

MRN ¹⁵⁰⁰ :	Encounter Date ¹⁵¹⁰ : mm / dd / yyyy	Practice ID ¹⁵²⁰ :	Location ID ¹⁵³⁰ :
Provider NPI ¹⁵⁵⁰ :	Encounter TIN ¹⁵⁵⁵ :	Patient new to the Practice ¹⁵⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes	

A. PATIENT DEMOGRAPHICS

Patient Name (Last, First, MI) ^{2000, 2010, 2020} :		SSN ²⁰³⁰ :	PatientID ²⁰⁴⁰ : (auto)	Patient Zip ²²⁰⁰ :
Date of Birth ²⁰⁵⁰ : mm / dd / yyyy	Sex ²⁰⁶⁰ : <input type="radio"/> Male <input type="radio"/> Female	<input type="checkbox"/> Patient Deceased ²⁰⁶⁵ → Date ²⁰⁶⁷ mm / dd / yyyy		
Race: (Check all that apply) <input type="checkbox"/> White ²⁰⁷⁰ <input type="checkbox"/> Black/African American ²⁰⁷¹ <input type="checkbox"/> American Indian/Alaskan Native ²⁰⁷³ <input type="checkbox"/> Asian ²⁰⁷² → If Yes, <input type="checkbox"/> Asian Indian ²⁰⁸⁰ <input type="checkbox"/> Chinese ²⁰⁸¹ <input type="checkbox"/> Filipino ²⁰⁸² <input type="checkbox"/> Japanese ²⁰⁸³ <input type="checkbox"/> Korean ²⁰⁸⁴ <input type="checkbox"/> Vietnamese ²⁰⁸⁵ <input type="checkbox"/> Other ²⁰⁸⁶ <input type="checkbox"/> Native Hawaiian/Pacific Islander ²⁰⁷⁴ → If Yes, <input type="checkbox"/> Native Hawaiian ²⁰⁹⁰ <input type="checkbox"/> Guamanian or Chamorro ²⁰⁹¹ <input type="checkbox"/> Samoan ²⁰⁹² <input type="checkbox"/> Other Island ²⁰⁹³				
Hispanic or Latino Ethnicity ²⁰⁷⁶ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Ethnicity Type: (Check all that apply) <input type="checkbox"/> Mexican, Mexican-American, Chicano ²¹⁰⁰ <input type="checkbox"/> Puerto Rican ²¹⁰¹ <input type="checkbox"/> Cuban ²¹⁰² <input type="checkbox"/> Other Hispanic, Latino or Spanish Origin ²¹⁰³				
Insurance Payers: (Check all that apply) <input type="checkbox"/> Medicaid (fee for service) ³⁰³⁰ <input type="checkbox"/> Medicare (fee for service) ³⁰²⁸ <input type="checkbox"/> Private Health Insurance ³⁰²⁰ <input type="checkbox"/> Medicaid (managed care) ³⁰³¹ <input type="checkbox"/> Medicare (managed care) ³⁰²⁹ <input type="checkbox"/> Military Health Care ³⁰²³ <input type="checkbox"/> State Specific Plan (non-Medicaid) ³⁰²⁴ <input type="checkbox"/> Indian Health Service ³⁰²⁵ <input type="checkbox"/> Non-US Insurance ³⁰²⁶ <input type="checkbox"/> None ³⁰²⁷				
Payer ID ³¹⁰⁰ : _____				

B. DIAGNOSES/CONDITIONS/CO-MORBIDITIES (CHECK ALL THAT APPLY) **NOTE:** INDICATE IF THE PATIENT HAS A HISTORY OF ANY OF THE FOLLOWING.

<input type="checkbox"/> Coronary Artery Disease ⁴⁰⁰⁰ → Date ⁴⁰⁰² mm / dd / yyyy <input type="checkbox"/> Atrial Fibrillation/Flutter ⁴⁰¹⁰ → Date ⁴⁰¹² mm / dd / yyyy <input type="checkbox"/> Dyslipidemia ⁴⁰²⁰ → Date ⁴⁰²² mm / dd / yyyy <input type="checkbox"/> Diabetes Mellitus (Any) ⁴¹⁵⁰ → Date ⁴¹⁵² mm / dd / yyyy <input type="checkbox"/> Hypertension ⁴⁰³⁰ → Date ⁴⁰³² mm / dd / yyyy <input type="checkbox"/> Peripheral Vascular Disease ⁴²³⁰ → Date ⁴²³² mm / dd / yyyy <input type="checkbox"/> Peripheral Arterial Disease ⁴⁰⁹⁰ → Date ⁴⁰⁹² mm / dd / yyyy <input type="checkbox"/> PAD – Acute Limb Ischemia ⁴¹⁰⁰ → Date ⁴¹⁰² mm / dd / yyyy <input type="checkbox"/> PAD – Claudication ⁴¹¹⁰ → Date ⁴¹¹² mm / dd / yyyy <input type="checkbox"/> PAD – Critical Limb Ischemia ⁴¹²⁰ → Date ⁴¹²² mm / dd / yyyy <input type="checkbox"/> PAD – Foot/Leg cellulitis ⁴¹³⁰ → Date ⁴¹³² mm / dd / yyyy <input type="checkbox"/> PAD – Lower Extremity Osteomyelitis ⁴¹⁴⁰ → Date ⁴¹⁴² mm / dd / yyyy <small>(with or without limb ischemia)</small>	<input type="checkbox"/> Heart Failure ⁴⁰⁴⁰ → Date ⁴⁰⁴² mm / dd / yyyy → If Yes, <input type="checkbox"/> New diagnosis ⁴⁰⁵⁰ (within 12 months) → If Yes, Etiology ⁴⁰⁵² <input type="radio"/> Ischemic <input type="radio"/> Hypertensive <input type="radio"/> Valvular <input type="radio"/> Congenital <input type="radio"/> Idiopathic/dilated <input type="radio"/> Peripartum <input type="radio"/> Chemotherapy induced <input type="radio"/> Substance related <input type="radio"/> Tachycardia <input type="checkbox"/> CAD - Unstable Angina ⁴⁰⁸⁰ → Date ⁴⁰⁸² mm / dd / yyyy <input type="checkbox"/> CAD - Stable Angina ⁴⁰⁶⁰ → Date ⁴⁰⁶² mm / dd / yyyy → If Yes, <input type="checkbox"/> New diagnosis ⁴⁰⁷⁰ (within 12 months) <input type="checkbox"/> Ischemic Vascular Disease ⁴²²⁰ → Date ⁴²²² mm / dd / yyyy <input type="checkbox"/> Chronic Kidney Disease ⁴²⁴⁰ → Date ⁴²⁴² mm / dd / yyyy <input type="checkbox"/> Chronic Liver Disease ⁴²⁵⁰ → Date ⁴²⁵² mm / dd / yyyy
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C. CARDIAC EVENTS **NOTE:** INDICATE IF THE PATIENT HAS A HISTORY OF ANY OF THE FOLLOWING.

SPECIFY ALL EVENT(S) AND IF AVAILABLE, EVENT DATE(S) THAT OCCURRED.

EVENT ⁵¹³⁵	EVENT DATE(S) ⁵¹³⁶	EVENT ⁵¹³⁵	EVENT DATE(S) ⁵¹³⁶
CAD – Myocardial Infarction ^{E001}	mm / dd / yyyy	Minor Hemorrhage ^{E006}	mm / dd / yyyy
PCI (Any) ^{E029}	mm / dd / yyyy	Intracranial Hemorrhage ^{E007}	mm / dd / yyyy
PCI – Bare Metal Stent Implant ^{E002}	mm / dd / yyyy	Non Intracranial Major Hemorrhage (Any) ^{E032}	mm / dd / yyyy
PCI – Drug Eluting Stent Implant ^{E003}	mm / dd / yyyy	Non Intracranial Major Hemorrhage Location – Intra-articular (Atraumatic) ^{E009}	mm / dd / yyyy
PCI – Other (non-stent) Intervention ^{E004}	mm / dd / yyyy	Non Intracranial Major Hemorrhage Location – Intra-ocular ^{E010}	mm / dd / yyyy
Coronary Artery Bypass Graft ^{E017}	mm / dd / yyyy	Non Intracranial Major Hemorrhage Location – Intra-spinal ^{E011}	mm / dd / yyyy
Systemic Embolism ^{E005}	mm / dd / yyyy		
Hemorrhage (Any) ^{E031}	mm / dd / yyyy	PTCA ^{E026}	mm / dd / yyyy

C. CARDIAC EVENTS (CONT.) NOTE: INDICATE IF THE PATIENT HAS A HISTORY OF ANY OF THE FOLLOWING.

SPECIFY ALL EVENT(S) AND IF AVAILABLE, EVENT DATE(S) THAT OCCURRED.

EVENT ⁵¹³⁵	EVENT DATE(S) ⁵¹³⁶	EVENT ⁵¹³⁵	EVENT DATE(S) ⁵¹³⁶
Non Intracranial Major Hemorrhage Location – Pericardial ^{E012}	mm / dd / yyyy	ICD Implant ^{E025}	mm / dd / yyyy
Non Intracranial Major Hemorrhage Location – Retroperitoneal/Abdominal ^{E013}	mm / dd / yyyy	Permanent Pacemaker ^{E027}	mm / dd / yyyy
TIA ^{E014}	mm / dd / yyyy	Vascular Complication Requiring Intervention ^{E028}	mm / dd / yyyy
Stroke (Any) ^{E030}	mm / dd / yyyy	Carotid Endarterectomy (Any) ^{E033}	mm / dd / yyyy
Stroke – Ischemic ^{E015}	mm / dd / yyyy	Carotid Endarterectomy – Right ^{E034}	mm / dd / yyyy
Stroke – Hemorrhagic ^{E016}	mm / dd / yyyy	Carotid Endarterectomy – Left ^{E035}	mm / dd / yyyy
Cardiac Valve Surgery ^{E018}	mm / dd / yyyy	Carotid Artery Stent (Any) ^{E036}	mm / dd / yyyy
Heart Transplantation ^{E019}	mm / dd / yyyy	Carotid Artery Stent – Right ^{E037}	mm / dd / yyyy
Cardioversion ^{E021}	mm / dd / yyyy	Carotid Artery Stent – Left ^{E038}	mm / dd / yyyy
LVAD ^{E022}	mm / dd / yyyy	PAD – Peripheral Bypass ^{E043}	mm / dd / yyyy
CRT ^{E023}	mm / dd / yyyy	PAD – Peripheral Intervention ^{E044}	mm / dd / yyyy
CRT-D ^{E024}	mm / dd / yyyy	Left Bundle Branch Block ^{E066}	mm / dd / yyyy

D. ENCOUNTER INFORMATION NOTE: COMPLETE ONLY IF ASSESSED DURING TODAY'S ENCOUNTER. IF NOT ASSESSED, LEAVE BLANK.

Height: _____ O in⁶⁰⁰⁰ O cm⁶⁰⁰¹ Blood Pressure^{6010, 6011}: _____ / _____ mmHg Heart Rate⁶⁰¹⁵: _____ bpm

Weight: _____ O lbs⁶⁰²⁰ O kg⁶⁰²¹ Patient unable to be weighed⁶⁰²⁵ QRS Duration (Non-Ventricular Paced Complex)⁶⁰²⁸: _____ ms

Tobacco Use⁶⁰³⁰: Never Current Quit within past 12 months Quit more than 12 months ago
 Screening not performed for medical reasons

→ If Current or Quit within 12 months, Tobacco Type: (check all that apply) Cigarettes⁶⁰³⁵ Cigars⁶⁰³⁶ Pipe⁶⁰³⁷ Smokeless⁶⁰³⁸

→ If Current or Quit within 12 months, Smoking Cessation Counseling Provided⁶⁰⁴⁰: No Yes

Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco⁶⁰⁴⁵: No Yes

Alcohol Use⁶⁰⁴⁷: None <1 drinks/wk 2-7 drinks/wk 8-14 drinks/wk >= 15 drinks/wk

Advance Care Plan OR Discussion of Advance Care Plan Documented⁶⁰⁵⁰: No – Not documented No – patient reason Yes

ANGINA SYMPTOMS AND ACTIVITY ASSESSMENT(S) NOTE: COMPLETE AT LEAST ONE TO MEET MEASURE.

CAD CCS Class⁶⁴³⁰: No angina I II III IV Other Tool/Method to Assess Angina Symptoms and Activity Completed⁶⁴⁴⁰
 Seattle Angina Questionnaire Completed⁶⁴³⁵

HEART FAILURE ACTIVITY ASSESSMENT(S) NOTE: COMPLETE NYHA TO MEET MEASURE.

H.F. Stage of Heart Failure⁶¹²⁸: A B C D
 NYHA Class⁶¹³⁰: I II III IV

Kansas City Cardiomyopathy Questionnaire Completed⁶¹³⁵ → If Yes, _____ score (0-100)⁶¹³⁶
 Other Tool/Method to Assess Heart Failure Activity Completed⁶¹⁵⁵

HEART FAILURE SYMPTOMS ASSESSMENT(S) NOTE: COMPLETE AT LEAST ONE TO MEET MEASURE.

LLH Dyspnea Present⁶²⁰⁰: No Yes Orthopnea Present⁶²¹⁰: No Yes

HEART FAILURE PHYSICAL ASSESSMENT(S) NOTE: COMPLETE AT LEAST ONE TO MEET MEASURE.

LLH Rales Present⁶²²⁰: No Yes Peripheral Edema Present⁶²³⁰: No Yes S₃ Gallop Present⁶²⁴⁰: No Yes

Ascites Present⁶²⁵⁰: No Yes Hepatomegaly Present⁶²⁶⁰: No Yes S₄ Gallop Present⁶²⁷⁰: No Yes

Jugular Venous Distention Present⁶²⁷⁵: No Yes

PLAN OF CARE

BMI	<input type="checkbox"/> Body Mass Index Screen Performed ⁶⁹⁰⁰ → Date ⁶⁹⁰² mm / dd / yyyy		<input type="checkbox"/> BMI Management Plan ⁶⁹¹⁰						
CAD	Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months ⁶⁴⁵⁰ : <table style="width: 100%; border: none;"> <tr> <td><input type="radio"/> Yes – Referral/Plan Documented</td> <td><input type="radio"/> No Referral/Plan – Medical Reason</td> </tr> <tr> <td><input type="radio"/> No Qualifying Event/Diagnosis</td> <td><input type="radio"/> No Referral/Plan – System Reason</td> </tr> <tr> <td colspan="2"><input type="radio"/> Patient Already Participating in Rehab</td> </tr> </table> (Note: Cardiac event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, CABG, PCI or new Stable Angina diagnosis.)			<input type="radio"/> Yes – Referral/Plan Documented	<input type="radio"/> No Referral/Plan – Medical Reason	<input type="radio"/> No Qualifying Event/Diagnosis	<input type="radio"/> No Referral/Plan – System Reason	<input type="radio"/> Patient Already Participating in Rehab	
<input type="radio"/> Yes – Referral/Plan Documented	<input type="radio"/> No Referral/Plan – Medical Reason								
<input type="radio"/> No Qualifying Event/Diagnosis	<input type="radio"/> No Referral/Plan – System Reason								
<input type="radio"/> Patient Already Participating in Rehab									
	Referral for Consideration for Coronary Revascularization ⁶⁴⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes								
	Referral for Additional Evaluation/Treatment of Anginal Symptoms ⁶⁴⁷⁰ : <input type="radio"/> No <input type="radio"/> Yes								
	Discussion of Lifestyle Modifications Documented ⁶¹⁰⁰ : <input type="radio"/> No <input type="radio"/> Yes								

EF	LVEF Assessed Date ⁶⁴⁰⁰ : mm / dd / yyyy								
	LVEF ⁶⁴¹⁰ : _____ %	LV Qualitative Assessment ⁶⁴²⁰ : <table style="width: 100%; border: none;"> <tr> <td><input type="radio"/> Hyperdynamic: > 70</td> <td><input type="radio"/> Normal: 50 – 70</td> </tr> <tr> <td><input type="radio"/> Mildly reduced: 40 – 49</td> <td><input type="radio"/> Moderately reduced: 30 – 39</td> </tr> <tr> <td><input type="radio"/> Severely reduced: ≤ 29</td> <td></td> </tr> </table>	<input type="radio"/> Hyperdynamic: > 70	<input type="radio"/> Normal: 50 – 70	<input type="radio"/> Mildly reduced: 40 – 49	<input type="radio"/> Moderately reduced: 30 – 39	<input type="radio"/> Severely reduced: ≤ 29		
<input type="radio"/> Hyperdynamic: > 70	<input type="radio"/> Normal: 50 – 70								
<input type="radio"/> Mildly reduced: 40 – 49	<input type="radio"/> Moderately reduced: 30 – 39								
<input type="radio"/> Severely reduced: ≤ 29									
	(Note: If a LVEF range is documented, take the average, round up and refer to the LVEF Status ranges (right) to code.)								

HF	HF Education Completed/Documented: (Check all that apply)														
	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> All of the following⁶²⁸⁰</td> <td><input type="checkbox"/> Weight Monitoring⁶²⁸¹</td> <td><input type="checkbox"/> Diet (Sodium Restriction)⁶²⁸²</td> <td><input type="checkbox"/> Symptom Management⁶²⁸³</td> </tr> <tr> <td><input type="checkbox"/> Physical Activity⁶²⁸⁴</td> <td><input type="checkbox"/> Smoking Cessation⁶²⁸⁵</td> <td><input type="checkbox"/> Medication Instruction⁶²⁸⁶</td> <td><input type="checkbox"/> Prognosis/end-of-life Issues⁶²⁸⁷</td> </tr> <tr> <td><input type="checkbox"/> Minimizing or Avoiding use of NSAIDs⁶²⁸⁸</td> <td colspan="3"><input type="checkbox"/> Referral for visiting nurse or specific educational or management programs⁶²⁸⁹</td> </tr> </table>			<input type="checkbox"/> All of the following ⁶²⁸⁰	<input type="checkbox"/> Weight Monitoring ⁶²⁸¹	<input type="checkbox"/> Diet (Sodium Restriction) ⁶²⁸²	<input type="checkbox"/> Symptom Management ⁶²⁸³	<input type="checkbox"/> Physical Activity ⁶²⁸⁴	<input type="checkbox"/> Smoking Cessation ⁶²⁸⁵	<input type="checkbox"/> Medication Instruction ⁶²⁸⁶	<input type="checkbox"/> Prognosis/end-of-life Issues ⁶²⁸⁷	<input type="checkbox"/> Minimizing or Avoiding use of NSAIDs ⁶²⁸⁸	<input type="checkbox"/> Referral for visiting nurse or specific educational or management programs ⁶²⁸⁹		
<input type="checkbox"/> All of the following ⁶²⁸⁰	<input type="checkbox"/> Weight Monitoring ⁶²⁸¹	<input type="checkbox"/> Diet (Sodium Restriction) ⁶²⁸²	<input type="checkbox"/> Symptom Management ⁶²⁸³												
<input type="checkbox"/> Physical Activity ⁶²⁸⁴	<input type="checkbox"/> Smoking Cessation ⁶²⁸⁵	<input type="checkbox"/> Medication Instruction ⁶²⁸⁶	<input type="checkbox"/> Prognosis/end-of-life Issues ⁶²⁸⁷												
<input type="checkbox"/> Minimizing or Avoiding use of NSAIDs ⁶²⁸⁸	<input type="checkbox"/> Referral for visiting nurse or specific educational or management programs ⁶²⁸⁹														
	ICD Counseling ⁶³⁰⁰ : <input type="radio"/> Yes – Patient Counseled <input type="radio"/> No – Patient Not Counseled <input type="radio"/> No Counseling – Medical Reason														
	HF Plan of Care ⁶³¹⁰ : <input type="radio"/> No <input type="radio"/> Yes														

ATRIAL FIBRILLATION/FLUTTER ASSESSMENT AND TREATMENT

AFIB	AFib/Flutter Duration ⁶⁵⁰⁰ : <input type="radio"/> First diagnosed <input type="radio"/> Paroxysmal <input type="radio"/> Persistent <input type="radio"/> Long-standing Persistent <input type="radio"/> Permanent				
	AFib/Flutter Type ⁶⁵¹⁰ : <input type="radio"/> Non-Valvular <input type="radio"/> Valvular				
	<input type="checkbox"/> Afib/Flutter Etiology – Transient/Reversible Cause ⁶⁵²⁰ (e.g., pneumonia, hyperthyroidism, pregnancy, post-surgery)				
	INR Value ⁶⁵³⁰ : _____ → Date ⁶⁵³² mm / dd / yyyy	Atrial Fibrillation Symptom Frequency ⁶⁵⁷⁰ : (every) _____ days			
	<input type="checkbox"/> EP Study ⁶⁵⁴⁰ → Date ⁶⁵⁴² mm / dd / yyyy	Atrial Fibrillation Symptom Duration ⁶⁵⁸⁰ :			
	<input type="checkbox"/> Atrial Ablation ⁶⁵⁵⁰ → Date ⁶⁵⁵² mm / dd / yyyy	<input type="radio"/> < 48 hours <input type="radio"/> ≥ 48 hours – 7 days <input type="radio"/> > 7 days – 3 months <input type="radio"/> > 3 months			
	<input type="checkbox"/> Atrial Fibrillation Recurrence ⁶⁵⁶⁰ → Date ⁶⁵⁶² mm / dd / yyyy	<input type="checkbox"/> Rate Control Therapy ⁶⁵⁹⁰ <input type="checkbox"/> Rhythm Control Therapy ⁶⁵⁹⁵			
TE RISK FACTORS	CHADS₂ Score ⁶⁶⁰⁰ : _____ CHA₂DS₂-VASc Score ⁶⁶¹⁰ : _____ HAS-BLED Score ⁶⁶²⁰ : _____				

E. LABORATORY RESULTS NOTE: ENTER ALL LAB RESULTS AND/OR INDICATE THE LABS ORDERED DATES.

CAD	Lipid Panel Obtained Date ⁷⁰⁰⁰ : mm / dd / yyyy		Glucose timing ⁷⁰⁶⁰ : <input type="radio"/> Fasting <input type="radio"/> Random	
	Total Cholesterol ⁷⁰¹⁰ : _____ mg/dL	Diabetes	Plasma Glucose Results ⁷⁰⁷⁰ : _____ mg/dL → Date ⁷⁰⁷² mm / dd / yyyy	
	High Density Lipoprotein (HDL) ⁷⁰²⁰ : _____ mg/dL		HbA1c ⁷⁰⁸⁰ : _____ % → Date ⁷⁰⁸² mm / dd / yyyy	
	Low Density Lipoprotein (LDL) ⁷⁰³⁰ : _____ mg/dL		HgB ⁷⁵¹⁰ : _____ g/dL → Date ⁷⁵¹² mm / dd / yyyy	
	Direct Low Density Lipoprotein (DLDL) ⁷⁰⁴⁰ : _____ mg/dL			
	Triglycerides ⁷⁰⁵⁰ : _____ mg/dL			
HF	Potassium ⁷¹¹⁰ : _____ mEq/L → Date ⁷¹¹² mm / dd / yyyy			
	Sodium ⁷¹¹⁵ : _____ mEq/L → Date ⁷¹¹⁷ mm / dd / yyyy			
	B-type Natriuretic Peptide ⁷¹²⁰ : _____ pg/mL → Date ⁷¹²² mm / dd / yyyy			
	N-terminal pro b-type Natriuretic Peptide ⁷¹²⁵ : _____ pg/mL → Date ⁷¹²⁷ mm / dd / yyyy			
RENAL	Estimated Glomerular Filtration Rate ⁷²⁰⁰ : _____ mL/min → Date ⁷²⁰² mm / dd / yyyy			
	Creatinine Clearance ⁷²²⁰ : _____ → Date ⁷²²² mm / dd / yyyy			
	Serum Creatinine ⁷²³⁰ : _____ mg/dL → Date ⁷²³² mm / dd / yyyy			

F. MEDICATIONS PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.		DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ 9309	ADMINISTERED ⁹³⁰⁵				
							YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
ANTIANGINAL	Nitroglycerin						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Ranolazine						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ANTIARRHYTHMIC	Antiarrhythmic (Any)						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Amiodarone						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Dronedarone						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ANTICOAGULANTS*	Apixaban						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Dabigatran						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Edoxaban						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Rivaroxaban						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Warfarin						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR	Sacubitril/Valsartan						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ANTIHYPERTENSIVE	ACE Inhibitor*						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	ARB*						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Combination Antihypertensive						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	CA CHANNEL BLOCKERS	Calcium Channel Blocker (any)						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Dihydropyridine						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Non-Dihydropyridine						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	DIURETICS*	Diuretic (Any)						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Loop Diuretic						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Thiazide Diuretic						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Potassium Sparing Diuretic						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ANTIPLATELETS	Aspirin						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Aspirin-dipyridamole (Aggrenox)						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	P2Y12 INHIBITOR	Clopidogrel						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Ticlopidine						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Prasugrel						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Ticagrelor						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
THROMBIN RECEPTOR ANTAGONIST	Vorapaxar (Zontivity)						<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RxNORM 5. SNOMED-CT 6. OTHER

F. MEDICATIONS PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.	DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ 9309	ADMINISTERED ⁹³⁰⁵				
						YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
BETA BLOCKER	Beta Blocker (Any)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Atenolol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Metoprolol Tartrate					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sustained release metoprolol succinate					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bisoprolol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Carvedilol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Nebivolol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEART RATE LOWERING	Ivabradine					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLUCOSE LOWERING	Insulin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Metformin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pioglitazone					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Rosiglitazone					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	SGLT-2 INHIBITORS	Canagliflozin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Dapagliflozin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Empagliflozin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DPP-4 INHIBITORS	Sitagliptin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Saxagliptin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Linagliptin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Alogliptin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ALPHA-GLUCOSIDASE	Acarbose					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Miglitol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LIPID LOWERING	Lipid Lowering Non-Statins					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATIN		Lipid Lowering Statin (Any)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Atorvastatin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Rosuvastatin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Simvastatin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Low Intensity Statin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Moderate Intensity Statin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		High Intensity Statin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCSK9 INHIBITORS		Alirocumab					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Evolocumab					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RxNORM 5. SNOMED-CT 6. OTHER

MRN: _____ Encounter Date: mm / dd / yyyy Practice ID: _____ Location ID: _____

F. MEDICATIONS PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.	DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ ⁹³⁰⁹	ADMINISTERED ⁹³⁰⁵			
						YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)
SMOKING CESSATION	Bupropion					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Nicotine Replacement Therapy					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Varenicline					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER	Corticosteroids					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Digoxin (Any)					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	NSAID					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Proton Pump Inhibitor					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	SSRI					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RXNORM 5. SNOMED-CT 6. OTHER

G. HOSPITALIZATIONS

Hospital Admission Date⁹⁵⁰⁰: mm / dd / yyyy → If Admitted, Primary Reason⁹⁵⁰⁵: _____ Coding Standard⁹⁵¹⁰: ICD-9 ICD-10
 Discharge Date⁹⁵⁰²: mm / dd / yyyy Secondary Diagnosis⁹⁵⁰⁷: _____