CARDIA PID: __-__-__-__-__-__-__-__-__-__ Contact Period: __________

Admission Date: ____/____/______ Hospitalization/Event Number: __________
Month Day Year

Did the participant die during this admission?
1 ☐ No
2 ☐ Yes → complete Form 33F - Mortality Review/Adjudication Form

Reviewer/Adjudicator ID: ____ (BL-601;SS-608;CI-612;GW-619;RD-620;HK-620;DS-621;DL-622;DD-623;SG-624)

Review/Adjudication Date: ____/____/______
Month Day Year

Please review/adjudicate for the endpoints marked below. If additional endpoints are identified during the review/adjudication process, please mark them and record any comments in the space provided below.

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Question No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction (MI)</td>
<td>Questions 1- 4</td>
</tr>
<tr>
<td>Non-MI Acute Coronary Syndrome</td>
<td>Questions 1- 3, 5</td>
</tr>
<tr>
<td>Coronary Revascularization</td>
<td>Question 6</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>Questions 1-3, 7</td>
</tr>
<tr>
<td>Stroke</td>
<td>Question 8</td>
</tr>
<tr>
<td>Transient Ischemic Attack (TIA)</td>
<td>Question 9</td>
</tr>
<tr>
<td>Carotid Artery Disease (CAD)</td>
<td>Question 10</td>
</tr>
<tr>
<td>Peripheral Arterial Disease (PAD)</td>
<td>Question 11</td>
</tr>
<tr>
<td>Deep Venous Thrombosis (DVT)</td>
<td>Question 12</td>
</tr>
<tr>
<td>Pulmonary Embolism (PE)</td>
<td>Question 13</td>
</tr>
<tr>
<td>Diabetes Mellitus (DM)</td>
<td>Question 14</td>
</tr>
<tr>
<td>Asthma/ Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Question 15</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Question 16</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>Question 17</td>
</tr>
<tr>
<td>Atrial Fibrillation/ Atrial Flutter</td>
<td>Question 18</td>
</tr>
</tbody>
</table>

COMMENTS (Please include any other information you deem important here):
1. **ECG Pattern**  
   (Mark the one category that best applies.)
   
   1  □ Evolving diagnostic ECG (e.g. new diagnostic Q wave)
   2  □ Positive ECG (e.g. evolving ST elevation or new LBBB)
   3  □ Non-specific ECG (e.g. evolving non-ST elevation, non-Q wave pattern)
   4  □ ECG negative for ischemia
   5  □ ECG not available

2. **Is cardiac enzyme information available?**  
   (At least two measurements of same marker taken at least six hours apart)
   
   1  □ No  ➔ Go to Question 3
   2  □ Yes—adequate (see Table 2 “Algorithm for enzyme diagnostic criteria of MI”)
   3  □ Yes—inadequate

2.1. **Serum creatine kinase (CK)**  
   (Always record % or index if available.)
   
   If CK-MB available:
   2.1a. **CK-MB expressed as a % or index** (Record peak results only.)
      
      5  □ CK-MB at least 5x ULN for % or index
      4  □ CK-MB at least 3x ULN but less than 5x ULN
      1  □ CK-MB at least 2x ULN but less than 3x ULN
      2  □ CK-MB greater than ULN but less than 2x ULN
      3  □ CK-MB within normal limits for % or index

   2.1b. **CK-MB expressed in units (usually ng/ml)** (Record peak results only.)
      
      5  □ CK-MB at least 5x ULN for units
      4  □ CK-MB at least 3x ULN but less than 5x ULN
      1  □ CK-MB at least 2x ULN but less than 3x ULN
      2  □ CK-MB greater than ULN but less than 2x ULN
      3  □ CK-MB within normal limits for units

   2.1c. **No units or % index given for CK-MB**
      
      1  □ CK-MB reported as “present” without quantification
      2  □ CK-MB reported as “weakly present” without quantification

   2.1d. **If CK-MB not available**  
      (Mark the one category that best applies.)
      
      1  □ Total CK at least 2x ULN
      2  □ Total CK greater than ULN but less than 2x ULN
      3  □ Total CK within normal limits
      4  □ CK result not available
2.2. **Troponin lab test**  
(Mark the one category that best applies. If more than one test was conducted, record the type with the most elevated lab result.)

1  □  Troponin C → Go to Question 2.2.1.
2  □  Troponin I → Go to Question 2.2.1.
3  □  Troponin T → Go to Question 2.2.1.
4  □  Troponin, not specified → Go to Question 2.2.1.
5  □  Troponin not available → Go to Question 2.3.

2.2.1. **Results**  
(Mark the one category that best applies.)

5  □  Troponin at least 5x ULN
6  □  Troponin at least 3x ULN but less than 5x ULN
1  □  Troponin at least 2x ULN but less than 3x ULN
2  □  Troponin greater than ULN but less than 2x ULN
3  □  Troponin within normal limits
4  □  Other

2.3. **Myoglobin**

1  □  At least 2x ULN
2  □  Greater than ULN but less than 2x ULN
3  □  Within normal limits
4  □  Other (specify): ______________________________

2.4. **“Other” Cardiac-Specific Lab (specify): ______________________________**

Results  
(Mark the one category that best applies.)

1  □  At least 2x ULN
2  □  Greater than ULN but less than 2x ULN
3  □  Within normal limits
4  □  Other (specify): ______________________________

3. **Were there cardiac signs or symptoms of ischemia on admission or within 24 hours of the event?**

1  □  No
2  □  Yes
8  □  Unknown/Not Recorded

Cardiac Symptoms:  
Presence of acute chest, epigastric, neck, jaw or arm pain or discomfort or pressure without apparent non-cardiac cause
Myocardial Infarction (MI)

1. No
2. Definite (see Table 1)
3. Probable (see Table 1)
4. Possible (see Table 1)
5. Aborted (see Table 1)
8. Unknown/Not Sure

4.1. Was the MI during, or resulting from, a procedure?
1. No
2. Yes
8. Unknown/Not Sure

4.2. Was a thrombolytic agent (e.g. TPA, streptokinase, urokinase) or procedure (e.g. angioplasty) administered?
1. No
2. Yes → Go to Question 4.2.1
8. Unknown

4.2.1. Type of procedure on this admission
(Mark all that apply.)
- Coronary artery bypass graft (CABG)
- Percutaneous transluminal coronary angioplasty (PTCA), coronary stent, or coronary atherectomy
- Thrombolytic agent

Non-MI Acute Coronary Syndrome

Requires an unscheduled admission to r/o MI, including collection of cardiac biomarkers (i.e., cardiac enzymes), due to accelerating or new symptoms consistent with coronary artery ischemia. Favor the discharge summary/discharge diagnoses over the admitting note, admitting diagnosis, differential diagnosis. Non-MI ACS must be distinct from MI. Elective admission for revascularization does NOT meet criteria for non-MI ACS.

1. No
2. Definite (5.1.1 and 5.1.2) AND (at least one criterion of 5.1.4 – 5.1.8)
3. Probable (5.1.1 and 5.1.2) OR (5.1.1 and 5.1.3)
8. Unknown/Not Sure

5.1. Non-MI ACS is based on: (Mark all that apply.)
5.1.1. New chest pain or changing symptom pattern consistent with cardiac ischemia prompting admission
5.1.2. Final physician diagnosis of Non-MI ACS by treating physician and receiving medical treatment on this admission (e.g. nitrate, beta blocker or calcium channel blocker.)
5.1.3. Current medical record documenting a history of coronary heart disease by previous catheterization or revascularization procedure
5.1.4. CABG surgery or other revascularization procedure on this admission
5.1.5. ≥ 70% obstruction of any coronary artery on angiography on this admission
5.1.6. Horizontal or down-sloping ST-segment depression or abnormal ST elevation ≥ 1 mm on exercise or pharmacological stress testing with pain on this admission or immediately preceding and leading to this admission
5.1.7. Scintigraphic or echocardiographic stress test positive for ischemia on this admission or immediately preceding and leading to this admission
5.1.8. Resting ECG shows horizontal or down-sloping ST depression or abnormal ST elevation ≥ 1 mm with pain that is not present on ECG without pain on this admission
6. **Coronary revascularization during this episode of care**

   1. □ No
   2. □ Yes → Go to Questions 6a. & 6b.

6a. **Type of procedure:** Any one of the following procedures aimed at improving cardiac status. (Mark all that apply.)

   - □ Coronary artery bypass graft (CABG)
   - □ Percutaneous transluminal coronary angioplasty (PTCA), coronary stent, or coronary atherectomy

6b. **Second myocardial infarction (MI)** (e.g. second MI not already reported in Question 4, occurring as a result of, or during the, revascularization procedure)

   1. □ No
   2. □ Yes

7. **Congestive Heart Failure (CHF)**

Assign an overall heart failure diagnosis based on your clinical judgment (select only one). Historical information can be considered when assigning this diagnosis. However imaging results recorded no this form should be from this admission only.

   1. □ Heart failure unlikely → Skip to Item 7.2
   2. □ Definite decompensated heart failure
   3. □ Possible decompensated heart failure
   4. □ Chronic stable heart failure → Skip to Item 7.2
   8. □ Unclassifiable → Skip to Item 7.2

7.1. Was definite or possible decompensated heart failure present at admission?

   1. □ No
   2. □ Yes

7.2. **Is there evidence of:**

   (Please record findings present during current admission only.)

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal LV systolic function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal RV systolic function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LV diastolic dysfunction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.3. **Estimated LVEF (worst):**

   (Mark the one category that best applies. If reported as “normal” record as ≥50%. Please record findings present during current admission only.)

   1. □ ≥50%
   2. □ 35-49%
   3. □ <35%
   8. □ Unknown/Not Sure
8. **Stroke**
Rapid onset of headache, meningismus or a persistent neurologic deficit attributable to an obstruction or rupture of the arterial system (including stroke occurring during a procedure such as angiography or surgery). Deficit is not known to be a secondary to brain trauma, infection, or other non-ischemic cause. Deficit must last more than 24 hours, unless death supervenes or there is a demonstrable lesion compatible with acute stroke on CT or MRI scan.

1  □  No
2  □  Definite (8.2.1 OR 8.2.4 OR 8.2.5 OR 8.2.6 OR 8.2.8)
3  □  Probable (8.2.2 OR 8.2.3 OR 8.2.9)
8  □  Unknown/Not Sure

8.1. **Final stroke diagnosis** (Mark the one category that best applies.)
1  □  Definite ischemic stroke (confirmed by CT, MRI, or autopsy)

<table>
<thead>
<tr>
<th></th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Large artery atherosclerosis</td>
</tr>
<tr>
<td>2</td>
<td>Cardioembolic (High, medium, or low risk source – If more than one is present, mark the highest risk only)</td>
</tr>
</tbody>
</table>

**High Risk Source (Mark all that apply.)**

- Mechanical prosthetic valve(s)
- Mitral stenosis with atrial fibrillation
- Atrial fibrillation
- Left ventricular or left atrial appendage thrombus
- Sick sinus syndrome
- MI within 4 weeks
- Dilated cardiomyopathy
- Akinetic left ventricular segment
- Atrial myxoma
- Infective endocarditis

**Medium Risk Source (Mark all that apply.)**

- Mitral valve prolapse
- Mitral annulus calcification
- Mitral stenosis without atrial fibrillation
- Left atrial turbulence
- Atrial septal aneurysm
- Patent foramen ovale
- Atrial flutter
- Bioprosthetic cardiac valve
- Nonbacterial thrombotic endocarditis
- Congestive heart failure
- Hypokinetic left ventricular segment
- MI more than 4 weeks but less than 6 months before onset

**Low Risk Source**

- Lone atrial fibrillation

3  □  Small vessel occlusion (lacunar)
4  □  Stroke of other determined etiology (Mark all that apply.)

- Vasculitis
- Noninflammatory vasculopathy
- Hypercoagulable state
- Other

5  □  Stroke of indeterminate etiology
2  □ Probable ischemic stroke (negative or nonspecific CT or MRI performed within 48 hours of onset)
3  □ Definite primary intracerebral hemorrhage (confirmed by CT, MRI, or autopsy)
4  □ Probable intracerebral hemorrhage (decreased consciousness for at least 24 hours with bloody or xanthochromic CSF and no CT)
5  □ Subarachnoid hemorrhage
6  □ Possible subarachnoid hemorrhage
7  □ Stroke of unknown type (CT, MRI, or autopsy not done)

8.2. Stroke diagnosis was based on:
(Mark the one category that best applies.)

8.2.1 □ Rapid onset of neurological deficit and CT or MRI scan shows acute focal brain lesion consistent with neurological deficit and without evidence of blood (except mottled cerebral pattern)
8.2.2 □ Rapid onset of localizing neurological deficit with duration > 24 hours but imaging studies are not available
8.2.3 □ Rapid onset of neurological deficit with duration > 24 hours and the only available CT or MRI scan was done early and shows no acute lesion consistent with the neurological deficit
8.2.4 □ Surgical evidence of ischemic infarction of brain
8.2.5 □ CT or MRI findings of blood in subarachnoid space
8.2.6 □ Intra-parenchymal hemorrhage, consistent with neurological signs or symptoms
8.2.7 □ Positive lumbar puncture (for subarachnoid hemorrhage)
8.2.8 □ Surgical evidence of subarachnoid or intra-parenchymal hemorrhage as the cause of a clinical syndrome consistent with stroke
8.2.9 □ None of the above (e.g. fatal strokes where no imaging studies or clinical evidence are available)
9. **Transient Ischemic Attack (TIA)**

Assign an overall diagnosis based on clinical judgment. It is possible to downgrade the diagnosis based on the medical history evidence (e.g., weak documentation, symptoms atypical) regardless of parenthetical criteria. (select only one)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Definite (9.1.1 or 9.1.2; and 9.1.3)</td>
</tr>
<tr>
<td>3</td>
<td>Probable (9.1.1 or 9.1.2; and 9.1.4) or (9.1.3 and 9.1.5)</td>
</tr>
<tr>
<td>8</td>
<td>Unknown/Not Sure</td>
</tr>
</tbody>
</table>

**Transient Ischemic Attack:**
One or more episodes of the sudden onset of a focal neurologic deficit involving ONE *major* neurologic symptom or TWO *minor* neurologic symptoms. No head trauma occurring immediately before the onset of the neurological event. If deficits resolve, but imaging is negative, consistent with TIA.

### 9.1. Diagnosis of TIA based on:
(Mark all that apply.)

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>9.1.1</td>
<td>Transient episode involving ONE <em>major</em> neurologic symptom (hemiparesis of two or more body parts, homonymous hemianoparia, amaurosis fugax, speech disturbance)</td>
</tr>
<tr>
<td>9.1.2</td>
<td>Transient episode of TWO <em>minor</em> neurologic symptoms (diplopia, vertigo plus gait disturbance, dysphagia, dysphonia, or unilateral numbness of one or more body parts)</td>
</tr>
<tr>
<td>9.1.3</td>
<td>No clinically relevant lesion on brain imaging</td>
</tr>
<tr>
<td>9.1.4</td>
<td>Brain imaging not done (cannot be definite without brain imaging)</td>
</tr>
<tr>
<td>9.1.5</td>
<td>Non-focal symptoms, such as headache (if present without 1 or 2 could not be definite)</td>
</tr>
</tbody>
</table>

10. **Carotid Artery Disease (CAD)**

<p>| | |</p>
<table>
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<th></th>
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<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Definite (10.2.1 AND 10.2.2 or 10.2.3)</td>
</tr>
<tr>
<td>3</td>
<td>Probable (10.2.1)</td>
</tr>
<tr>
<td>8</td>
<td>Unknown/Not Sure</td>
</tr>
</tbody>
</table>

#### 10.1. Diagnosis
(Mark the one category that best applies.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Carotid artery occlusion and stenosis <em>without</em> documentation of cerebral infarction</td>
</tr>
<tr>
<td>2</td>
<td>Carotid artery occlusion and stenosis <em>with</em> written documentation of cerebral infarction</td>
</tr>
</tbody>
</table>

#### 10.2. Carotid artery disease based on:
(Mark all that apply.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2.1</td>
<td>Symptomatic disease with carotid artery disease listed on the hospital discharge summary</td>
</tr>
<tr>
<td>10.2.2</td>
<td>Abnormal findings (≥ 50% stenosis) on carotid angiogram or Doppler flow study</td>
</tr>
<tr>
<td>10.2.3</td>
<td>Vascular or surgical procedure to improve flow to the ipsilateral brain</td>
</tr>
</tbody>
</table>
Peripheral Arterial Disease (PAD) (aorta, iliac arteries, or below)

1. No
2. Definite (11.2.2 or 11.2.5 or 11.2.9)
3. Probable (11.2.7 AND 11.2.8) or (11.2.1 AND any one of 11.2.3, 11.2.4, 11.2.6, 11.2.7, or 11.2.8)
4. Unknown/Not Sure

Peripheral Arterial Disease:
Symptomatic disease including intermittent claudication, ischemic ulcers, or gangrene. Disease must be symptomatic and/or requiring intervention (e.g. vascular or surgical procedure for arterial insufficiency in the lower extremities or abdominal aortic aneurysm).

11.1. Diagnosis
(Mark the one category that best applies.)

1. Lower extremity claudication
2. Atherosclerosis of arteries of the lower extremities
3. Arterial embolism and/or thrombosis of the lower extremities
4. Abdominal aortic aneurysm (AAA)

11.2. Diagnosis specified in 11.1 based on:
(Mark all that apply.)

11.2.1 Final diagnosis of PAD during hospitalization by treating physician
11.2.2 Angiographically-demonstrated obstruction, or ulcerated plaque (≥ 50% of the diameter or ≥ 75% of the cross-sectional area) demonstrated on ultrasound or angiogram of the iliac arteries or below
11.2.3 Absence of pulse by Doppler in any major vessel of lower extremities
11.2.4 Exercise test that is positive for lower extremity claudication
11.2.5 Surgery, angioplasty, or thrombolysis for PAD
11.2.6 Amputation of one or more toes or part of the lower extremity because of ischemia or gangrene
11.2.7 Exertional leg pain relieved by rest
11.2.8 Ankle-arm systolic blood pressure ratio ≤ 0.8
11.2.9 Surgical or vascular procedure for abdominal aortic aneurysm
### 12. Deep Venous Thrombosis (DVT)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Definite (12.2.1 \textbf{AND} at least one criterion of 12.2.2.-12.2.5)</td>
</tr>
<tr>
<td>3</td>
<td>Probable (12.2.3 \textbf{AND/OR} 12.2.4 \textbf{AND/OR} 12.2.5)</td>
</tr>
<tr>
<td>8</td>
<td>Unknown/Not Sure</td>
</tr>
</tbody>
</table>

#### 12.1. Diagnosis for Deep Venous Thrombosis (DVT)

(Mark the \textbf{one} category that best applies.)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Deep venous thrombosis of lower extremities not resulting from a procedure within 60 days</td>
</tr>
<tr>
<td>2</td>
<td>Deep venous thrombosis of lower extremities during or following a procedure within 60 days</td>
</tr>
</tbody>
</table>

#### 12.2. Diagnosis of deep venous thrombosis is based on:

(Mark all that apply.)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2.1</td>
<td>Hospital discharge summary or physician’s note with a diagnosis of deep venous thrombosis</td>
</tr>
<tr>
<td>12.2.2</td>
<td>Positive findings on a venogram</td>
</tr>
<tr>
<td>12.2.3</td>
<td>Positive findings using impedance plethysmography</td>
</tr>
<tr>
<td>12.2.4</td>
<td>Positive findings on Doppler duplex, ultrasound, sonogram, or other non-invasive test examination</td>
</tr>
<tr>
<td>12.2.5</td>
<td>Positive findings on isotope scan</td>
</tr>
</tbody>
</table>

#### 12.3. Was a work-up for pulmonary embolism performed?

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Unknown/Not sure</td>
</tr>
</tbody>
</table>
13. **Pulmonary Embolism**

1. [ ] No
2. [ ] Definite (13.2.3) OR (13.2.4)
3. [ ] Probable (13.2.1 and 13.2.2) OR (13.2.2 and 13.2.5) OR (13.2.1 and 13.2.6) OR (13.2.5 and 13.2.6)
4. [ ] Unknown/Not sure

13.1. **Diagnosis for Pulmonary Embolism (PE)**

(Mark the one category that best applies.)

1. [ ] Pulmonary embolism **not resulting from a procedure** within 60 days
2. [ ] Pulmonary embolism **during or following a procedure** within 60 days

13.2. **Diagnosis of pulmonary embolism is based on:**

(Mark all that apply.)

13.2.1 [ ] Hospital discharge summary with a diagnosis of pulmonary embolism
13.2.2 [ ] High probability positive ventilation-perfusion lung scan
13.2.3 [ ] Diagnostic (reported as definite) pulmonary arteriogram or contrast-enhanced CT pulmonary angiogram
13.2.4 [ ] Diagnostic spiral CT scan with contrast (not a dedicated contrast-enhanced CT pulmonary angiogram)
13.2.5 [ ] Diagnosis of deep venous thrombosis (DVT) based on > 1 DVT criterion in 12.2 plus signs and symptoms suggestive of PE (e.g. acute chest pain, dyspnea, tachypnea, hypoxemia, tachycardia, or chest x-ray findings suggestive of PE)
13.2.6 [ ] Finding from contrast enhanced CT scan reported as probable or possible PE
13.2.7 [ ] Autopsy
14. **Diabetes Mellitus (DM) is the primary reason for the hospitalization**

1  □  No
2  □  Definite (14.1.1 AND 14.1.2 OR 14.1.3 OR 14.1.4 OR 14.1.5)
3  □  Probable (only one criterion of 14.1.1 OR 14.1.3 OR 14.1.4 OR 14.1.5)
8  □  Unknown/Not Sure

**14.1. Diagnosis of diabetes is based on:**
(Mark all that apply.)

14.1.1  □  Diagnosis of diabetes by treating physician
14.1.2  □  Receiving medications for diabetes (e.g. insulin, oral agent)
14.1.3  □  Fasting blood sugar ≥ 126 mg/dl (7 mmol/l)
14.1.4  □  Abnormal Oral Glucose Tolerance Test (OGTT) at this admission (fasting ≥ 126 mg/dl and 2 hour ≥ 200, mg/dl [11.1 mmol/l])
14.1.5  □  For any other glucose measurement >200 mg/dl (11.1 mmol/l)

**14.2.a Highest glucose level**
(Record Lab measure if possible. Do not use minimally elevated or borderline glucometer readings for determining diabetes)

<table>
<thead>
<tr>
<th>Lab Value</th>
<th>Glucometer</th>
</tr>
</thead>
<tbody>
<tr>
<td>□  Fasting blood sugar ______ ______ ______ mg/dl</td>
<td></td>
</tr>
<tr>
<td>□  Other blood sugar ______ ______ ______ mg/dl</td>
<td></td>
</tr>
</tbody>
</table>

**14.2.b HbA1c (enter the value from the medical record)**

□  ______ . ______%

**14.3. Type of diabetes mellitus**
(Mark the one category that best applies.)

1  □  Type I
2  □  Type II
8  □  Unknown/Not Sure

15. **Asthma or COPD exacerbation is the primary reason for the hospitalization**

1  □  No
2  □  Definite asthma
3  □  Probable asthma
4  □  Definite COPD
5  □  Probable COPD
6  □  Asthma/COPD indeterminate

**15.1. Diagnosis is based on:**
(Mark all that apply.)

15.1.1  □  Hospital discharge diagnosis of asthma or asthma exacerbation as the primary reason for hospitalization
15.1.2  □  Hospital discharge of diagnosis of COPD or COPD exacerbation as the primary reason for the hospitalization
15.1.3  □  Documentation of prescription of specific asthma medication as an outpatient (anti IgE [Omalizumab])
15.1.4  □  Treatment during admission with medication for acute exacerbation of COPD or asthma (β2 agonist (eg, albuterol), anticholinergics (eg, ipratropium), or corticosteroids, xanthines [eg, theophylline])
15.1.5  □  Other (specify): ________________________________
15.2. Severity of exacerbation is based on:  
(Mark all that apply.)

15.2.1  □ Presence of acute respiratory failure defined as decreased PaO_2_ (<60 mm Hg on room air) or O_2_ saturation (<88%) with or without increased PaCO_2_  
15.2.2  □ Report of severe dyspnea with or without agitation, confusion, tachycardia, or sweating  
15.2.3  □ Treatment with supplemental O_2_ or increased O_2_ if on chronic supplemental O_2_  
15.2.4  □ Treatment with noninvasive positive pressure ventilation (NIPPV)  
15.2.5  □ Intubated and treated with mechanical ventilation  
15.2.6  □ PEF <100 L/min  
15.2.7  □ None of the above

16. Hypertension is the primary reason for the hospitalization

1  □ No  
2  □ Definite (see definition below)  
3  □ Probable (see definition below)  
8  □ Unknown/Not Sure

Definite Hypertension:  
1. Physician diagnosis of hypertension and on blood pressure lowering medication(s); OR  
2. Systolic blood pressure is greater than 140 mm Hg AND/OR diastolic blood pressure is greater than 90 mmHg on more than one occasion.

Probable Hypertension:  
1. Only one measure of systolic blood pressure is greater than 140 mmHg AND/OR diastolic blood pressure is greater than 90 mmHg, AND  
2. Not on blood pressure lowering medication(s), AND/OR  
3. Physician diagnosis is not clearly defined.

16.1. Diagnosis of hypertension is based on:  
(Mark all that apply.)

□ Final diagnosis of hypertension by treating physician  
□ On blood pressure lowering medication(s) (e.g. diuretic, beta-blocker, ACE-inhibitor, calcium channel blocker, vasodilator)  
□ Systolic blood pressure is greater than 140 mmHg  
□ Diastolic blood pressure is greater than 90 mmHg

16.2. Type of hypertension:

1  □ Primary  
2  □ Secondary  
8  □ Unknown/Not Sure
17. **End stage renal disease (ESRD)**

   1. No
   2. Definite (17.1.1 OR 17.1.2 OR 17.1.3)
   3. Probable
   8. Unknown/Not Sure

17.1. **Diagnosis of end stage renal disease is based on:**  
(Mark all that apply.)

   17.1.1. Physician diagnosis of ESRD
   17.1.2. Is undergoing chronic dialysis
   17.1.3. Has had (or is undergoing) renal transplant

18. **Atrial Fibrillation (A-fib) / Atrial Flutter**

   Assign an overall diagnosis based on your clinical judgment (select only one). Do not assign definite or probable diagnosis if atrial fibrillation was only induced during EP study.

   1. No
   2. Definite (18.1.1 AND 18.1.2) OR (18.1.2 AND 18.1.3) OR (18.1.4) OR (18.1.5) OR (18.1.1 and 18.1.6)
   3. Probable (18.1.1) OR (18.1.2) OR (18.1.3) OR (18.1.1 AND 18.1.3) OR (18.1.6)
   8. Unknown/Not Sure

18.1. **Diagnosis of Atrial fibrillation / Atrial flutter based on:**  
(Mark all that apply.)

   18.1.1. Documentation of atrial fibrillation/flutter as present during this hospitalization in a physician note such as the ER note, admission and physical, cardiology consult or discharge summary. Do not include atrial fibrillation if present only in the acute setting of EP study, e.g. only present when induced by the EP study.
   18.1.2. A computer-based reading of the 12-lead ECG from this admission that says atrial fibrillation/flutter
   18.1.3. Documentation of history of atrial fibrillation/flutter with use of an appropriate antiarrhythmic medication
   18.1.4. Adjudicator diagnosis of atrial fibrillation/flutter on 12-lead ECG or rhythm strip from this admission. The rhythm strip must be at least 10 seconds.
   18.1.5. Documented cardioversion attempt (chemical or electrical) for atrial fibrillation/flutter during this admission. Do not select if A-fib was induced during EP study.
   18.1.6. Documented procedure to treat atrial fibrillation/flutter (e.g. ablation) and documentation of atrial fibrillation/flutter history

18.2. If atrial fibrillation/flutter is found, is it present only in the post-CABG setting?

   1. No
   2. Yes
   8. Unknown

18.3. Was the participant discharged in atrial fibrillation/flutter?

   1. No
   2. Yes
   8. Unknown
TABLE 1. SUMMARY OF DIAGNOSTIC CRITERIA FOR MYOCARDIAL INFARCTION

<table>
<thead>
<tr>
<th>ECG FINDINGS</th>
<th>CARDIAC ENZYME LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostic</td>
</tr>
<tr>
<td><strong>Cardiac symptoms or signs present</strong></td>
<td></td>
</tr>
<tr>
<td>Evolving diagnostic</td>
<td>Definite</td>
</tr>
<tr>
<td>Positive</td>
<td>Definite</td>
</tr>
<tr>
<td>Nonspecific</td>
<td>Definite</td>
</tr>
<tr>
<td>Normal or other ECG</td>
<td>Definite</td>
</tr>
<tr>
<td><strong>Cardiac symptoms or signs absent</strong></td>
<td></td>
</tr>
<tr>
<td>Evolving diagnostic</td>
<td>Definite</td>
</tr>
<tr>
<td>Positive</td>
<td>Definite</td>
</tr>
<tr>
<td>Nonspecific</td>
<td>Definite*</td>
</tr>
<tr>
<td>Normal or other ECG</td>
<td>Definite*</td>
</tr>
</tbody>
</table>

*in absence of diagnostic troponin, downgrade to possible

TABLE 2. ALGORITHM FOR ENZYME DIAGNOSTIC CRITERIA OF MI

<table>
<thead>
<tr>
<th>ENZYME</th>
<th>Abnormal</th>
<th>Equivocal</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine Kinase MB fraction (CK-MB)</td>
<td>• &gt;2x ULN or 10% of total CK or “present” without quantification</td>
<td>1-2x ULN or 5-9% of total CK or “weakly present”</td>
<td>WNL or &lt;5% of total CK</td>
</tr>
<tr>
<td></td>
<td>• &gt;3x ULN during 48 hrs after PTCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• &gt;5x ULN during 48 hrs after CABG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myoglobin</td>
<td>&gt; 2x ULN</td>
<td>1-2x ULN</td>
<td>WNL</td>
</tr>
<tr>
<td>Troponin (C, I, or T)</td>
<td>• 2x ULN</td>
<td>1-2x ULN</td>
<td>WNL</td>
</tr>
<tr>
<td></td>
<td>• 3x ULN during 48 hrs after PTCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 5x ULN during 48 hrs after CABG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Creatinine Kinase (CK)</td>
<td>&gt; 2x ULN</td>
<td>1-2x ULN and Troponin 1-2x ULN</td>
<td>WNL</td>
</tr>
</tbody>
</table>

ULN = Upper Limit of Normal; WNL = Within Normal Limit

DEFINITION OF ABORTED MYOCARDIAL INFARCTION

For classification as ABORTED Myocardial Infarction, the event must meet all of the following criteria:

- symptoms and ECG evidence for acute MI at presentation
- intervention (e.g. thrombolytic therapy procedure) is followed by resolution of ECG changes
- all cardiac enzymes are within normal limits