <input type="checkbox"/> None (isolated in situ mammary)													
CABG NUMBER (one column per distal insertion)				1	2	3	4	5	6	7	8	9	10
GRAFT				Yes	NA								

	No										
DISTAL INSERTION SITE	Left Main										
	Proximal LAD										
	Mid LAD										
	Distal LAD										
	Diagonal 1										
	Diagonal 2										
	Diagonal 3										
	Circumflex										
	Obtuse Marginal 1										
	Obtuse Marginal 2										
	Obtuse Marginal 3										
	Ramus										
	RCA										
	Acute Marginal (AM)										
	Posterior Descending (PDA)										
	Posterolateral (PLB)										
	Other										
	PROXIMAL SITE	In Situ Mammary									
Ascending aorta											
Descending aorta											
Subclavian artery											
Innominate artery											
T-graft off SVG											
T-graft off Radial											
T-graft off LIMA											
T-graft off RIMA											
Natural Y vein graft											
Other											
CONDUIT		Vein graft									
	In Situ LIMA										
	In Situ RIMA										
	Free IMA										
	Composite artery-vein										
	Radial artery										
	Other arteries, homograft										
	Synthetic graft										
DISTAL POSITION	End to Side										
	Sequential (side to side)										
ENDARTERECTOMY	Yes										
	No										
VEIN PATCH ANGIOPLASTY	Yes										
	No										

K. Valve Surgery (If Valve Surgery=Yes ↓)

Valve Prosthesis Explant: ☐ Yes ☐ No (If Yes ↓)

Explant Position: ☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonic

Explant Type: ☐ Mechanical Valve ☐ Bioprosthetic Valve ☐ Homograft ☐ Annuloplasty Device
☐ Leaflet Clip ☐ Transcatheter Device ☐ Other ☐ Unknown

Explant Etiology: ☐ Endocarditis ☐ Incompetence ☐ Prosthetic Deterioration ☐ Thrombosis
☐ Failed Repair ☐ Pannus ☐ Sizing/Positioning issue ☐ Other
☐ Hemolysis ☐ Paravalvular leak ☐ Stenosis ☐ Unknown

Explant Device known: ☐ Yes ☐ No (If Yes→) Explant model#:_____ Unique Device Identifier (UDI):_____

Second Valve Prosthesis Explant: ☐ Yes ☐ No (If Yes↓)

Explant Position: ☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonic

Explant Type: ☐ Mechanical Valve ☐ Bioprosthetic Valve ☐ Homograft ☐ Annuloplasty Device
☐ Leaflet Clip ☐ Transcatheter Device ☐ Other ☐ Unknown

Explant Etiology: ☐ Endocarditis ☐ Incompetence ☐ Prosthetic Deterioration ☐ Thrombosis
☐ Failed Repair ☐ Pannus Formation ☐ Sizing/Positioning issue ☐ Other
☐ Hemolysis ☐ Paravalvular leak ☐ Stenosis ☐ Unknown

Explant Device known: ☐ Yes ☐ No (If Yes→) Explant model#:_____ Unique Device Identifier (UDI):_____

Aortic Valve Procedure Performed: ☐ Yes, planned ☐ Yes, unplanned due to surgical complication ☐ Yes, unplanned due to unsuspected disease or anatomy ☐ No (If Yes ↓)

Procedure Performed:

☐ Replacement (If Replacement↓)

Transcatheter Valve Replacement: ☐ Yes ☐ No (If Yes ↓)

Approach: ☐ Transapical ☐ Transaxillary ☐ Transfemoral ☐ Transaortic ☐ Subclavian ☐ Other

Surgical valve Replacement: ☐ Yes ☐ No

(If Yes →) Device type: ☐ Mechanical ☐ Bioprosthetic ☐ Surgeon fashioned pericardium (Ozaki) ☐ Other

(If Bioprosthetic→) Valve type: ☐ Stented ☐ Stentless subcoronary valve only ☐ Sutureless/rapid deployment

☐ Repair/Reconstruction (If Repair/Reconstruction ↓)

Repair Type (Select all that apply)

Commissural suture annuloplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ring annuloplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No
External Suture Annuloplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes →) Type:	<input type="checkbox"/> External Ring <input type="checkbox"/> Internal Ring
Leaflet plication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leaflet resection suture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nodular Release	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leaflet Shaving	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leaflet free edge reinforcement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leaflet pericardial patch	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leaflet commissural resuspension suture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leaflet debridement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Division of fused leaflet raphe	<input type="checkbox"/> Yes <input type="checkbox"/> No	Repair of periprosthetic leak	<input type="checkbox"/> Yes <input type="checkbox"/> No

Aortic annular enlargement with patch ☐ Yes ☐ No (If Yes →) Technique: ☐ Nicks-Nunez ☐ Manouagian ☐ Konno ☐ Other ☐ Unknown

Root Procedure ☐ Yes ☐ No (If Yes ↓) (For AV surgery involving the aortic root→ also complete section M-2)

Root Replacement with coronary Ostial Reimplantation (Bentall) ☐ Yes ☐ No

Type:

(If Yes →) ☐ Mechanical ☐ Bioprosthetic
☐ Autograft with native pulmonary valve (Ross procedure) ☐ Homograft root replacement

(If Bioprosthetic→) ☐ Stented valve composite graft ☐ Stentless biologic full root

Valve Sparing root operation: ☐ Yes ☐ No (If Yes ↓)

☐ Resuspension AV without replacement of ascending aorta
☐ Resuspension AV with replacement of ascending aorta
☐ Valve sparing root reimplantation (David)
☐ Valve sparing root remodeling (Yacoub)
☐ Valve sparing root reconstruction (Florida Sleeve)

Major root reconstruction/ debridement with or without pericardial patch ☐ Yes ☐ No

Patch used: ☐ Yes ☐ No (If Yes →) Patch type: ☐ Synthetic ☐ Bioprosthetic ☐ Autologous

Aortic Valve Implant: ☐ Yes ☐ No (If Yes ↓)

Implant Model Number: _____ Implant Size: _____

Unique Device identifier (UDI): _____

Mitral Valve Procedure Performed: ☐ Yes, planned ☐ Yes, unplanned due to surgical complication ☐ Yes, unplanned due to unsuspected disease or anatomy ☐ No (If Yes ↓)

Procedure Performed:

☐ Repair (If Repair↓)

Repair Approach: ☐ Transcatheter ☐ Surgical

If Surgical (Select all that apply↓)

Annuloplasty: ☐ Yes ☐ No

Leaflet resection: ☐ Yes ☐ No (If Yes↓)

Resection Type: ☐ Triangular ☐ Quadrangular ☐ Other

Anterior resection: ☐ Yes ☐ No

(If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)

Anterior leaflet resection location: A1 ☐ Yes ☐ No

A2 ☐ Yes ☐ No

A3 ☐ Yes ☐ No

Resection Posterior Resection: ☐ Yes ☐ No

Location(s): (If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)

Posterior leaflet resection location: P1 ☐ Yes ☐ No

P2 ☐ Yes ☐ No

P3 ☐ Yes ☐ No

Commissure Resection: ☐ Yes ☐ No (If Yes↓)

Commissural resection location: ☐ Medial (C2) ☐ Lateral (C1) ☐ Both ☐ Not Documented

Neochords (PTFE): ☐ Yes ☐ No (If Yes↓)

Anterior Neochords: ☐ Yes ☐ No
 (If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)
 Anterior neochord location: A1 ☐ Yes ☐ No A2 ☐ Yes ☐ No A3 ☐ Yes ☐ No

Neochord Location(s): Posterior Neochords: ☐ Yes ☐ No
 (If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)
 Posterior Neochord location: P1 ☐ Yes ☐ No P2 ☐ Yes ☐ No P3 ☐ Yes ☐ No

☐ Commissure Neochords: ☐ Yes ☐ No (If Yes↓)
 Commissure Neochord location: ☐ Medial (C2) ☐ Lateral (C1) ☐ Both ☐ Not Documented

Chordal/ Leaflet transfer: ☐ Yes ☐ No (If Yes↓)

Chordal/ Leaflet Transfer Location(s): ☐ Anterior Chordal/Leaflet transfer: ☐ Yes ☐ No
 (If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)
 Anterior chordal/leaflet transfer location: A1 ☐ Yes ☐ No A2 ☐ Yes ☐ No A3 ☐ Yes ☐ No

☐ Posterior Chordal/Leaflet transfer: ☐ Yes ☐ No
 (If Yes→) Location documented: ☐ Yes ☐ No (If Yes↓)
 Posterior chordal/leaflet transfer location: P1 ☐ Yes ☐ No P2 ☐ Yes ☐ No P3 ☐ Yes ☐ No

☐ Commissure Chordal/Leaflet transfer: ☐ Yes ☐ No (If Yes↓)
 Commissural chordal/leaflet transfer location: ☐ Medial (C2) ☐ Lateral (C1) ☐ Both ☐ Not Documented

Folding Plasty: ☐ Yes ☐ No
 Sliding Plasty: ☐ Yes ☐ No
 Annular decalcification/ debridement: ☐ Yes ☐ No
 Leaflet extension/replacement patch: ☐ Yes ☐ No
 (If Yes→) Patch Location: ☐ Anterior ☐ Posterior ☐ Both ☐ Not Documented

Edge to edge repair: ☐ Yes ☐ No
 Mitral commissurotomy: ☐ Yes ☐ No
 Mitral commissuroplasty: ☐ Yes ☐ No
 Mitral cleft repair: (scallop closure): ☐ Yes ☐ No
 Mitral paraprosthetic leak repair: ☐ Yes ☐ No

☐ Replacement (If Replacement ↓)
 Mitral repair attempted prior to replacement: ☐ Yes ☐ No
 Mitral chords preserved: ☐ Anterior ☐ Posterior ☐ Both ☐ None
 Transcatheter replacement: ☐ Yes ☐ No

Implant: ☐ Yes ☐ No (If Yes↓)

Implant type: ☐ Mechanical valve ☐ Bioprosthetic valve ☐ Annuloplasty device ☐ Mitral Leaflet clip ☐ Transcatheter device
☐ Surgically implanted transcatheter device ☐ Other

Implant Model Number: _____ Implant Size: _____

Unique Device identifier (UDI): _____

Tricuspid Valve Procedure Performed: ☐ Yes, planned ☐ Yes, unplanned due to surgical complication
☐ Yes, unplanned due to unsuspected disease or anatomy ☐ No (If Yes ↓)

Repair : ☐ Yes ☐ No (If Yes↓)
 Annuloplasty ☐ Yes ☐ No (If Yes↓)
 Type of Annuloplasty: ☐ Pericardium ☐ Suture ☐ Prosthetic Ring ☐ Prosthetic Band ☐ Other

Leaflet Resection: ☐ Yes ☐ No

Replacement: ☐ Yes ☐ No (If Yes→) Transcatheter Replacement: ☐ Yes ☐ No

Valvectomy: ☐ Yes ☐ No

Implant: ☐ Yes ☐ No (If Yes ↓)

Implant Type: ☐ Mechanical Valve ☐ Bioprosthetic Valve ☐ Homograft
☐ Annuloplasty ☐ Transcatheter Device ☐ Other Device

Implant Model Number: _____ Size: _____

Unique Device Identifier (UDI): _____

Pulmonic Valve Procedure Performed: ☐ Yes, planned ☐ Yes, unplanned due to surgical complication
☐ Yes, unplanned due to unsuspected disease or anatomy ☐ No (If Yes ↓)

Procedure Performed:

☐ Repair/Leaflet Reconstruction
☐ Replacement (If Replacement→) Transcatheter Replacement: ☐ Yes ☐ No
☐ Valvectomy

Implant: ☐ Yes ☐ No (If Yes ↓)

Implant Type: ☐ Surgeon Fashioned ☐ Commercially Supplied

(If Surgeon Fashioned →) Material: ☐ PTFE (Gore-Tex) ☐ Pericardium ☐ Other

(If Commercially Supplied →) Device Type: ☐ Mechanical Valve ☐ Annuloplasty Device
☐ Bioprosthetic Valve ☐ Homograft
☐ Transcatheter Device ☐ Other

Implant Model Number: _____ Size: _____
 Unique Device Identifier (UDI): _____

L. Mechanical Cardiac Assist Devices

Intra-Aortic Balloon Pump (IABP): ☐ Yes ☐ No (If Yes ↓)

IABP Insertion: ☐ Preop ☐ Intraop ☐ Postop

Primary Reason for Insertion: ☐ Hemodynamic Instability ☐ Procedural Support ☐ Unstable Angina
☐ CPB Weaning Failure ☐ Prophylactic ☐ Other

Catheter Based Assist Device Used: ☐ Yes ☐ No (If Yes ↓)

Type: ☐ RV ☐ LV ☐ BiV

When Inserted: ☐ Preop ☐ Intraop ☐ Postop

Primary Reason for Insertion: ☐ Hemodynamic instability ☐ CPB weaning failure ☐ PCI failure ☐ Procedural support ☐ Other

ECMO: ☐ Veno-venous ☐ Veno-arterial ☐ Veno-venous converted to Veno-arterial ☐ No (If Yes ↓)

ECMO Initiated: ☐ Preop ☐ Intraop ☐ Postop ☐ Non-operative

Clinical Indication for ECMO: ☐ Cardiac Failure ☐ Respiratory Failure ☐ Hypothermia ☐ Rescue/salvage ☐ Other

L.2 Ventricular Assist Devices

(Use Key to complete table below -will be dropdown lists in software)

Timing: 1. Pre-Operative (during same hospitalization but not same OR trip as CV surgical procedure)
 2. Stand-alone VAD procedure
 3. In conjunction with CV surgical procedure (same trip to the OR)- planned
 4. In conjunction with CV surgical procedure (same trip to the OR)- unplanned
 5. Post-Operative (after surgical procedure during reoperation)

Indication:	1. Bridge to Transplantation	Type:	1. Right VAD (RVAD)	Reason:	1. Cardiac Transplant
	2. Bridge to Recovery		2. Left VAD (LVAD)		2. Recovery
	3. Destination		3. Biventricular VAD		3. Device Transfer
	4. Post cardiectomy Ventricular Failure		(BiVAD)		4. Device-Related Infection
	5. Device Malfunction		4. Total Artificial Heart (TAH)		5. Device Malfunction
	6. End of (device) Life				6. End of (device) Life
	7. Salvage				

Device: See VAD list

Was patient admitted with VAD ☐ Yes ☐ No

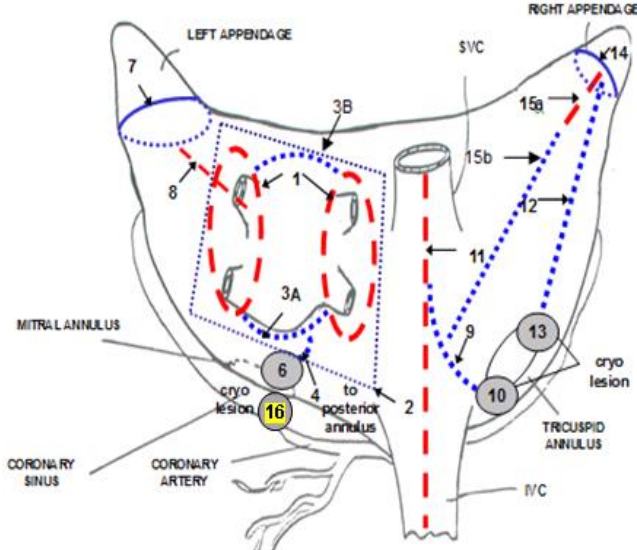
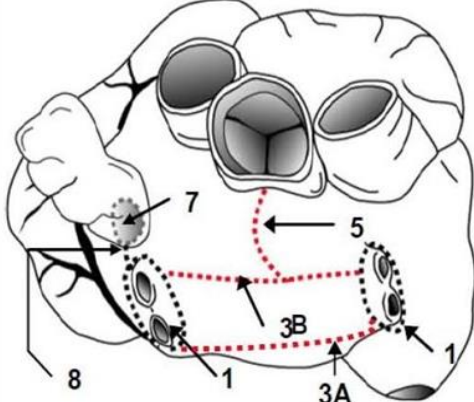
(If Yes →)	Previous VAD implanted at another facility <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Insertion date: __/__/____	
	Indication:	
	Type:	
	Device Model Number: _____	UDI: _____
	Previous VAD Explanted During This Admission:	<input type="checkbox"/> Yes, not during this procedure <input type="checkbox"/> Yes, during this procedure <input type="checkbox"/> No
	(If "Yes, not during this procedure" or "Yes, during this procedure" →)	Reason:
	(If "Yes, not during this procedure" →)	Date: __/__/____

Ventricular Assist Device Implanted during this hospitalization ☐ Yes ☐ No

(If Yes, provide data on up to 3 separate devices implanted ↓)

VAD IMPLANT(s)	Initial implant	2nd device implanted? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	3rd Device implanted? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)
Timing			
Indication			
Type			
Device			
Implant Date	__/__/____	__/__/____	__/__/____
UDI	_____	_____	_____
VAD was explanted	<input type="checkbox"/> Yes, not during this procedure <input type="checkbox"/> Yes, during this procedure <input type="checkbox"/> No	<input type="checkbox"/> Yes, not during this procedure <input type="checkbox"/> Yes, during this procedure <input type="checkbox"/> No	<input type="checkbox"/> Yes, not during this procedure <input type="checkbox"/> Yes, during this procedure <input type="checkbox"/> No
Reason (If "Yes, not during this procedure" or "Yes, during this procedure" →)			
Date (If "Yes, not during this procedure" →)	__/__/____	__/__/____	__/__/____

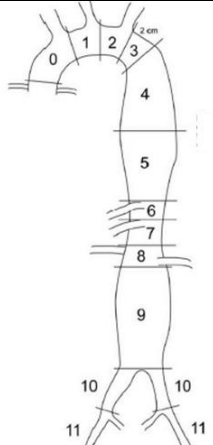
M. Other Cardiac Procedures	
(If Other Cardiac Procedure = Yes ↓) See Proc ID Table to determine whether these procedures impact isolate procedure categories	
ASD repair- PFO type <input type="checkbox"/> Yes <input type="checkbox"/> No	Myocardial Stem Cell Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No
ASD Repair- secundum or sinus venosus <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary <input type="checkbox"/> Yes, Acute <input type="checkbox"/> Yes, Chronic <input type="checkbox"/> No Thromboembolectomy:
AFib Intracardiac lesions (If yes, complete M-1) <input type="checkbox"/> Yes <input type="checkbox"/> No	Subaortic Stenosis Resection: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)
AFib Epicardial lesions (If yes, complete M-1) <input type="checkbox"/> Yes <input type="checkbox"/> No	Type : <input type="checkbox"/> Muscle <input type="checkbox"/> Ring <input type="checkbox"/> Membrane <input type="checkbox"/> Web <input type="checkbox"/> Not Reported
Atrial Appendage procedure: <input type="checkbox"/> RAA <input type="checkbox"/> LAA <input type="checkbox"/> Both <input type="checkbox"/> No (If not No ↓)	Surgical Ventricular Restoration: <input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate method for atrial appendage ligation/exclusion: <input type="checkbox"/> Intra-atrial oversewing <input type="checkbox"/> Epicardial Suture Ligation <input type="checkbox"/> Amputation with oversewing <input type="checkbox"/> Stapler (cutting) <input type="checkbox"/> Stapler (noncutting) <input type="checkbox"/> Epicardially applied occlusion device	
If epicardial applied occlusion device → Model: <input type="checkbox"/> AtriClip <input type="checkbox"/> Lariat <input type="checkbox"/> Other UDI: _____	
Arrhythmia Device: <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pacemaker with CRT <input type="checkbox"/> ICD <input type="checkbox"/> ICD with CRT <input type="checkbox"/> Implantable Recorder <input type="checkbox"/> None	Transmyocardial revascularization (TMR): <input type="checkbox"/> Yes <input type="checkbox"/> No Tumor: <input type="checkbox"/> Myxoma <input type="checkbox"/> Fibroelastoma <input type="checkbox"/> Hypernephroma <input type="checkbox"/> Sarcoma <input type="checkbox"/> Other <input type="checkbox"/> No
Lead Insertion: <input type="checkbox"/> Yes <input type="checkbox"/> No	Transplant, Cardiac : <input type="checkbox"/> Yes <input type="checkbox"/> No
Lead Extraction : <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No	Trauma, Cardiac : <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Defect Repair: (If yes, complete M-3) <input type="checkbox"/> Yes <input type="checkbox"/> No	VSD Repair: <input type="checkbox"/> Yes-congenital <input type="checkbox"/> Yes-acquired <input type="checkbox"/> No
LV Aneurysm Repair: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Cardiac Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No

M.1. Atrial Fibrillation Procedures	
(If Other Cardiac Procedure, AFib = Yes ↓)	
Lesion location: <input type="checkbox"/> Primarily epicardial <input type="checkbox"/> Primarily Intracardiac	
Method of Lesion Creation: (Select all that apply↓)	
Radiofrequency	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Bipolar <input type="checkbox"/> Yes <input type="checkbox"/> No
Cut-and-sew	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cryo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesions Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
<div style="display: flex; justify-content: space-around;">   </div> <p style="text-align: center;">Epicardial Left Sided Lesions</p>	
Lesions: (check all that apply ↓)	
<input type="checkbox"/> 1 Bilateral Pulmonary Vein Isolation	<input type="checkbox"/> 9 Intercaval Line to Tricuspid Annulus ("T" lesion)
<input type="checkbox"/> 2 Box Lesion Only	<input type="checkbox"/> 10 Tricuspid Cryo Lesion, Medial
<input type="checkbox"/> 3a Inferior Pulmonary Vein Connecting Lesion	<input type="checkbox"/> 11 Intercaval Line (SVC and IVC)
<input type="checkbox"/> 3b Superior Pulmonary Vein Connecting Lesion	<input type="checkbox"/> 12 Tricuspid Annular Line to RAA
<input type="checkbox"/> 4 Posterior Mitral Annular Line Lesion	<input type="checkbox"/> 13 Tricuspid Cryo Lesion
<input type="checkbox"/> 5 Pulmonary Vein Connecting Lesion to Anterior Mitral Annulus	<input type="checkbox"/> 14 RAA Ligation/Removal/Obliteration
<input type="checkbox"/> 6 Mitral Valve Annular Lesion	<input type="checkbox"/> 15a RAA Lateral Wall (Short)
<input type="checkbox"/> 7 LAA /Removal/Obliteration	<input type="checkbox"/> 15b RAA Lateral Wall to "T" Lesion
<input type="checkbox"/> 8 Pulmonary Vein to LAA Lesion	<input type="checkbox"/> 16 Coronary Sinus Lesion

M.2. Aorta And Aortic Root Procedures				
Family history of disease of aorta: <input type="checkbox"/> Aneurysm <input type="checkbox"/> Dissection <input type="checkbox"/> Both Aneurysm and Dissection <input type="checkbox"/> Sudden Death <input type="checkbox"/> None <input type="checkbox"/> Unknown				
Patient's genetic history: <input type="checkbox"/> Marfan <input type="checkbox"/> Ehlers-Danlos <input type="checkbox"/> Loeys-Dietz <input type="checkbox"/> Non-Specific familial thoracic aortic syndrome <input type="checkbox"/> Bicuspid AV <input type="checkbox"/> Turner syndrome <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown				
Prior aortic intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓)				
Location	Previous repair location(s)	Repair Type	Repair failure (If Yes ↓)	Disease progression (If Yes ↓)
	Select all that apply	Select all that apply	Select all that apply	Select all that apply
Root	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ascending	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arch	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Descending	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suprarenal abdominal	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infrarenal abdominal	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Endovascular <input type="checkbox"/> Hybrid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endoleak: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes, select all ↓)				
<input type="checkbox"/> Type I: leak at graft attachment site: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Type I location: <input type="checkbox"/> Ia-proximal <input type="checkbox"/> Ib-distal <input type="checkbox"/> Ic- iliac occluder				
<input type="checkbox"/> Type II: aneurysm sac filling via branch vessel: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Number of vessels: <input type="checkbox"/> IIa: single vessel <input type="checkbox"/> IIb: two vessels or more				
<input type="checkbox"/> Type III: leak through defect in graft: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Graft defect type: <input type="checkbox"/> IIIa: junctional separation of modular components <input type="checkbox"/> IIIb: endograft fractures or holes				
<input type="checkbox"/> Type IV: leak through graft fabric – porosity: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Type V: endotension - expansion aneurysm sac without leak: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) Aorta Infection Type: <input type="checkbox"/> Graft infection <input type="checkbox"/> Valvular endocarditis <input type="checkbox"/> Nonvalvular endocarditis <input type="checkbox"/> Native aorta <input type="checkbox"/> Multiple infection types				
Trauma: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) Location: Select all that apply				
Root		<input type="checkbox"/> Yes <input type="checkbox"/> No	Descending	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ascending		<input type="checkbox"/> Yes <input type="checkbox"/> No	Thoracoabdominal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arch		<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Presentation: <input type="checkbox"/> Pain <input type="checkbox"/> CHF <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Syncope <input type="checkbox"/> Stroke <input type="checkbox"/> Limb numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Fatigue <input type="checkbox"/> Infection <input type="checkbox"/> Weakness <input type="checkbox"/> Hoarseness (vocal cord dysfunction) <input type="checkbox"/> Asymptomatic				
Primary Indication: <input type="checkbox"/> Aneurysm <input type="checkbox"/> Dissection <input type="checkbox"/> Valvular Dysfunction <input type="checkbox"/> Obstruction <input type="checkbox"/> Intramural Hematoma <input type="checkbox"/> Infection <input type="checkbox"/> Stenosis <input type="checkbox"/> Coarctation				
(if Aneurysm→)	Etiology:	<input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Infection <input type="checkbox"/> Inflammatory <input type="checkbox"/> Connective Tissue Disorder <input type="checkbox"/> Penetrating Ulcer <input type="checkbox"/> Pseudoaneurysm <input type="checkbox"/> Mycotic <input type="checkbox"/> Traumatic transection <input type="checkbox"/> Intercostal visceral patch <input type="checkbox"/> Anastomotic site <input type="checkbox"/> Unknown		
	Type:	<input type="checkbox"/> Fusiform <input type="checkbox"/> Saccular <input type="checkbox"/> Unknown		
	Rupture:	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Contained rupture: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Location:	<input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11		
(if Dissection→)	Timing:	<input type="checkbox"/> Hyperacute (<48 hrs) <input type="checkbox"/> Acute (48hrs-2weeks) <input type="checkbox"/> Subacute (>2weeks -90 days) <input type="checkbox"/> Chronic (>90 days) <input type="checkbox"/> Acute on Chronic <input type="checkbox"/> Unknown		
	Dissection onset date known	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Date of onset: _/_/_-_-_-		
	Primary tear location:	<input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11		
	Secondary tear location:	<input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11		
	Retrograde extension:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓)		
	Retrograde Location:	<input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4		
	Post TEVAR:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Distal extension:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓)		
	Distal Extension Location:	<input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11		
	Malperfusion:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓ select all that apply)		
	Coronary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Superior Mesenteric	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Right Subclavian	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal, left	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Right Common Carotid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal, right	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Left Common Carotid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iliofemoral	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Left Subclavian	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Celiac <input type="checkbox"/> Yes <input type="checkbox"/> No Lower Extremity Motor Function: <input type="checkbox"/> No deficit <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Unknown Lower Extremity Sensory Deficit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Rupture: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Contained rupture: <input type="checkbox"/> Yes <input type="checkbox"/> No Rupture Location: <input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11					
Root	Aorto-annular ectasia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Asymmetric Root Dilation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) Dilation Location <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non-coronary Sinus of Valsalva aneurysm: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes →) SV Aneurysm Location: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non-coronary					
Arch	Arch Type : <input type="checkbox"/> Left <input type="checkbox"/> Right		Aberrant Left Subclavian: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Aberrant Right Subclavian : <input type="checkbox"/> Yes <input type="checkbox"/> No		Bovine: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Kommerell : <input type="checkbox"/> Yes <input type="checkbox"/> No		Patent internal mammary artery bypass graft: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Variant vertebral origin: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Ascending	Asymmetric Dilatation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Proximal coronary bypass grafts: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
3-D reconstruction aortic diameter measurements available: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓ indicate maximal diameter for each zone in mm)						
	Annulus	_____mm	Zone 2	_____mm	Zone 8	_____mm
	Sinus segment	_____mm	Zone 3	_____mm	Zone 9	_____mm
	Sinotubular junction	_____mm	Zone 4	_____mm	Zone 10	_____mm
	Mid-ascending	_____mm	Zone 5	_____mm	Zone 11	_____mm
	Distal Ascending	_____mm	Zone 6	_____mm		
	Zone 1	_____mm	Zone 7	_____mm		
Largest (pre-operative) diameter of treated segment(s)						
	Annulus	_____mm	Zone 2	_____mm	Zone 8	_____mm
	Sinus segment	_____mm	Zone 3	_____mm	Zone 9	_____mm
	Sinotubular junction	_____mm	Zone 4	_____mm	Zone 10	_____mm
	Mid-ascending	_____mm	Zone 5	_____mm	Zone 11	_____mm
	Distal Ascending	_____mm	Zone 6	_____mm		
	Zone 1	_____mm	Zone 7	_____mm		
Intervention						
Planned Staged Hybrid: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Open Arch Procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)						
Distal Technique: <input type="checkbox"/> Open <input type="checkbox"/> Clamped						
Distal Site: <input type="checkbox"/> Ascending Aorta <input type="checkbox"/> Hemiarch <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4						
Distal Extention: <input type="checkbox"/> Elephant trunk <input type="checkbox"/> Frozen Elephant trunk <input type="checkbox"/> No						
Arch Branch Reimplantation: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)						
Innominate: <input type="checkbox"/> Yes <input type="checkbox"/> No Right Subclavian: <input type="checkbox"/> Yes <input type="checkbox"/> No Right Common Carotid: <input type="checkbox"/> Yes <input type="checkbox"/> No Left Common						
Carotid: <input type="checkbox"/> Yes <input type="checkbox"/> No Left Subclavian: <input type="checkbox"/> Yes <input type="checkbox"/> No Left Vertebral: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Open Descending Thoracic Aorta or Thoracoabdominal Procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)						
Proximal Location: <input type="checkbox"/> Reverse Hemiarch <input type="checkbox"/> Zone 0 <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9						
Intercostal Reimplantation: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Distal Location: <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11						
Visceral vessel intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)						
Celiac: <input type="checkbox"/> Reimplantation <input type="checkbox"/> Branch Graft <input type="checkbox"/> None						
Superior mesenteric: <input type="checkbox"/> Reimplantation <input type="checkbox"/> Branch Graft <input type="checkbox"/> None						
Right Renal: <input type="checkbox"/> Reimplantation <input type="checkbox"/> Branch Graft <input type="checkbox"/> None						

Left Renal: <input type="checkbox"/> Reimplantation <input type="checkbox"/> Branch Graft <input type="checkbox"/> None	
Endovascular Procedure(s) : <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Access: <input type="checkbox"/> Femoral <input type="checkbox"/> Iliac <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Lt. Subclavian <input type="checkbox"/> Rt. Subclavian <input type="checkbox"/> Ascending Aorta <input type="checkbox"/> LV Apex	
Percutaneous Access: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Proximal landing zone: <input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11	
Distal landing zone: <input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending to distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11	
TAVR (for combination procedures): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ascending TEVAR : <input type="checkbox"/> Dedicated IDE <input type="checkbox"/> Off Label Stent <input type="checkbox"/> No	
Arch Vessel management	
Innominate: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta-Innominate <input type="checkbox"/> Yes <input type="checkbox"/> No Aorta-right carotid <input type="checkbox"/> Yes <input type="checkbox"/> No Aorta- right subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Right Carotid- Right subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Left Carotid: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- left carotid <input type="checkbox"/> Yes <input type="checkbox"/> No Innominate- left carotid <input type="checkbox"/> Yes <input type="checkbox"/> No Right carotid- Left carotid <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Left Subclavian: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- left subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Left carotid- left subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Arch Vessel(s) Extra-anatomic bypass: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Innominate – carotid <input type="checkbox"/> Yes <input type="checkbox"/> No Innominate- subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Subclavian-subclavian <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Visceral Vessel management	
Celiac: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- celiac <input type="checkbox"/> Yes <input type="checkbox"/> No Iliac-celiac <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Superior mesenteric: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- superior mesenteric <input type="checkbox"/> Yes <input type="checkbox"/> No Iliac- superior mesenteric <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Right renal: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- right renal <input type="checkbox"/> Yes <input type="checkbox"/> No Iliac- right renal <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Left renal: <input type="checkbox"/> Native Flow <input type="checkbox"/> Endovascular Branch Graft <input type="checkbox"/> Endovascular Parallel Graft <input type="checkbox"/> Extra-anatomic Bypass <input type="checkbox"/> Fenestrated (If Extra-anatomic bypass→) Aorta- left renal <input type="checkbox"/> Yes <input type="checkbox"/> No Iliac – left renal <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Right Iliac: <input type="checkbox"/> Native Flow <input type="checkbox"/> Bifurcated Graft <input type="checkbox"/> Extra-anatomic Bypass (If Extra-anatomic bypass→) Femoral- Femoral <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Left Iliac: <input type="checkbox"/> Native Flow <input type="checkbox"/> Bifurcated Graft <input type="checkbox"/> Extra-anatomic Bypass (If Extra-anatomic bypass→) Femoral- Femoral <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Internal Iliac Preserved: <input type="checkbox"/> Right Iliac only <input type="checkbox"/> Left Iliac only <input type="checkbox"/> Both <input type="checkbox"/> No	
Other Visceral Vessel(s) Extra-anatomic Bypass: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Aorta-other <input type="checkbox"/> Yes <input type="checkbox"/> No Iliac-other <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dissection proximal entry tear covered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Endoleak at end of procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Type: <input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V
Conversion to open: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Conversion reason: <input type="checkbox"/> Deployment failure <input type="checkbox"/> Endoleak <input type="checkbox"/> Rupture <input type="checkbox"/> Occlusion/loss of branch	
Intraop Dissection Extension: <input type="checkbox"/> None <input type="checkbox"/> Antegrade <input type="checkbox"/> Retrograde <input type="checkbox"/> Both	
Unintentional rupture of dissection septum: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) <input type="checkbox"/> Below STJ <input type="checkbox"/> STJ-midascending <input type="checkbox"/> Midascending-distal ascending <input type="checkbox"/> Zone 1 <input type="checkbox"/> Zone 2 <input type="checkbox"/> Zone 3 <input type="checkbox"/> Zone 4 <input type="checkbox"/> Zone 5 <input type="checkbox"/> Zone 6 <input type="checkbox"/> Zone 7 <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 <input type="checkbox"/> Zone 11	
Spinal Drain Placement: <input type="checkbox"/> Pre- aortic procedure <input type="checkbox"/> Post- aortic procedure <input type="checkbox"/> None	
IntraOp Motor Evoked Potential: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes →) Documented MEP abnormality <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IntraOp Somatosensory Evoked Potential: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes →) Documented SEP abnormality <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IntraOp EEG: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes →) Documented EEG abnormality <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IntraOp Intravascular Ultrasound(IVUS): <input type="checkbox"/> Yes <input type="checkbox"/> No	IntraOp Transcutaneous Doppler: <input type="checkbox"/> Yes <input type="checkbox"/> No

Intraoperative Angiogram: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)	Volume of contrast: _____ml	Fluoroscopy time: _____ min
Devices		
Device(s) Inserted: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, list proximal to distal using device key ↓)		
Location :		X. No additional devices inserted (only for locations 2 – 15) A. Below sinotubular junction B. Sinotubular junction to mid ascending C. Mid ascending to distal ascending D. Zone 1 (between innominate and left carotid) E. Zone 2 (between left carotid and left subclavian) F. Zone 3 (first 2 cm. distal to left subclavian) G. Zone 4 (end of zone 3 to mid descending aorta ~ T6) H. Zone 5 (mid descending aorta to celiac) I. Zone 6 (celiac to superior mesenteric) J. Zone 7 (superior mesenteric to renals) K. Zone 8 (renal to infra-renal abdominal aorta) L. Zone 9 (infra-renal abdominal aorta) M. Zone 10 (common iliac) N. Zone 11 (external iliacs)
Delivery Method:	1=Open 2= Endovascular	
Outcome:	1= Maldeployed 2= Deployed and removed 3= Successfully deployed	
Model Number:	Enter device model number	
UDI:	Enter unique device identifier (not serial number)	
Location (Letter)	Delivery Method	Outcome

M.3. Congenital Defect Repair (other than ASD, VSD or Bicuspid valve)
Congenital Diagnoses: Select up to three most significant diagnoses: (refer to “Congenital Diagnoses/Procedures List” document) Diagnosis 1: _____ (If not “No additional congenital diagnoses”→) Diagnosis 2: _____ (If not “No additional congenital diagnoses”→) Diagnosis 3: _____
Congenital Procedures: Select up to three most significant: (refer to “Congenital Diagnoses/Procedures List” document) Procedure 1: _____ (If not “No additional congenital procedures”→) Procedure 2: _____ (If not “No additional congenital procedures”→) Procedure 3: _____

N. Other Non-Cardiac Procedures (If Other Non-Cardiac Procedure = Yes ↓)
Carotid Endarterectomy: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No
Other Vascular: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No
Other Thoracic: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No
Other: <input type="checkbox"/> Yes, planned <input type="checkbox"/> Yes, unplanned due to surgical complication <input type="checkbox"/> Yes, unplanned due to unsuspected disease or anatomy <input type="checkbox"/> No

O. Post-Operative
Peak Glucose within 18-24 hours of anesthesia end time: _____
Postoperative Creatinine Level: _____ Discharge Hemoglobin: _____ Discharge Hematocrit: _____
Blood Products Used Postoperatively: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Red Blood Cell Units: _____ Fresh Frozen Plasma Units: _____ Cryoprecipitate Units: _____ Platelet Units: _____
Extubated in OR: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Re-intubated /or intubated Post Op During Hospital Stay: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes →) Additional Hours Ventilated: _____ Total post-operative ventilation hours _____ (System Calculation)
ICU Visit: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Initial ICU Hours: _____
Readmission to ICU: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Additional ICU Hours: _____
Post Op Echo Performed to evaluate valve(s): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓) Level aortic insufficiency found: <input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented Aortic Paravalvular leak: <input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented Level mitral insufficiency found: <input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented

Mitral Paravalvular leak:			
<input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented			
Level tricuspid insufficiency found: <input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented			
Level pulmonic insufficiency found: <input type="checkbox"/> None <input type="checkbox"/> Trivial/Trace <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not Documented			
Post Op Ejection Fraction: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)		Post Op Ejection Fraction: _____ (%)	
Cardiac Enzymes (biomarkers) Drawn: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)		Peak CKMB: _____ Peak Troponin I _____ Peak Troponin T _____	
12-Lead EKG Findings:			
<input type="checkbox"/> Not performed <input type="checkbox"/> No ischemic changes <input type="checkbox"/> New ST changes <input type="checkbox"/> New Pathological Q-wave or LBBB			
<input type="checkbox"/> New RBBB <input type="checkbox"/> New AV Conduction Block <input type="checkbox"/> New STEMI <input type="checkbox"/> Other <input type="checkbox"/> NA (no pre-op EKG for comparison, transplant)			

P. Postoperative Events	
Surgical Site Infection within 30 days of operation: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Sternal Superficial Wound Infection: <input type="checkbox"/> Yes, within 30 days of procedure <input type="checkbox"/> Yes, >30 days after procedure but during hosp. for surgery <input type="checkbox"/> No	
Deep Sternal Infection/ Mediastinitis: <input type="checkbox"/> Yes, within 30 days of procedure <input type="checkbox"/> Yes, >30 days after procedure but during hosp. for surgery <input type="checkbox"/> No	
(If either Yes value →) Diagnosis Date: ____/____/____ (mm/dd/yyyy)	
Thoracotomy: <input type="checkbox"/> Yes, within 30 days of procedure <input type="checkbox"/> Yes, >30 days after procedure but during hosp. for surgery <input type="checkbox"/> No	
Conduit Harvest: <input type="checkbox"/> Yes, within 30 days of procedure <input type="checkbox"/> Yes, >30 days after procedure but during hosp. for surgery <input type="checkbox"/> No	
Cannulation Site: <input type="checkbox"/> Yes, within 30 days of procedure <input type="checkbox"/> Yes, >30 days after procedure but during hosp. for surgery <input type="checkbox"/> No	
Wound Intervention/Procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Wound Intervention – Open with Packing/Irrigation: <input type="checkbox"/> Yes, primary incision <input type="checkbox"/> Yes, secondary incision <input type="checkbox"/> Both <input type="checkbox"/> No	
Wound Intervention – Wound Vac: <input type="checkbox"/> Yes, primary incision <input type="checkbox"/> Yes, secondary incision <input type="checkbox"/> Both <input type="checkbox"/> No	
Secondary Procedure Muscle Flap: <input type="checkbox"/> Yes, primary incision <input type="checkbox"/> Yes, secondary incision <input type="checkbox"/> Both <input type="checkbox"/> No	
Secondary Procedure Omental Flap: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other <u>In Hospital</u> Postoperative Event Occurred: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
<u>Operative</u>	
ReOp for Bleeding /Tamponade: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Bleed Timing: <input type="checkbox"/> Acute <input type="checkbox"/> Late	
ReOp for Valvular Dysfunction: <input type="checkbox"/> Yes, surgical <input type="checkbox"/> Yes, transcatheter <input type="checkbox"/> No	
Reintervention for Myocardial Ischemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If Yes →) Vessel: <input type="checkbox"/> Native coronary <input type="checkbox"/> Graft <input type="checkbox"/> Both Intervention Type: <input type="checkbox"/> Surgery <input type="checkbox"/> PCI <input type="checkbox"/> Both	
Aortic Reintervention: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes→) Type: <input type="checkbox"/> Open <input type="checkbox"/> Endovascular	
ReOp for Other Cardiac Reasons: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Returned to the OR for Other Non-Cardiac Reasons: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Open chest with planned delayed sternal closure: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sternotomy Issue: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Sternal instability/dehiscence (sterile): <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Infection</u>	
Sepsis: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Positive Blood Cultures: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Neurologic, Central</u>	
Postoperative Stroke: <input type="checkbox"/> Yes, hemorrhagic <input type="checkbox"/> Yes, ischemic <input type="checkbox"/> Yes, undetermined type <input type="checkbox"/> No	
Transient Ischemic Attack (TIA): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Encephalopathy: <input type="checkbox"/> None <input type="checkbox"/> Anoxic <input type="checkbox"/> Drug <input type="checkbox"/> Metabolic <input type="checkbox"/> Mixed <input type="checkbox"/> Unknown	
Coma/unresponsive state (not stroke): <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Neurologic, Peripheral</u>	
Lower Extremity Paralysis: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Paralysis Type: <input type="checkbox"/> Transient <input type="checkbox"/> Permanent Paresis: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Paresis Type:	
<input type="checkbox"/> Transient <input type="checkbox"/> Permanent	
Phrenic Nerve Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent Laryngeal Nerve Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Pulmonary</u>	
Prolonged Ventilation: <input type="checkbox"/> Yes <input type="checkbox"/> No (OR exit time until initial extubation, plus any additional reintubation hours)	
Pneumonia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Venous Thromboembolism – VTE: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Pulmonary Thromboembolism: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Deep Venous Thrombosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pleural Effusion Requiring Drainage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumothorax Requiring Intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Renal</u>	
Renal Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dialysis (Newly Required): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →) Required after Hospital Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Duration: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Unknown	
Ultra-Filtration Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Vascular</u>	
Iliac/Femoral Dissection: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acute Limb Ischemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Mechanical assist device related complication</u> : <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes ↓)	
Cannula/Insertion site issue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemorrhagic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thrombotic/Embolic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemolytic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other mechanical assist device related complication: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other
Rhythm Disturbance Requiring Permanent Device: <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Other <input type="checkbox"/> None
Cardiac Arrest: <input type="checkbox"/> Yes <input type="checkbox"/> No
Post Op Aortic Endoleak: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes→) Type: <input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V
Aortic Rupture: <input type="checkbox"/> Yes <input type="checkbox"/> No
Aortic Dissection: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes→) Type: <input type="checkbox"/> Antegrade <input type="checkbox"/> Retrograde <input type="checkbox"/> Both
Aortic Side Branch malperfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No
Aortic stent graft induced entry tear: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulant Event: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pericardiocentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Gastro-Intestinal Event: <input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Dysfunction/ Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Multi-System Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Atrial Fibrillation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: <input type="checkbox"/> Yes <input type="checkbox"/> No

Q. Discharge / Mortality

Date of Last Follow-up: __/__/____ (mm/dd/yyyy)	
Status at 30 days After Surgery: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	
Primary method used to verify 30-day status:	
<input type="checkbox"/> Phone call to patient or family	<input type="checkbox"/> Office visit >= 30 days after procedure
<input type="checkbox"/> Letter from medical provider	<input type="checkbox"/> Social Security Death Master File /NDI
<input type="checkbox"/> Medical record (evidence of life or death)	<input type="checkbox"/> Other
Discharge/Mortality status: <input type="checkbox"/> In hospital, alive <input type="checkbox"/> Discharged alive, last known status = alive	
<input type="checkbox"/> Died in hospital <input type="checkbox"/> Discharged alive, died after discharge	
(If Discharge/Mortality Status = "Discharged alive, last know status=alive" or "Discharged alive, died after discharge" ↓)	
Discharge Date __/__/____ (mm/dd/yyyy)	
Discharge Location: <input type="checkbox"/> Home <input type="checkbox"/> Extended Care/Transitional Care Unit/Rehab <input type="checkbox"/> Other Acute Care Hospital	
<input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospice <input type="checkbox"/> Left AMA <input type="checkbox"/> Other	
Cardiac Rehabilitation Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Smoking Cessation Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Medications Prescribed at Discharge	
Antiplatelet	Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	ADP Inhibitor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Other Antiplatelet <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
Anticoagulant	Thrombin Inhibitors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Warfarin (Coumadin) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Factor Xa inhibitors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Novel Oral Anticoagulant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
	Other Anticoagulant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
ACE or ARB	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Not Indicated (no CHF or EF > 40%)
Amiodarone	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
Beta Blocker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
Lipid Lowering - Statin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
Lipid Lowering - Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated
(If Discharge/Mortality Status = "Died in hospital" or "Discharged alive, died after discharge" ↓)	
Mortality - Date __/__/____ (mm/dd/yyyy)	
Primary Cause of Death (select only one) <input type="checkbox"/> Cardiac <input type="checkbox"/> Neurologic <input type="checkbox"/> Renal <input type="checkbox"/> Vascular <input type="checkbox"/> Infection <input type="checkbox"/> Pulmonary <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
(If Discharge/Mortality Status = "Died in hospital" ↓)	
In-Hospital death location: <input type="checkbox"/> OR During Initial Surgery <input type="checkbox"/> OR during reoperation <input type="checkbox"/> In Hospital (Other than OR)	
(If Discharge/Mortality Status = "Discharged alive, died after discharge")	
Operative Death: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Post Discharge death location: <input type="checkbox"/> Home <input type="checkbox"/> Extended Care Facility <input type="checkbox"/> Hospice <input type="checkbox"/> Acute Rehabilitation <input type="checkbox"/> Hospital during readmission	
<input type="checkbox"/> Other <input type="checkbox"/> Unknown	

R. Readmission

(If Discharge/Mortality Status = "Discharged alive, last know status=alive" or "Discharged alive, died after discharge" ↓)	
Readmit : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes ↓)	
Readmit Date: __/__/____ (mm/dd/yyyy)	
Readmit Primary Reason:	
<input type="checkbox"/> Angina	<input type="checkbox"/> Pericardial Effusion and/or Tamponade
<input type="checkbox"/> Anticoagulation Complication - Pharmacological	<input type="checkbox"/> Pericarditis/Post Cardiotomy Syndrome
<input type="checkbox"/> Anticoagulation Complication – Valvular	<input type="checkbox"/> Pleural effusion requiring intervention
<input type="checkbox"/> Aortic Complication	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Arrhythmia or Heart Block	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Blood Pressure (hyper or hypotension)	<input type="checkbox"/> Renal Insufficiency
<input type="checkbox"/> Chest pain, noncardiac	<input type="checkbox"/> Respiratory complication, Other

<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery/Graft Dysfunction <input type="checkbox"/> Depression/psychiatric issue <input type="checkbox"/> DVT <input type="checkbox"/> Electrolyte imbalance <input type="checkbox"/> Endocarditis <input type="checkbox"/> Failure to thrive <input type="checkbox"/> GI issue <input type="checkbox"/> Infection, Conduit Harvest Site <input type="checkbox"/> Infection, Deep Sternum / Mediastinitis <input type="checkbox"/> Mental status changes <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> PE	<input type="checkbox"/> Sepsis <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Transfusion <input type="checkbox"/> Transplant Rejection <input type="checkbox"/> VAD Complication <input type="checkbox"/> Valve Dysfunction <input type="checkbox"/> Vascular Complication, acute <input type="checkbox"/> Wound , other (drainage, cellulitis) <input type="checkbox"/> Other – Related Readmission <input type="checkbox"/> Other – Nonrelated Readmission <input type="checkbox"/> Other – Planned Readmission <input type="checkbox"/> Unknown
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p>Readmit <u>Primary</u> Procedure:</p> <input type="checkbox"/> No Procedure Performed <input type="checkbox"/> Cath lab for Valve Intervention <input type="checkbox"/> Cath lab for Coronary Intervention (PCI) <input type="checkbox"/> Dialysis <input type="checkbox"/> OR for Bleeding <input type="checkbox"/> OR for Coronary Artery Intervention <input type="checkbox"/> OR for Sternal Debridement / Muscle Flap <input type="checkbox"/> OR for Valve Intervention</div> <div style="width: 48%;"> <input type="checkbox"/> OR for Vascular Procedure <input type="checkbox"/> OR for Aorta Intervention <input type="checkbox"/> Pacemaker Insertion / AICD <input type="checkbox"/> Pericardiotomy / Pericardiocentesis <input type="checkbox"/> Planned noncardiac procedure <input type="checkbox"/> Thoracentesis/ Chest tube insertion <input type="checkbox"/> Wound vac <input type="checkbox"/> Other Procedure <input type="checkbox"/> Unknown </div> </div> <p>(if OR for Aorta intervention→)</p> <p style="margin-left: 40px;">Type: <input type="checkbox"/> Open <input type="checkbox"/> Endovascular</p> <p style="margin-left: 40px;">Indication: <input type="checkbox"/> Rupture <input type="checkbox"/> Endoleak <input type="checkbox"/> Infection <input type="checkbox"/> Dissection <input type="checkbox"/> Expansion <input type="checkbox"/> Loss of side branch patency <input type="checkbox"/> Other</p>	

Adult Cardiac Anesthesiology (for sites participating in the optional anesthesiology component)							
Primary Anesthesiologist Name: _____		Primary Anesthesiologist National Provider Number: _____					
Anesthesiology Care Team Model: <input type="checkbox"/> Anesthesiologist working alone <input type="checkbox"/> Attending anesthesiologist teaching/medically directing fellow <input type="checkbox"/> Attending anesthesiologist teaching/medically directing house staff <input type="checkbox"/> Attending anesthesiologist medically directing CRNA (1:4 ratio or less) <input type="checkbox"/> Attending anesthesiologist medically directing CRNA (1:5 ratio or greater) <input type="checkbox"/> Surgeon medically directing CRNA <input type="checkbox"/> CRNA practicing independently							
Pain Score Baseline: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Recorded							
Algorithm to Guide Transfusion: <input type="checkbox"/> Yes, SCA/STS algorithm used <input type="checkbox"/> Yes, other algorithm used <input type="checkbox"/> No Algorithm used		Cell Saver Volume: _____					
Heparin Total Dose: _____		(If TotHep > 0 →) Heparin Management: <input type="checkbox"/> Heparin titration based on activated clotting time (ACT) <input type="checkbox"/> Heparin titration based on heparin concentration (e.g. Hepcon system) <input type="checkbox"/> Other method					
Protamine Total Dose: _____		Antithrombin III Total Dose: _____ Viscoelastic Testing Used Intraop: <input type="checkbox"/> Yes <input type="checkbox"/> No					
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Volatile Agent Used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)</td> <td style="width: 20%;">Volatile Agent(s) used:</td> <td style="width: 20%;">Isoflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Sevoflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Pre CPB <input type="checkbox"/> Yes <input type="checkbox"/> No Post CPB <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 20%;">Desflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No During CPB <input type="checkbox"/> Yes <input type="checkbox"/> No Maintenance (if no CPB) <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>				Volatile Agent Used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes →)	Volatile Agent(s) used:	Isoflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Sevoflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Pre CPB <input type="checkbox"/> Yes <input type="checkbox"/> No Post CPB <input type="checkbox"/> Yes <input type="checkbox"/> No	Desflurane <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No During CPB <input type="checkbox"/> Yes <input type="checkbox"/> No Maintenance (if no CPB) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Intraop Infusion <input type="checkbox"/> Yes Dexmedetomidine: <input type="checkbox"/> No		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Intraop Infusion <input type="checkbox"/> Yes Propofol: <input type="checkbox"/> No</td> <td style="width: 30%;">Intraop Mgs Midazolam: _____</td> <td style="width: 40%;">Intraop Insulin Total Dose: _____</td> </tr> </table>		Intraop Infusion <input type="checkbox"/> Yes Propofol: <input type="checkbox"/> No	Intraop Mgs Midazolam: _____	Intraop Insulin Total Dose: _____	
Intraop Infusion <input type="checkbox"/> Yes Propofol: <input type="checkbox"/> No	Intraop Mgs Midazolam: _____	Intraop Insulin Total Dose: _____					
Pre Induction Systolic BP: _____		Pre Induction Diastolic BP: _____ Pre Induction Mean BP: _____					
Pre Induction Heart Rate: _____		Pulmonary Artery Catheter Used: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Core Temperature Source: <input type="checkbox"/> Esophageal <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Tympanic <input type="checkbox"/> Bladder <input type="checkbox"/> PA Catheter Thermistor <input type="checkbox"/> Rectal		Core Temp Max: _____					
Intra Op Nitric Oxide: <input type="checkbox"/> Yes <input type="checkbox"/> No		Anesth. Total Crystalloid: _____ Anesth. Synthetic Colloid: _____					
Anesthesiology Total Albumin: _____		Intraop Glucose Trough: _____					
Intraop Vasodilators Used: <input type="checkbox"/> Yes <input type="checkbox"/> No							
Intraoperative Processed EEG (BIS): <input type="checkbox"/> Yes <input type="checkbox"/> No							
Intraop Transesophageal Echo (TEE): <input type="checkbox"/> Yes <input type="checkbox"/> No							
(If Pre Proc TEE is Yes→)	Pre-procedure LVEF Measured: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) LVEF: _____						
	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Pre-procedure RV Function:</td> <td style="width: 30%;"> <input type="checkbox"/> Normal <input type="checkbox"/> Moderate Dysfunction <input type="checkbox"/> Mild Dysfunction <input type="checkbox"/> Severe Dysfunction </td> <td style="width: 40%;"> <input type="checkbox"/> Not Assessed </td> </tr> </table>			Pre-procedure RV Function:	<input type="checkbox"/> Normal <input type="checkbox"/> Moderate Dysfunction <input type="checkbox"/> Mild Dysfunction <input type="checkbox"/> Severe Dysfunction	<input type="checkbox"/> Not Assessed	
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	Mitral Regurgitation:	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Trace/trivial <input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not assessed				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Mitral Stenosis:</td> <td style="width: 30%;"> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe </td> <td style="width: 40%;"> <input type="checkbox"/> Not Assessed </td> </tr> </table>			Mitral Stenosis:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe	<input type="checkbox"/> Not Assessed	
	Mitral Stenosis:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe	<input type="checkbox"/> Not Assessed				
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Aortic Regurgitation:</td> <td style="width: 30%;"> <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Trace/trivial <input type="checkbox"/> Moderate </td> <td style="width: 40%;"> <input type="checkbox"/> Severe <input type="checkbox"/> Not assessed </td> </tr> </table>			Aortic Regurgitation:	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Trace/trivial <input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not assessed		
Aortic Regurgitation:	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Trace/trivial <input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not assessed					
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Aortic Stenosis:</td> <td style="width: 30%;"> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe </td> <td style="width: 40%;"> <input type="checkbox"/> Not Assessed </td> </tr> </table>			Aortic Stenosis:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe	<input type="checkbox"/> Not Assessed		
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<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Aortic Valve Area Assessed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→)</td> <td style="width: 50%;">Aortic Valve Area: _____</td> </tr> <tr> <td>Tricuspid Regurgitation:</td> <td> <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Severe </td> </tr> </table>			Aortic Valve Area Assessed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→)	Aortic Valve Area: _____	Tricuspid Regurgitation:	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Severe	
Aortic Valve Area Assessed: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→)	Aortic Valve Area: _____						
Tricuspid Regurgitation:	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Severe						

	<input type="checkbox"/> Trace/trivial <input type="checkbox"/> Moderate <input type="checkbox"/> Not assessed
	Patent Foramen Ovale: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed
	Ascending Aorta Assessed <input type="checkbox"/> Yes <input type="checkbox"/> No Maximal Ascending Aorta Diameter: _____ (If Yes→) Maximal Ascending Aorta Atheroma Thickness: _____ Ascending Aorta Atheroma Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Aortic Arch Visualized: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Maximal Aortic Arch Atheroma Thickness: _____ Aortic Arch Atheroma Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiopulmonary Bypass Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If CPB Use is Yes→)	Retrograde Autologous Priming of CPB Circuit: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Total Crystalloid Administered by Perfusion Team: _____
	Total Synthetic Colloid Administered by Perfusion Team: _____
	Total Albumin Administered by Perfusion Team: _____
	Hemofiltration Volume Removed by Perfusion Team: _____
	Inotropes used to wean from CPB: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Vasopressors used to wean from CPB: <input type="checkbox"/> Yes <input type="checkbox"/> No
Post-Procedure Use Of Intraoperative TEE: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If Post Proc TEE is Yes→)	Systolic Anterior Motion of Mitral Valve: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed
	Return to CPB for Echo Related Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Post-Procedure LVEF Measured: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Post-Procedure LVEF: _____
	Post-Procedure RV Function: <input type="checkbox"/> Normal <input type="checkbox"/> Mild Dysfunction <input type="checkbox"/> Moderate Dysfunction <input type="checkbox"/> Not Assessed
Intraoperative cardiac arrest related to anesthesia care: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Died in the OR: <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If OR Death is No→)	Core Temp Measured upon Entry to ICU/PACU: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Post Op Core Temp: _____
	Post-Op INR Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) INR: _____
	WBC Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) WBC : _____
	Platelets Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Platelet Count: _____
	Hematocrit Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Hematocrit: _____
	Fibrinogen Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Fibrinogen _____
	Lactate Measured upon admission to post op care location (PACU, ICU): <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes→) Lactate: _____
	Post Op Dexmedetomidine: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Post Op Propofol: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Post Op Delirium: <input type="checkbox"/> Yes <input type="checkbox"/> No

	Post Op Heparin Induced Thrombocytopenia: <input type="checkbox"/> Yes <input type="checkbox"/> No												
	Pain Score POD #3:												
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not recorded	<input type="checkbox"/> NA
	Pain Score Discharge:												
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not recorded	<input type="checkbox"/> NA