INSTRUCTIONS: The Hospital Record Abstraction Form is completed for each eligible hospitalized event as determined by the Surveillance Event Eligibility Form, and for all eligible Cohort hospitalizations as determined by the Cohort Eligibility Form. Event ID, Name (or Soundex code) must be entered above. Refer to this form's Q by Q instructions for information on entering numerical responses. For multiple choice and "yes/no" questions, record the letter corresponding to the most appropriate response.

0.a. Hospital code number: 

0.b. Medical Record Number: 

0.c. Date of discharge (for nonfatal case) or death: (Same as Month Day Year)
A. MEDICAL ABSTRACTION

1. Hospital code number: (Renumbered as HRAF0a) □□
   [If code 96-99, name and location]:
   ____________________________
   ____________________________

b. Medical Record Number: (Renumbered as HRAF0b)

   □□□□□□□□□□□□□□□□□□□□□□□□□

   □□□□□□□□□□□□□□□□□□□□□□□□□

   [Specify if diagnosis is not ICD coded]
   ____________________________

2. Record the ICD9-CM diagnoses and procedure codes from the hospital discharge index (or Eligibility Form): (Renamed from HRAF to CHI1A)

   □□□□□□□□□□□□□□□□□□□□□□□□□

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3a. Abstracting for: (Removed from HRAF to CFDC5A)

ARIC Cohort……………………. C (go to question 3b)
Community……………………… S (go to question 4)
JHS Cohort-not ARIC Cohort…… J (go to question 4)

(Removed from HRAF to CFDC5B)

3b. Is the patient’s address in the ARIC community surveillance catchment area?
Yes……………..  Y
No………………  N
Not determined…..U

4. Has the hospital chart for (Removed from HRAF to CFD0D) this event been located? ................. Yes  Y

Go to Item 97, Screen 35.

No  N

5. a. Last name: (Removed from HRAF to CFD1A) ________________________

b. Initials: _____________

6. ENTER ON CFDB FORM (Removed from HRAF to CFD2)
Social Security/Medicare Number:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

7. ENTER ON CFDB FORM
Do you know the Patient's address?

Yes........Y
No ..........N

8. Sex: ...................................... Male  M
   Female  F

9. Race or ethnic group: (Removed from HRAF to CHI4)

White/Caucasian  .......................W
Black/African American  ...............B
Asian/Pacific Islander  .................A
American Indian/ Native Alaskan .........I
Other  ........................................O
Unknown/not recorded  .................... U

a. Does this person (Removed from HRAF to CHI5A) have health insurance? .......... Yes  Y

Go to Item 11, Screen 4.

No  N
Unknown  U

b. Indicate type of insurance recorded:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prepaid insurance or health plan, such as BC/BS or HMO</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. Medicare</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3. Medicaid</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4. Other</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
10. ENTER ON CFDB FORM

Birthdate: (Removed from HRAF to CFD3)

\[
\begin{array}{ccc}
\text{Month} & \text{Day} & \text{Year} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]

= 11.a. Date of arrival at this hospital: (Removed from HRAF to CHI6A)

\[
\begin{array}{ccc}
\text{Month} & \text{Day} & \text{Year} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]

b. Arrival time at this hospital (24 hr clock): (Removed from HRAF to CHI6B)

\[
\begin{array}{ccc}
\text{H} & \text{H} & \text{M} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]

FIRST TRANSFER: (Removed from HRAF to CHI)

13.b. Was this an in-catchment hospital? ... Yes Y

b.1. Hospital Code: _________ (Removed from HRAF to CHI8B)

If 96 - 99, specify:

\[
\begin{array}{c}
\text{Hospital Name} \\
\text{City} \\
\text{State} \\
\end{array}
\]

c. Date of admission to that hospital: (Removed from HRAF to CHI8C)

\[
\begin{array}{ccc}
\text{Month} & \text{Day} & \text{Year} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]

c.1. Was the patient transferred a second time?................. Yes Y

SECOND TRANSFER: (Removed from HRAF to CHI)

13.d. Was this an in-catchment hospital? ... Yes Y

d.1. Hospital Code: _________ (Removed from HRAF to CHI8D)

If 96 - 99, specify:

\[
\begin{array}{c}
\text{Hospital name} \\
\text{City} \\
\text{State} \\
\end{array}
\]

e. Date of admission to that hospital:

\[
\begin{array}{ccc}
\text{Month} & \text{Day} & \text{Year} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]

e.1. Was the patient transferred a second time?................. Yes Y

(Re-numbered as HRAF0C)

14. Date of discharge (for nonfatal case) or death:

\[
\begin{array}{ccc}
\text{Month} & \text{Day} & \text{Year} \\
\hline
\text{ } & \text{ } & \text{ } \\
\end{array}
\]
15. List the hospital discharge diagnosis and procedure codes exactly as they appear on the front sheet of the medical record and/or on the discharge summary:

a. 

b. 

c. 

d. 

e. 

f. 

g. 

h. 

i. 

j. 

k. 

l. 

m. 

n. 

o. 

p. 

q. 

r. 

s. 

t. 

u. 

v. 

w. 

x. 

y. 

z. 
16. Discharge diagnoses Transcribed (as they appear on front sheet of medical record and/or discharge summary)?
   Yes (Y)* or No (N)
   [If Yes, specify on notelog]
17. What was the disposition of the patient on discharge?
   Deceased D
   Discharged alive A — Go to item 20

18. (Removed from HRA) Was an autopsy performed? ............
   Yes Y
   No  N

19.a. Was the patient either dead on arrival or did he/she die in the emergency room? ..........
     Yes Y
     No  N

19.b. First recorded Systolic BP: __________ mmHg

If zero or not recorded, and patient died within 24 hours, record 000 and go to item 19e. If zero or not recorded and patient lived at least 24 hours, enter 001.

19.c. First recorded Diastolic BP: __________ mmHg

19.d. First recorded Pulse Rate: __________ bpm

If pulse rate is greater than 0, go to Item 21d, If 0 or not recorded, and patient lived at least 24 hours, enter 001 and go to Item 21d. If 0 or not recorded and patient died within 24 hours, enter 000 and continue with Item 19e.

19.e. Was there (an) acute episode(s) of pain or discomfort anywhere in the chest, left arm or shoulder or jaw either just before death or within 72 hours of death? ....................... Yes Y
     No  N
     Unknown U

Go to item 20
19.f. Is there a history of myocardial infarction prior to onset of this event? ...................... Yes Y

Go to Item 19h. 

No N

Unknown U

19.i. Is there any history of any other chronic ischemic heart disease? .................. Yes Y

No N

Unknown U

Skip to Item 97, and treat as an out-of-hospital death.

20. Answer the following:

a. Do the Discharge Diagnoses include any 410 or 411 codes? ... Yes Y

Go to Item 21a

No N

d. Is there mention of acute MI in the discharge summary? .... Yes Y

Go to Item 21a

No N

b. *Item deleted*

c. *Item deleted*
20.e. The following apply to this chart:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(Auto filled as Yes on HRA) Is this person a cohort participant?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2.</td>
<td>Is there more than one ECG?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3.</td>
<td>Is any Cardiac Enzyme above the normal limit?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4.</td>
<td>Was there a transfer (in or out)?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

If all of Items 20.e.2 - 20.e.4 are answered No, go to Item 97.

21. (Removed from HRA) First recorded blood pressure and pulse rate (not during CPR).

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Systolic BP:</td>
<td>mmHg</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Diastolic BP:</td>
<td>mmHg</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Pulse Rate:</td>
<td>bpm</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Smoking Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current smoker</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past smoker</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smoker NOS</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never smoker</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>U</td>
<td></td>
</tr>
</tbody>
</table>

22. (Removed from HRA) Has the Discharge Summary been transcribed or attached (include symptom onset, timing, hospital course, etc.)?

Yes (Y)* or No (N) [If Yes, specify on notelog]

23.a. Did acute cardiac symptoms begin prior to arrival at this hospital?

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>No, after arrival</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>No acute cardiac symptoms</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>U</td>
<td></td>
</tr>
</tbody>
</table>

Go to Item 24a.

23.b. Estimated time from onset of acute cardiac symptoms to arrival at this hospital.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 hour</td>
<td>A</td>
</tr>
<tr>
<td>≥1 hour and &lt;2 hours</td>
<td>B</td>
</tr>
<tr>
<td>≥2 hours and &lt;4 hours</td>
<td>C</td>
</tr>
<tr>
<td>≥4 hours and &lt;6 hours</td>
<td>D</td>
</tr>
<tr>
<td>≥6 hours and &lt;12 hours</td>
<td>E</td>
</tr>
<tr>
<td>≥12 hours and &lt;24 hours</td>
<td>F</td>
</tr>
<tr>
<td>≥1 day and &lt;3 days</td>
<td>G</td>
</tr>
<tr>
<td>≥3 days</td>
<td>H</td>
</tr>
<tr>
<td>Not recorded</td>
<td>U</td>
</tr>
</tbody>
</table>

Go to Item 24b.
24.a. What was the primary diagnosis or reason for admission to this hospital?

<table>
<thead>
<tr>
<th>Diagnosis/Reason for Admission</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective cardiac catheterization</td>
<td>A</td>
</tr>
<tr>
<td>Elective coronary bypass surgery</td>
<td>B</td>
</tr>
<tr>
<td>Other non-acute CHD evaluation</td>
<td>C</td>
</tr>
<tr>
<td>Cancer</td>
<td>D</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>E</td>
</tr>
<tr>
<td>Stroke</td>
<td>F</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>G</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>H</td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td>I</td>
</tr>
<tr>
<td>Other</td>
<td>O</td>
</tr>
</tbody>
</table>

24.b. Was there mention of an acute CHD event with onset after arrival at this hospital?  

- **Yes** (Y)  
- **No** (N)  

Go to Item 25.a.

24.c. Date of in-hospital CHD event:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

[NOTE: If patient had both CHD event present on admission (Item 23=Y) and after admission (Item 24b=Y), you must decide which event is more important (see Instructions). Answer subsequent questions for the more important event.]
25.a. Was there an acute episode(s) of pain or discomfort anywhere in the chest, left arm or shoulder or jaw, either within 72 hours prior to arrival to this hospital, or in conjunction with the in-hospital CHD event defined in Item 24b?  

- Yes \( Y \)
- No \( N \)
- Unknown \( U \)

Go to Item 26.a.

b. Date of onset of pain:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

25.c. Did this pain or discomfort specifically involve the chest?  

- Yes \( Y \)
- No \( N \)
- Unknown \( U \)

Go to Item 25f.

d. Was the discomfort or pain diagnosed as having a non-cardiac origin?  

- Yes \( Y \)
- No \( N \)
- Unknown \( U \)

Go to Item 25f.

e. If Yes, specify:

__________________________________________

25.g. Approximately how long was it from the onset of this event to death?  

- <1 hour \( \leq 1 \) hour \( A \)
- >1 hour and <6 hours \( B \)
- >6 hours and <24 hours \( C \)
- 24 hrs or more \( D \)
- Unknown \( U \)

26.a. Was coronary reperfusion (coronary angioplasty, coronary atherectomy, bypass, intravenous or intracoronary thrombolysis) attempted in the first 24 hours after onset of this event?  

- Yes \( Y \)
- No \( N \)
- Unknown \( U \)

Go to Item 27.

26.b. (Removed from HRAH) Approximately how long was it between event onset and attempt at reperfusion?  

- < 1 hour \( \leq 1 \) hour \( A \)
- ≥ 1 hour and <2 hours \( B \)
- ≥2 hours and <4 hours \( C \)
- ≥4 hours and <6 hours \( D \)
- ≥6 hours and <8 hours \( E \)
- ≥8 hours \( F \)
- Unknown \( U \)

27. (Removed from HRAH) Was the patient ever in a CCU/ICU or telemetry bed during this hospitalization?  

- Yes \( Y \)
- No \( N \)
- Unknown \( U \)
28. Were any of the following mentioned as being present during this hospital stay?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock or cardiogenic shock (pump failure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Did shock occur within the first 24 hours after onset of this event?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>b. Congestive heart failure or pulmonary edema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Did CHF or pulmonary edema occur within the first 24 hours after onset of this event?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>c. (Removed from HRA) S3 Gallop (third heart sound)</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

28.d. (Removed from HRA) Rales (not just basilar) .... Yes Y

28.e. (Removed from HRA) Ventricular fibrillation or cardiac arrest or asystole .... Yes Y

28.f. (Removed from HRA) Pulmonary embolus ........ Yes Y

28.g. (Removed from HRA) Stroke ......................... Yes Y

28.h. (Removed from HRA) Pneumonia ..................... Yes Y

29. Were the following special procedures or operations performed during this hospital stay?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. (Removed from HRA) Cardiac catheterization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. (Removed from HRA) Coronary angiography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Coronary angioplasty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29.c.1. (Removed from HRA) Approximately how long after the onset of this event was the performance of the coronary angioplasty?

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before onset</td>
<td>A</td>
</tr>
<tr>
<td>&lt; 1 hour</td>
<td>B</td>
</tr>
<tr>
<td>≥ 1 hour and &lt;2 hours</td>
<td>C</td>
</tr>
<tr>
<td>≥2 hours and &lt;4 hours</td>
<td>D</td>
</tr>
<tr>
<td>≥4 hours and &lt;6 hours</td>
<td>E</td>
</tr>
<tr>
<td>≥6 hours and &lt;8 hours</td>
<td>F</td>
</tr>
<tr>
<td>≥8 hours and &lt;24 hours</td>
<td>G</td>
</tr>
<tr>
<td>≥24 hours</td>
<td>H</td>
</tr>
<tr>
<td>Unknown</td>
<td>U</td>
</tr>
</tbody>
</table>
29.c.2 Coronary atherectomy  ❈ Yes Y ❈ No N

c.3. (Removed from HRA) Approximately how long after the onset of this event was the performance of the coronary atherectomy?

Before onset  ❈ A
< 1 hour  ❈ B
≥ 1 hour and < 2 hours  ❈ C
≥ 2 hours and < 4 hours  ❈ D
≥ 4 hours and < 6 hours  ❈ E
≥ 6 hours and < 8 hours  ❈ F
≥ 8 hours and < 24 hours  ❈ G
≥ 24 hours  ❈ H
Unknown  ❈ U

29.d. (Removed from HRA) Swan-Ganz catheterization  ❈ Yes Y ❈ No N

e. (Removed from HRA) Echocardiography  ❈ Yes Y ❈ No N

f. Coronary bypass surgery  ❈ Yes Y ❈ No N

Go to Item 29g.

f.1. (Removed from HRA) Approximately how long after the onset of this event was the performance of the coronary bypass surgery?

Before onset  ❈ A
< 1 hour  ❈ B
≥ 1 hour and < 2 hours  ❈ C
≥ 2 hours and < 4 hours  ❈ D
≥ 4 hours and < 6 hours  ❈ E
≥ 6 hours and < 8 hours  ❈ F
≥ 8 hours and < 24 hours  ❈ G
≥ 24 hours  ❈ H
Unknown  ❈ U

29.g. Intracoronary streptokinase, urokinase, anistreplase, APSAC, or TPA reperfusion  ❈ Yes Y ❈ No N

h. Intravenous streptokinase, urokinase, anistreplase APSAC, or TPA reperfusion  ❈ Yes Y ❈ No N

If 29g and 29h were answered "No", Go to Item 29i.

29.h.1. (Removed from HRA) Approximately how long after the onset of this event was the performance of the intracoronary or intravenous reperfusion?

Before onset  ❈ A
< 1 hour  ❈ B
≥ 1 hour and < 2 hours  ❈ C
≥ 2 hours and < 4 hours  ❈ D
≥ 4 hours and < 6 hours  ❈ E
≥ 6 hours and < 8 hours  ❈ F
≥ 8 hours and < 24 hours  ❈ G
≥ 24 hours  ❈ H
Unknown  ❈ U
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.i. (Removed from HRA) Aortic balloon pump</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>j. (Removed from HRA) Radionuclide scan of heart</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Go to Item 29m.]</td>
</tr>
<tr>
<td>k. (Removed from HRA) If yes, specify type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. <em>Item deleted</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. (Removed from HRA) MRI scan of heart</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>n. (Removed from HRA) Exercise stress test</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>29.o. (Removed from HRA) Holter monitoring</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>p. (Removed from HRA) Pacemaker (temporary, wires)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>1. Coronary stent</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Go to Item 29p2.]</td>
</tr>
<tr>
<td>a. (Removed from HRA) Approximately how long after the onset of this event was the placement of the coronary stent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Before onset</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>&lt; 1 hour</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>≥ 1 hour and &lt;2 hours</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>≥2 hours and &lt;4 hours</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>≥4 hours and &lt;6 hours</td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>≥6 hours and &lt;8 hours</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>≥8 hours and &lt;24 hours</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>≥24 hours</td>
<td>H</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>U</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.p.2. (Removed from HRA) Implant defibrillator</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Go to Item 29p2c]</td>
</tr>
<tr>
<td>a. (Removed from HRA) Approximately how long after the onset of this event was the defibrillator implanted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Before onset</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>&lt; 1 hour</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>≥ 1 hour and &lt;2 hours</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>≥2 hours and &lt;4 hours</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>≥4 hours and &lt;6 hours</td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>≥6 hours and &lt;8 hours</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>≥8 hours and &lt;24 hours</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>≥24 hours</td>
<td>H</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>U</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.p.2. c. (Removed from HRA) Coronary CT</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>d. (Removed from HRA) MRI Stress Test</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>29.q. (Removed from HRA) Other (specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>
30a. Was closed chest massage (CPR) and/or cardioversion attempted within 24 hours prior to arrival at this hospital or anytime during this hospitalization? .... Yes Y No N  

Go to Item 31.a.  

b. Date of first onset of attempted CPR and/or cardioversion:  

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

(Circle one)  

Private residence ....... R  
Work ................... W  
Public place ............ P  
Emergency vehicle ....... V  
Emergency room ........... E  
Hospital ................. H  
Other ..................... O  
Not recorded ............. U  

31. Where was first CPR and/or cardioversion started?

30c. (Removed from HRAH) Where was first CPR and/or cardioversion started?  

(Circle one)  

Private residence ....... R  
Work .................... W  
Public place ............ P  
Emergency vehicle ...... V  
Emergency room ........ E  
Hospital ............... H  
Other .................. O  
Not recorded ........... U  

31. (Removed from HRAH) Were any of the following drugs given during this hospitalization or at discharge?  

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Nitrates</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>b. Calcium channel blockers</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>c. Beta-blockers</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>d. Digitalis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>e. Lidocaine (xylocaine) I.V. or I.M. only</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>f. Coumadin (Warfarin, Panwarfin, Dicumarol)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>g. Aspirin - on regular basis (not PRN)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>h. ACE or Angiotensin II inhibitors</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>i. Intravenous heparin infusion</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>j. Antiplatelet agents (non-aspirin)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>k. Glucose, insulin, potassium infusion (GIK)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>l. Lipid lowering medications (Statins, Niacin, Other)</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
32. Is there a history of myocardial infarction prior to the onset of this event? ......................... Yes Y
                No N
                Unknown U

[If U, also review previous discharge diagnoses.]

33. Is there any history of angina pectoris or coronary insufficiency? ......................... Yes Y
                No N
                Unknown U

34.a. Is there a history of any other chronic ischemic heart disease? ..... Yes Y
                No N

                Go to Item 35.

b. Specify: __________________________________________

35. Is there a history of valvular disease or cardiomyopathy? ............. Yes Y
                No N

36. Is there a history of coronary bypass surgery prior to this event? .... Yes Y
                No N

37. Is there a history of coronary angioplasty prior to this event? ...... Yes Y
                No N
38. a. Is there a history of hypertension (high blood pressure) prior to this event?  
   Yes Y  
   No N  
   Unknown U

   b. Does this patient have diabetes (high blood sugar), either history or diagnosed this hospitalization?  
   Yes Y  
   No N  
   Unknown U

39. (Removed from HRAH) Is there a history of stroke prior to this event?  
   Yes Y  
   No N  
   Unknown U

40. (Removed from HRAH) Did a stroke occur within 4 weeks prior to this event?  
   Yes Y  
   No N  
   Unknown U

41. Were any cardiac enzymes reported within days 1-4 after arrival at the hospital or after in-hospital CHD event?  
   Yes Y  
   No N

42. a. Is there mention of the patient having either trauma, a surgical procedure, or rhabdomyolysis, within one week prior to measurement of enzymes?  
   Yes Y  
   No N

   b. Indicate type of procedure or trauma:  
   Yes No
   1. Cardiac procedure.................. Y N
   2. CPR or cardioversion............... Y N
   3. Other cardiac trauma.............. Y N
   4. Specify:____________________
   5. Rhabdomyolysis................... Y N
   6. Intramuscular injection........... Y N
   7. Non-cardiac procedure............ Y N
   8. Specify:____________________
   9. Non-cardiac trauma............... Y N

42. c. Enter the item number from the biomarkers section of this form corresponding to the first biomarker measurement performed after the trauma, cardiac procedure or rhabdomyolysis:

42. d. Is there any evidence of hemolytic disease during the hospitalization?  
   Yes Y  
   No N
### B. BIOMARKERS
#### 43. LABORATORY STANDARDS

<table>
<thead>
<tr>
<th>Range Set 1</th>
<th>Upper Limit of Normal</th>
<th>Special** Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CK (CPK)</td>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>CK-MB (hrt frac)</td>
<td>b.</td>
<td>c.</td>
</tr>
</tbody>
</table>

**Removed from HRAH** Total LDH

<table>
<thead>
<tr>
<th>Removed from HRAH</th>
<th>Upper Limit of Normal</th>
<th>Special** Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDH1</td>
<td>d.</td>
<td>f.</td>
</tr>
<tr>
<td>LDH2</td>
<td>g.</td>
<td>h.</td>
</tr>
<tr>
<td>LDH1/LDH2</td>
<td>i.</td>
<td>j.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Removed from HRAH</th>
<th>Upper Limit of Normal</th>
<th>Special** Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total LDH</td>
<td>k.</td>
<td>m.</td>
</tr>
<tr>
<td>LDH1</td>
<td>l.</td>
<td>n.</td>
</tr>
<tr>
<td>LDH2</td>
<td>o.</td>
<td>p.</td>
</tr>
<tr>
<td>LDH1/LDH2</td>
<td>q.</td>
<td>r.</td>
</tr>
</tbody>
</table>

| Troponin I       | u. | v. |
| Troponin T       | w. | x. |

<table>
<thead>
<tr>
<th>BNP (brain natriuretic peptide):</th>
<th>cc.</th>
<th>pg/ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum Creatinine:</td>
<td>dd.</td>
<td>mg/dl</td>
</tr>
</tbody>
</table>

Pro- BNP: ee. pg/ml

If Q41=N, then answer only Q43cc, Q43dd and Q43ee. Then skip to Q56aa.

**Range Set 2**

<table>
<thead>
<tr>
<th>Upper Limit of Normal</th>
<th>Special** Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CK (CPK)</td>
<td>k.</td>
</tr>
<tr>
<td>CK-MB (hrt frac)</td>
<td>l.</td>
</tr>
</tbody>
</table>

**Removed from HRAH** Total LDH

<table>
<thead>
<tr>
<th>Removed from HRAH</th>
<th>Upper Limit of Normal</th>
<th>Special** Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDH1</td>
<td>d.</td>
<td>p.</td>
</tr>
<tr>
<td>LDH2</td>
<td>g.</td>
<td>r.</td>
</tr>
<tr>
<td>LDH1/LDH2</td>
<td>i.</td>
<td>t.</td>
</tr>
</tbody>
</table>

| Troponin I       | y. | z. |
| Troponin T       | aa. | bb. |

**Special Units:**
- CK-MB, Troponin I, Troponin T
- LDH1/LDH2
  - 1 = (Negative/Positive) or (Absent/Present) or (Normal/Abnormal)
  - 2 = (Negative/Weak Positive/Positive) or (Absent/Trace/ Present) or (Normal/High Normal/Abnormal)
  - 3 = Expressed as % of total enzyme
  - 4 = Expressed as proportion (decimal units) of total enzyme
  - 5 = %
  - 6 = Proportion (decimal)
  - 7 = (Negative/Positive) or (LDH1 ≤ LDH2 / LDH1 > LDH2)
**BIOMARKERS: DAY ONE**

44.a. Date  

|   |   |   |   |   |   |

Go To Item 48.a.  

|   |   |   |   |   |

b. Were enzyme measurements taken on this date?  

Yes  Y  

No  N

Record values in chronologic order for the three highest reports for each enzyme on Day One of arrival or in-hospital CHD event. (LDH1 and LDH2 must be on same specimen.)

**Value (See Footnote next page)***

<table>
<thead>
<tr>
<th>45.</th>
<th>Total CK (CPK)</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CK-MB (hrt frac)</td>
<td>c.</td>
<td>d.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Removed from HRA)  

<table>
<thead>
<tr>
<th>46.</th>
<th>Total CK (CPK)</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CK-MB (hrt frac)</td>
<td>c.</td>
<td>d.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Removed from HRA)  

<table>
<thead>
<tr>
<th>47.</th>
<th>Total CK (CPK)</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CK-MB (hrt frac)</td>
<td>c.</td>
<td>d.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Removed from HRA)  

---

Footnote: See next page.
BIOMARKERS: DAY TWO

48.a. Date

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Were enzyme measurements taken on this date? ........ Yes Y

No N

Go to Item 51.a.

Record values in chronologic order for the two highest reports for each enzyme on Day Two following arrival or in-hospital CHD event. (LDH1 and LDH2 must be on same specimen.)

<table>
<thead>
<tr>
<th>Value*</th>
<th>Range Set</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49.

| Total CK (CPK) | a. |       |
| CK-MB (hrt frac) | c. |       |
|                 | d. |       |

(Removed from HRA) Total LDH

(Removed from HRA) LDH1

(Removed from HRA) LDH2

(Removed from HRA) LDH1/LDH2

Troponin I

m. |       |

n. |       |

Troponin T

o. |       |

p. |       |

50.

| Total CK (CPK) | a. |       |
| CK-MB (hrt frac) | c. |       |
|                 | d. |       |

(Removed from HRA) Total LDH

(Removed from HRA) LDH1

(Removed from HRA) LDH2

(Removed from HRA) LDH1/LDH2

Troponin I

m. |       |

n. |       |

Troponin T

o. |       |

p. |       |

*Special Values:
CK-MB, Troponin I, Troponin T
A = Negative or absent or normal
B = Weak positive or weak present or trace or high-normal or small
C = Present or positive or abnormal or medium or large
LDH1/LDH2
D = LDH1/LDH2 reported only as ≥ upper limit or positive or LDH1 > LDH2 (or “flipped”)
E = LDH1/LDH2 reported only as < upper limit or negative or LDH1 ≤ LDH2 (or “non-flipped”)
### BIOMARKERS: DAY THREE

51.a. Date _________ _________ _________

b. Were enzyme measurements taken on this date? ........ Yes Y No N

Go to Item 54.a.

Record values in chronologic order for the two highest reports for each enzyme on Day Three following arrival or in-hospital CHD event. (LDH1 and LDH2 must be on same specimen.)

<table>
<thead>
<tr>
<th>Value*</th>
<th>Range Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. Total CK (CPK)</td>
<td>a.</td>
</tr>
<tr>
<td>CK-MB (hrt frac)</td>
<td>c.</td>
</tr>
<tr>
<td>(Removed from HRA) Total LDH</td>
<td>e.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH1</td>
<td>g.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH2</td>
<td>i.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH1/LDH2</td>
<td>k.</td>
</tr>
<tr>
<td>Troponin I</td>
<td>m.</td>
</tr>
<tr>
<td>Troponin T</td>
<td>o.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value*</th>
<th>Range Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>53. Total CK (CPK)</td>
<td>a.</td>
</tr>
<tr>
<td>CK-MB (hrt frac)</td>
<td>c.</td>
</tr>
<tr>
<td>(Removed from HRA) Total LDH</td>
<td>e.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH1</td>
<td>g.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH2</td>
<td>i.</td>
</tr>
<tr>
<td>(Removed from HRA) LDH1/LDH2</td>
<td>k.</td>
</tr>
<tr>
<td>Troponin I</td>
<td>m.</td>
</tr>
<tr>
<td>Troponin T</td>
<td>o.</td>
</tr>
</tbody>
</table>

*Special Values:
- CK-MB, Troponin I, Troponin T
  - A = Negative or absent or normal
  - B = Weak positive or weak present or trace or high-normal or small
  - C = Present or positive or abnormal or medium or large
- LDH1/LDH2
  - D = LDH1/LDH2 reported only as ≥ upper limit or positive or LDH1 > LDH2 (or "flipped")
  - E = LDH1/LDH2 reported only as < upper limit or negative or LDH1 ≤ LDH2 (or "non-flipped")
### BIOMARKERS: DAY FOUR

54.a. Date: [ ] [ ] [ ]

- b. Were enzyme measurements taken on this date? ....... Yes Y
- No N

Go to Item 56aa.

Record values in chronologic order for the two highest reports for each enzyme on Day Four following arrival or in-hospital CHD event. (LDH1 and LDH2 must be on same specimen.)

#### Value* | Range Set
---|---
55. Total CK (CPK) a. | b.  
CK-MB (hrt frac) c. | d.  
(Removed from HRA) Total LDH e. | f.  
(Removed from HRA) LDH1 g. | h.  
(Removed from HRA) LDH2 i. | j.  
(Removed from HRA) LDH1/LDH2 j. | l.  
Troponin I m. | n.  
Troponin T o. | p.  

#### Value* | Range Set
---|---
56. Total CK (CPK) a. | b.  
CK-MB (hrt frac) c. | d.  
Total LDH e. | f.  
(Removed from HRA) LDH1 g. | h.  
(Removed from HRA) LDH2 i. | j.  
(Removed from HRA) LDH1/LDH2 j. | l.  
Troponin I m. | n.  
Troponin T o. | p.  

*Special Values:
- CK-MB, Troponin I, Troponin T
  A = Negative or absent or normal
  B = Weak positive or weak present or trace or high-normal or small
  C = Present or positive or abnormal or medium or large

LDH1/LDH2
- D = LDH1/LDH2 reported only as ≥ upper limit or positive or LDH1 > LDH2 (or "flipped")
- E = LDH1/LDH2 reported only as < upper limit or negative or LDH1 < LDH2 (or "non-flipped")

---

Page 22 of 26
56.aa  Was BNP measured?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Go to Q56af.

56.ab. Record the value of the first, last, and highest measurements of BNP (pg/ml):

<table>
<thead>
<tr>
<th>1. First:</th>
<th>2. date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Last (if more than one):</th>
<th>4. date:</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>5. Highest of remaining values (if more than two):</th>
<th>6. date:</th>
</tr>
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<tbody>
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</table>

56.af  Was pro-BNP measured?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Go to Q56ac.

56.ag. Record the value of the first, last, and highest measurements of pro-BNP (pg/ml):

<table>
<thead>
<tr>
<th>1. First:</th>
<th>2. date:</th>
</tr>
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<tbody>
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<tr>
<th>3. Last (if more than one):</th>
<th>4. date:</th>
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<tr>
<th>5. Highest of remaining values (if more than two):</th>
<th>6. date:</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

56ac & ad was moved to the CEL form  

56.ac. Was serum creatinine measured?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Go to question 56.ae.

56.ad. Record the value of the first, last, and highest measurements of serum creatinine (mg/dl):

<table>
<thead>
<tr>
<th>1: First:</th>
<th>2. date:</th>
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<tbody>
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<table>
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<tr>
<th>5. Last (if more than one):</th>
<th>6. date:</th>
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<table>
<thead>
<tr>
<th>7. Highest of remaining values (if more than two):</th>
<th>8. date:</th>
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</table>

56.ae.  Is this patient currently on kidney dialysis (anytime in the last four weeks)?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
C. ECG CODING

57. Were any 12 lead ECGs taken during this admission? .......... Yes Y
   No N
Go to Item 97.

58. Are any of the ECGs codable: .......... Yes Y
   No N
Go to Item 97.

FIRST CODABLE ECG AFTER ARRIVAL AT HOSPITAL (ECGF)

59. Date of ECGF: Month - Day - Year
   [Check calibration mark]
   a. Time of ECGF: HH : MM

60a. Does ECGF have a (Removed from HRA B,C,D,F) Suppression Pattern?
    Yes ........ Y
    No......... N*

60b. Which suppression pattern? (Removed from HRA B,C,D,F)
    Complete heart block ............ C*
    WPW Pattern ....................... W*
    Pacemaker ......................... P*
    Ventricular Fibrillation ............ F*
    Persistent ventricular rhythm .... V*

61. Were any leads disqualified (Removed from HRA B,C,D,F)
    from Q-Wave measurement due to a majority of ventricular beats?
    Yes....... Y*
    No......... N

62a. Indicate any missing leads. (Removed from HRAB,C,D,F)
    Up to two are allowed; if AVR is missing, an additional two may be missing:
    First missing lead:

62b. Indicate any missing leads. (Removed from HRAB,C,D,F)
    Up to two are allowed; if AVR is missing, an additional two may be missing:
    Second missing lead:

63. Does ECGF have 7-1-1 or 7-2-1? (Removed from HRA B,C,D,F)
    Yes, 7-1-1........1
    Yes, 7-2-1........2
    No......... N

64. Do ANY Q or QS Patterns (Removed from HRAB,C,D,F) exist on ECGF in lateral
    leads listed on HRA Paper Form or in the "Help" Screen?
    Yes ........ Y*
    No......... N

65. Do ANY Q or QS Patterns (Removed from HRAB,C,D,F) exist on ECGF in inferior
    leads listed on HRA Paper Form or in the "Help" Screen?
    Yes ........ Y*
    No......... N

66. Do ANY Q or QS Patterns (Removed from HRAB,C,D,F) exist on ECGF in inferior
    leads listed on HRA Paper Form or in the "Help" Screen?
    Yes ........ Y*
    No......... N

67. Do ANY Q or QS Patterns (Removed from HRAB,C,D,F) exist on ECGF in inferior
    leads listed on HRA Paper Form or in the "Help" Screen?
    Yes ........ Y
    No......... N
78. Do ANY Q or QS Patterns (removed from HRA B,C,D,F) exist on ECGL in inferior leads listed on HRA Paper Form or in the "Help" Screen?  

Yes ........ Y*  
No.......... N

79. Do ANY Q or QS Patterns (removed from HRA B,C,D,F) exist on ECGL in inferior leads listed on HRA Paper Form or in the "Help" Screen?  

Yes ........ Y  
No.......... N

80. Do ANY Q or QS Patterns (removed from HRA B,C,D,F) exist on ECGL in anterior leads listed on HRA Paper Form or in the "Help" Screen?  

Yes ........ Y*  
No.......... N

81. Do ANY Q or QS Patterns (removed from HRA B,C,D,F) exist on ECGL in anterior leads listed on HRA Paper Form or in the "Help" Screen?  

Yes ........ Y  
No.......... N

82. Are there other codable ECGs taken on or after day 3 after admission, or on or after day 3 following an in-hospital event? .......... Yes Y  

No N  

Go to Item 94.

Find the last codable ECG on day 3 after admission, or on day 3 after an in-hospital event (ECGT). [If day 3 ECG is not available, use first available ECG thereafter.]

THIRD DAY ECG (ECGT)

83. Date of ECGT:  

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

a. Time of ECGT:  

| H | H | M | M |

(The following items # 72a-81 were removed from HRA versions B, C, D, E and F)

84a. Does ECGT have a Suppression Pattern? (removed from HRA B,C,D,E,F)  

Yes ........ Y*  
No.......... N

84b. Which suppression pattern? (removed from HRA B,C,D,F)  

Complete heart block……………C*  
WPW Pattern…………………W*  
Pacemaker……………………P*  
Ventricular Fibrillation…………F*  
Persistent ventricular rhythm …V*

85. Were any leads disqualified (removed from HRA B,C,D,F) from Q-Wave measurement due to a majority of ventricular beats?  

Yes……Y*  
No…….N

86a. Indicate any missing leads. (removed from HRA B,C,D,F)  
Up to two are allowed; if AVR is missing, an additional two may be missing:  
First missing lead:
86b. Indicate any missing leads. *(Removed from HRA B,C,D,F)*
Up to two are allowed; if AVR is missing, an additional two may be missing: Second missing lead:

87. Does ECGL have 7-1-1 or 7-2-1? *(Removed from HRA B,C,D,F)*

Yes, 7-1-1...... 1
Yes, 7-2-1...... 2
No. ............ N

88. Do ANY Q or QS Patterns *(Removed from HRA B,C,D,F)*
exist on ECGT in lateral leads listed on HRA Paper Form or in the "Help" Screen?

Yes ......... Y*
No. ........... N

89. Do ANY Q or QS Patterns *(Removed from HRA B,C,D,F)*
exist on ECGT in inferior leads listed on HRA Paper Form or in the "Help" Screen?

Yes ......... Y
No. ........... N

90. Do ANY Q or QS Patterns *(Removed from HRA B,C,D,F)*
exist on ECGT in anterior leads listed on HRA Paper Form or in the "Help" Screen?

Yes ......... Y*
No. ........... N

92. Do ANY Q or QS Patterns *(Removed from HRA B,C,D,F)*
exist on ECGT in anterior leads listed on HRA Paper Form or in the "Help" Screen?

Yes ....... Y*
No. ......... N

93. Do ANY Q or QS Patterns *(Removed from HRA B,C,D,F)*
exist on ECGT in anterior leads listed on HRA Paper Form or in the "Help" Screen?

Yes ....... Y
No. ......... N

94. Were ECGs sent to ECG Reading Center? ..... Yes Y

Go to Item 97. No N

95. ECG Coder number: *(Removed from HRA B,C,D,F)*

96. Date ECG coded: mm-dd-yy *(Removed from HRA B,C,D,F)*

D. ADMINISTRATIVE INFORMATION

97. Abstractor number: 

98. Date abstract completed: 

Month Day Year

99. Method of data collection: *(Removed from HRAF to CHI13 as "Source of information abstracted")*

C Computer
P Paper