Participant ID: _____ **Participant Initials:** _____

Clinical Center: _____ **Site:** _____ **Visit Number:** _____ Reset Patient / RC

CRF Date: ____ / ____ / ____ **RC ID:** _____ Reset All

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

Note: Coordinators should complete a separate Administrative Hospital Record (***ADMINEVAL***) case report form for each event that is indicated in Event Notification generated by the Data Management System.

1. DMS tracking number:

___ ___ ___

Please record DMS Tracking # on ***EVENTS*** case report form.

2. Medical Events Questionnaire (***EVENTS***) date:

__ __ / __ __ / __ __ __ __ (***mm/dd/yyyy***)

3. Was this hospitalization documented in Q. #5 – Medical Event Questionnaire (***EVENTS***) at this visit?

☐1 Yes ☐0 No

If "Yes" in question #3, go to question #3a. If "No" in question #3, go to question #4.

3a. Hospitalization dates reported by the participant in Q. #5 - Medical Event Questionnaire (***EVENTS***) for this event:

Admission __ __ / __ __ / __ __ __ __ (***mm/dd/yyyy***)

Discharge __ __ / __ __ / __ __ __ __ (***mm/dd/yyyy***)

4. Did you identify and obtain hospital records for this hospitalization?

☐1 Yes ☐0 No

If "Yes" in question #4, go to question #4a. If "No" in question #4, STOP here.

4a. Hospitalization dates from hospital records:

Admission __ __ / __ __ / __ __ __ __ (***mm/dd/yyyy***)

Discharge __ __ / __ __ / __ __ __ __ (***mm/dd/yyyy***)

Name and address of hospital from administrative records:
(This field should NOT be entered into the DMS.)

_____

_____

5. Did you identify administrative hospital codes for this hospitalization?

☐1 Yes ☐0 No

If "Yes" in question #5, go to question #6. If "No" in question #5, complete the Principal Investigator-Determined Events (***PIEVENTS***) case report form.

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

6. Check **ALL** of the codes in the following list that were identified for this hospitalization in administrative records:

	ICD-9 Code	Diagnosis	Category
☐	398.91	Rheumatic heart failure (includes all codes in series)	**Heart Failure (CHF)**
☐	402.01	Hypertensive heart disease (malignant) with CHF	
☐	402.11	Hypertensive heart disease (benign) with CHF	
☐	402.91	Hypertensive heart disease (unspecified) with CHF	
☐	410	Acute myocardial infarction (includes all codes in series)	**Myocardial Infarction (MI)**
☐	411	Other acute and subacute forms of ischemic heart disease (includes all codes in series)	
☐	412	Old myocardial infarction (include all codes in series in primary position only)	
☐	413	Angina pectoris (includes all codes in series)	
☐	414	Other forms of chronic ischemic heart disease (include all codes in series in primary position only)	
☐	425	Cardiomyopathy (includes all codes in series)	**Heart Failure (CHF)**
☐	427	Cardiac dysrhythmias (includes all codes in series)	**Arrhythmias**
☐	428	Heart failure (includes all codes in series)	**Heart Failure (CHF)**
☐	429	Ill-defined descriptions and complications of heart disease (includes all codes in series)	
☐	430	Subarachnoid hemorrhage	**Cerebrovascular**
☐	431	Intracerebral hemorrhage	
☐	432	Other and unspecified intracerebral hemorrhage (includes all codes in series)	
☐	433	Occlusion and stenosis of intracerebral arteries (includes all codes in series)	
☐	434	Occlusion of cerebral arteries (includes all codes in series)	
☐	435	Transient cerebral ischemia (TIA) (includes all codes in series)	
☐	436	Acute but ill-defined cerebrovascular disease	
☐	440	Atherosclerosis (includes all codes in series)	**Peripheral Vascular Disease (PVD)**
☐	441	Aortic aneurysm (includes all codes in series) and dissection	
☐	443	Other peripheral vascular disease (includes all codes in series)	
☐	444	Arterial embolism and thrombosis (includes all codes in series)	
☐	514	Pulmonary congestion and hypostasis	**Heart Failure (CHF)**
☐	518.4	Acute edema of lung, unspecified	
☐	798	Sudden death, cause unknown (includes all codes in series)**	**Deceased**
☐	799	Other ill-defined and unknown causes of morbidity and mortality** (includes all codes in series)	
☐	V68.0	Issue of medical certificate for cause of death**	

Death Record Evaluation Form (*DEATHREC***) should be completed

Participant ID: Participant Initials:

Clinical Center: Site: Visit Number: Reset Patient / RC

CRF Date: / / RC ID: Reset All

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	ICD-9 Procedure Code	Procedure	Category
☐	36.01	Percutaneous transluminal coronary angioplasty	Myocardial Infarction (MI)
☐	36.02		
☐	36.05		
☐	36.06		
☐	36.1	Coronary artery bypass graft	
☐	36.10		
☐	36.11		
☐	36.12		
☐	36.13		
☐	36.14		
☐	36.15		
☐	36.16		
☐	36.17		
☐	36.19		
☐	37	Other operations on heart or pericardium	
☐	37.2	Cardiac Catherization	
☐	37.21	Right vessel	Myocardial Infarction (MI)
☐	37.22	Left vessel	
☐	37.23	Both vessels	
☐	38.10	Carotid Endarterectomy	Cerebrovascular
☐	38.13	Coronary endarterectomy	Myocardial Infarction (MI)
☐	38.14		
☐	38.15		
☐	38.16		
☐	38.18		
☐	39.22	Coronary artery bypass graft with other than vein	
☐	39.24		
☐	39.25		
☐	39.26		
☐	39.28		

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	CPT Code	Procedure	Category
☐	24900	Amputation of upper and lower limbs or digits	Peripheral Vascular Disease (PVD)
☐	25900		
☐	25927		
☐	26910		
☐	27880		
☐	33200	Insertion, repositioning, repair, or removal of pacemaker or defibrillator	Arrhythmias
☐	33201		
☐	33206		
☐	33207		
☐	33208		
☐	33210		
☐	33211		
☐	33212		
☐	33213		
☐	33214		
☐	33215		
☐	33216		
☐	33217		
☐	33218		
☐	33220		
☐	33222		
☐	33223		
☐	33224		
☐	33225		
☐	33226		
☐	33233		
☐	33234		
☐	33235		
☐	33236		
☐	33237		
☐	33238		
☐	33240		
☐	33241		
☐	33243		
☐	33244		
☐	33245		
☐	33246		
☐	33249		
☐	33250	Electrophysiological operative procedures (ablation or incisions/reconstruction of atria)	
☐	33251		
☐	33253		
☐	33261		
☐	33282	Implantation/removal of patient-activated event recorder	
☐	33284		
☐	33322	Suture repair of aorta or great vessels; with cardiopulmonary bypass	Peripheral Vascular Disease (PVD)
☐	33335	Insertion of graft, aorta or great vessels; with cardiopulmonary bypass	

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	CPT Code	Procedure	Category
☐	33510	Coronary artery bypass with venous grafts	Myocardial Infarction (MI)
☐	33511		
☐	33512		
☐	33513		
☐	33514		
☐	33516		
☐	33517		
☐	33518		
☐	33519	Coronary artery bypass with venous and arterial grafts	
☐	33521		
☐	33522		
☐	33523		
☐	33533		
☐	33534		
☐	33535		
☐	33536		
☐	33572	Coronary endarterectomy	Cerebrovascular
☐	33860	Ascending aorta graft, w/cardiopulmonary bypass, with or w/o valve suspension	Peripheral Vascular Disease (PVD)
☐	33870	Transverse arch graft, w/cardiopulmonary bypass, with or w/o valve suspension	
☐	35301	Thromboendarterectomy	
☐	35311		
☐	35321		
☐	35331		
☐	35341		
☐	35351		
☐	35355		
☐	35361		
☐	35363		
☐	35371		
☐	35372		
☐	35381		
☐	35390		
☐	35450	Transluminal balloon angioplasty	
☐	35452		
☐	35454		
☐	35456		
☐	35458		
☐	35459		
☐	35470	Percutaneous transluminal coronary angioplasty	Myocardial Infarction (MI)
☐	35471		
☐	35472		
☐	35473		
☐	35474		
☐	35475		

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	CPT Code	Procedure	Category
☐	35511	Bypass graft with vein	Peripheral Vascular Disease (PVD)
☐	35516		
☐	35518		
☐	35521		
☐	35531		
☐	35533		
☐	35536		
☐	35541		
☐	35546		
☐	35548		
☐	35549		
☐	35551		
☐	35556	Bypass graft with vein	Peripheral Vascular Disease (PVD)
☐	35558		
☐	35560		
☐	35563		
☐	35565		
☐	35566		
☐	35571		
☐	35582	In situ vein bypass	
☐	35583		
☐	35585		
☐	35587	Bypass graft with other than vein	
☐	35612		
☐	35616		
☐	35621		
☐	35623		
☐	35631		
☐	35636		
☐	35641		
☐	35646		
☐	35650		
☐	35651		
☐	35654		
☐	35656		
☐	35661		
☐	35663		
☐	35665		
☐	35666		
☐	35671		
☐	35700	Reoperation, femoral-popliteal or femoral (popliteal), anterior tibial, posterior tibial, peroneal artery or other distal vessels (>1 month after original operation)	Peripheral Vascular Disease (PVD)
☐	35879	Revision, lower extremity arterial bypass w/o thrombectomy; with vein patch angioplasty	
☐	75962	Transluminal balloon angioplasty; with radiological supervision and interpretation	
☐	75964		
☐	75966		
☐	75968		

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	CPT Code	Procedure	Category
☐	92980	Transcatheter placement of intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	Myocardial Infarction (MI)
☐	92981	Transcatheter placement of intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	
☐	92982	Percutaneous transluminal coronary angioplasty	
☐	92984		
☐	92986	Percutaneous balloon valvuloplasty	Heart Failure (CHF)
☐	92987		
☐	92990		
☐	92995	Percutaneous transluminal coronary atherectomy	Myocardial Infarction (MI)
☐	92996		
☐	93600	Intracardiac electrophysiological procedures/studies (recordings, pacing, ablation, echocardiography)	Arrhythmias
☐	93602		
☐	93603		
☐	93609		
☐	93610		
☐	93612		
☐	93613		
☐	93615		
☐	93616		
☐	93618		
☐	93619		
☐	93620		
☐	93621		
☐	93622		
☐	93623		
☐	93624		
☐	93631		
☐	93640		
☐	93641		
☐	93642		
☐	39650		
☐	93652		
☐	93660		
☐	93662		
☐	93724	Electronic analysis of pacemaker/defribrillator	
☐	93727		
☐	93731		
☐	93732		
☐	93733		
☐	93734		
☐	93735		
☐	93736		
☐	93740		
☐	93741		
☐	93742		
☐	93743		
☐	93744		

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

	CPT Code	Procedure	Category
☐	V42.0*	Kidney transplant*	Renal Replacement Therapy
☐	V49.7	Lower limb amputation	Peripheral Vascular Disease (PVD)

*If the code for a kidney transplant is present, complete and data enter the ***RRTPRIM*** or ***RRTFUP*** case report form.

If one or more administrative codes are identified in item #6, obtain, copy and de-identify relevant (as defined by the table below) hospital records and transfer to the SDCC.

7. Administrative Hospital Record Evaluation Summary:

Check a response in item #7 and go to item #7a.

☐$_1$ No listed administrative codes (in item #6) were identified in medical records

☐$_2$ One or more listed administrative codes (in item #6) were identified

7a. List (first five) ICD-9 codes recorded in participant's administrative hospital records:

i. _____

ii. _____

iii. _____

iv. _____

v. _____

Participant ID: Participant Initials:

Clinical Center: Site: Visit Number: Reset Patient / RC

CRF Date: / / RC ID: Reset All

ADMINISTRATIVE HOSPITAL RECORD EVALUATION

Required Medical Records:

CRIC-related event date identified in hospital administrative records:

__ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

MEDICAL RECORDS	MI	CHF	Arrhythmia	PVD	CVA/ICH
ED physician note	☒	☒	☒		☒
Admission note	☒	☒	☒		☒
Selected daily progress notes	☒**(a)**	☒**(d)**	☒**(e)**		☒ **(f)**
Discharge summary	☒	☒	☒	☒	☒
Cardiologist notes	☒**(a)**	☒**(d)**	☒**(e)**		
Neurologist notes					☒ **(f)**
Cerebrovascular imaging of head or neck					
CT scans or CT angiograms					☒
Magnetic resonance imaging					☒
Magnetic resonance angiography					☒
Angiograms					☒
Carotid ultrasound					☒
Cardiovascular procedures and imaging					
Cardiac catheterizations	☒	☒			
Rhythm strips			☒ **(e)**		
Electrocardiograms (ECG)	☒ **(b)**		☒ **(e)**		
Chest X-rays		☒ **(d)**			
Pulmonary artery (Swan-Ganz) catheterization readings (wedge pressure, cardiac index, etc.)		☒ **(d)**			
Peripheral vascular arteriogram or angioplasty				☒	
Operative reports					
Coronary artery bypass	☒				
Cardioverter or pacemaker implantation			☒		
Neurologic operations					☒
Peripheral vascular amputations				☒	
Laboratory reports					
Cardiac enzymes	☒ **(c)**				
Brain natriuretic peptide		☒			
Lumbar puncture results					☒

(a) Copy all progress notes starting 48 hours before and ending 48 hours after the sets of cardiac enzymes and ECGs were performed to rule in or rule out MI and acute coronary syndrome (in the case of MI/ACS)
(b) Copy ECGs from 48 hours before until 48 hours after event; also include admission ECG and last ECG prior to discharge
(c) Includes CK, CK-MB, Troponin-I, Troponin-T, LDH, LDH1, and LDH2, if available
(d) Copy all progress notes, chest X-rays, and pulmonary artery catheterizations during first 48 hours of admission
(e) Copy all progress notes, ECGs, and rhythm/telemetry strips starting 48 hours before and ending 48 hours after the episode of arrhythmia (rhythm/telemetry strips should only include those that are pertinent to the arrhythmia)
(f) Copy all progress notes starting 48 hours before and ending 48 hours after the cerebrovascular event