DEMOGRAPHICS

Last Name[2000]:	**First Name**[2010]:	**Middle Name**[2020]:
Birth Date[2050]: mm / dd / yyyy	**SSN**[2030]: - -	☐ SSN N/A[2031]
Patient ID[2040]: *(auto)*	**Other ID**[2045]:	
Sex[2060]: O Male O Female	**Patient Zip Code**[2065]:	☐ Zip Code N/A[2066]

Race: (Select all that apply) ☐ White[2070] ☐ Black/African American[2071] ☐ American Indian/Alaskan Native[2073] ☐ Asian[2072] ☐ Native Hawaiian/Pacific Islander [2074] ☐ Middle Eastern/North African[2075]

Hispanic or Latino Ethnicity[2076]: O No O Yes

EPISODE OF CARE

Arrival Date[3000]: mm / dd / yyyy

Health Insurance[3005]: O No O Yes

→ **If** Yes, **Payment Source**[3010]: (Select all that apply)
☐ Private health insurance ☐ State-specific plan (non-Medicaid)
☐ Medicare (Part A or B) ☐ Medicare Advantage (Part C) ☐ Medicaid
☐ Military health care ☐ Indian Health Service ☐ Non-US insurance

→ **If any** Medicare**, Medicare Beneficiary Identifier (MBI)**[12846]: _____

Research Study[3020]: O No O Yes → **If** Yes, **Study Name**[3025]**, Patient ID**[3030]: _____, _____, _____, _____

HISTORY AND RISK FACTORS

Height[6000]: _____ cm **Weight**[6005]: _____ kg

Tobacco Use[4625]: O Never O Former O Current O Unknown if ever smoked

CONDITION HISTORY[12903]	OCCURRENCE[15510]		IF YES
	NO	YES	
Atrial fibrillation/atrial flutter	O	O	
Coronary artery disease	O	O	
Chronic kidney disease	O	O	
Diabetes mellitus	O	O	
Heart failure	O	O	
Obstructive sleep apnea	O	O	
Primary aldosteronism	O	O	
Renal artery stenosis	O	O	**Prior Renal Artery Stent**[16347]: O No O Yes → **If** Yes, **Renal Artery Stent Location**[16348]: O Left O Right O Both O Not documented
Stroke	O	O	
Transient ischemic attack	O	O	

PRE-PROCEDURE CLINICAL DATA

Hemoglobin[16370]**:**	_____	g/dL	☐ Not Drawn[12239]
Platelets[16374]**:**	_____	µL	☐ Not Drawn[13214]
Potassium[16375]**:**	_____	mEq/L	☐ Not Drawn[16345]
Creatinine[16371]**:**	_____	mg/dL	☐ Not Drawn[6051]
Glucose[16389]**:**	_____	mg/dL	☐ Not Drawn[16343]
Hemoglobin A1c[16376]**:**	_____	%	☐ Not Drawn[13006]
Albumin[16416]**:**	_____	g/dL	☐ Not Drawn[16417]
Plasma Renin Activity[16377]**:**	_____	ng/mL/hr	☐ Not Drawn[16346]
Aldosterone[16378]**:**	_____	ng/dL	☐ Not Drawn[16342]
Total Cholesterol[16372]**:**	_____	mg/dL	☐ Not Drawn[15539]
HDL[16373]**:**	_____	mg/dL	☐ Not Drawn[15540]
LDL[16379]**:**	_____	mg/dL	☐ Not Drawn[16344]

PRE-PROCEDURE IMAGING

LVEF Assessed[5111]**:** O No O Yes → **If** Yes, **Most Recent LVEF**[5116]**:** _____ **%**

BLOOD PRESSURE *(Note: Blood pressure measurements should be reflective of the patient's current medication regimen)*

24 Hour Ambulatory BP Monitor Available[16456]**:** O No O Yes

→ **If** Yes, **Date When Monitoring Began**[16463]**:** mm / dd / yyyy

→ **If** Yes, **Average Daytime BP**[16457/16458]**:** ___/___ mmHg

→ **If** Yes, **Average Nocturnal BP**[16459/16460]**:** ___/___ mmHg

→ **If** Yes, **Average Overall BP**[16461/16462]**:** ___/___ mmHg

Office BP and HR Available[16464]**:** O No O Yes

→ **If** Yes, **Office BP Date**[16465]**:** mm / dd / yyyy

→ **If** Yes, **Office BP**[16466/16467]**:** ___/___ mmHg

→ **If** Yes, **AOBP**[16508]**:** O No O Yes

→ **If** Yes, **Office Heart Rate**[16468]**:** _____ bpm

HOME BLOOD PRESSURE MEASUREMENTS

Home Blood Pressure Available[16433]**:** O No O Yes

PROVIDE THE AVERAGE BLOOD PRESSURE PER DAY FOR AS MANY DAYS AS AVAILABLE (UP TO 7 CONSECUTIVE DAYS) PRIOR TO THE PROCEDURE. IF ONLY ONE BP WAS AVAILABLE FOR THAT DAY, CODE THAT BP. IF LESS THAN 7 DAYS ARE AVAILABLE, LEAVE THE MISSED DAYS BLANK.

→ **If** Yes, **Home BP Measurement Day**[16483]	**Average Home Systolic and Diastolic BP**[16490/16492]
Day 1	___/___ mmHg
Day 2	___/___ mmHg
Day 3	___/___ mmHg
Day 4	___/___ mmHg
Day 5	___/___ mmHg
Day 6	___/___ mmHg
Day 7	___/___ mmHg

HOME MEDICATIONS

ANTIHYPERTENSIVE MEDICATIONS (CODE ALL ANTIHYPERTENSIVE MEDICATIONS THE PATIENT WAS TAKING AT HOME PRIOR TO THIS PROCEDURE)

1	**Antihypertensive Medication**[16423]**:** Select the medication	**Frequency**[16427]**:** O Daily O BID O TID O QID O Weekly O Other
2	**Antihypertensive Medication**[16423]**:** Select the medication	**Frequency**[16427]**:** O Daily O BID O TID O QID O Weekly O Other

OTHER MEDICATIONS - CODE OTHER MEDS (EXCLUDING ANTIHYPERTENSIVES) THE PATIENT WAS TAKING AT HOME PRIOR TO THIS PROCEDURE.

MEDICATION CODE[12297]	HOME MEDICATION USED [16494]
Aspirin	O No O Yes
Direct oral anticoagulants	O No O Yes
GLP-1 agonist	O No O Yes
Non-statin (lipid lowering)	O No O Yes
Nonsteroidal anti-inflammatory	O No O Yes
SGLT2 inhibitor	O No O Yes
Statin	O No O Yes
Warfarin	O No O Yes

PROCEDURE INFORMATION

Procedure Start Date/Time[7000]: mm/dd/yyyy / hh:mm **Procedure End Date/Time**[7005]: mm/dd/yyyy / hh:mm

Concomitant Procedure[7065]: O No O Yes

→ **If** Yes, **Concomitant Procedure Type**[7066]: Select all that apply

Procedure Indication[16403]: O Uncontrolled hypertension O Other

Shared Decision Making[14732]: O No O Yes

Operator's Name, NPI[7100,7105, 7110, 7115]: _____

Fellow Operator Name, NPI, Fellowship Training Program[15431,15433,15434,15435,15436]: _____ *(Optional)*

Procedure Location[12871]: O Ambulatory Surgery Center O Cath Lab O Interventional Radiology O EP Lab O OR O Other

Anesthesia Type[13331]: O General anesthesia O Deep sedation/analgesia O Moderate sedation/analgesia O Minimal sedation/anxiolysis/local only

Mechanical Ventilation Required[16382]: O Invasive mechanical ventilation O Non-invasive mechanical ventilation O None

RADIATION EXPOSURE AND CONTRAST CODE **ALL** AVAILABLE MEASUREMENTS

Fluoro Time[7214]: _____ minutes **Cumulative Air Kerma**[7210]: _____ O mGy O Gy

Dose Area Product[14278]: _____ O Gy·cm^2 O dGy·cm^2 O cGy·cm^2 O mGy·cm^2 O µGy·M^2

Contrast Volume[7215]: _____ mL

RENAL DENERVATION PROCEDURE INFORMATION

Accessory Artery(ies) Present[16418]: O No O Yes - Left O Yes - Right O Yes - Both

Renal Artery Sizing Method[16422]: ☐ Angiography ☐ Computed tomography angiography ☐ Intravascular ultrasound ☐ Magnetic resonance angiography ☐ Visual assessment with fluoroscopy ☐ Not Documented[16495]

Select all that apply

Renal Artery Treatment *(complete for each renal artery where ablation was attempted or performed)*	**1**	**2**
Renal Artery Ablation Attempted [16397]:	Select from dynamic list	Select from dynamic list
→ If Any value, **Ablations Performed**[16399]	O No O Yes	O No O Yes
→ If Yes, **Number of Ablations Performed On Artery Treated**[16398]: *(Note: For radiofrequency ablation, one catheter placement with four >45 second ablations equals four ablations. For ultrasound, one balloon-based treatment >7 seconds equals one ablation)*	_____	_____
Device Information *(Only enter the catheter used)*		
Renal Denervation Device ID[16394]:	Select from device list	Select from device list
Expiration date(17)	YYMMDD	YYMMDD
Lot (10)	_ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _
Post Ablation		

Post Ablation Intravascular Ultrasound [16401]: O No O Yes

Intra and Post-Procedure Events

Event(s)[9001]	Event(s) Occurred[9002]		If Yes		
Embolic event	O No	O Yes			
Major bleeding	O No	O Yes	**RBC Transfusion**[9275]**:**	O No	O Yes
New requirement for dialysis	O No	O Yes			
Renal artery injury requiring an invasive intervention	O No	O Yes			
Peripheral vascular injury (any)	O No	O Yes			

Discharge

Discharge Date[10100]**:** mm / dd / yyyy

Discharge Status[10105]**:** O Alive O Deceased

→ **If** Deceased, **Cause of Death**[10125]**:** O Cardiac O Non-Cardiac O Undetermined

FOLLOW-UP (COLLECTING FOLLOW-UP DATA IS OPTIONAL AND OCCURS AT THE DISCRETION OF THE FACILITY. FOLLOW UP WINDOWS ARE: 45 DAYS (1-91 DAYS), 1 YEAR (92-365 DAYS), 2 YEARS (366-730 DAYS), 3 YEARS (731-1095 DAYS), 4 YEARS (1096-1460 DAYS), AND 5 YEARS (1461-1825 DAYS) FOLLOWING THE PROCEDURE DATE.)

Assessment Date[11000]: mm / dd / yyyy

Reference Episode Arrival Date[14946]: mm / dd / yyyy

Reference Procedure Date/Time[11001]: mm / dd / yyyy / hh:mm

Reference Discharge Date[14338]: mm / dd / yyyy

Follow-up Status[11004]: O Alive O Deceased O Lost to follow-up

→ **If** Deceased, **Date of Death**[11006]: mm / dd / yyyy

→ **If** Deceased, **Cause of Death**[11007]: O Cardiac O Non-Cardiac O Undetermined

→ **If** Alive[11004] (Complete all follow-up sections)

Hospitalization[16381]: O No O Yes

→ **If** Hospitalization[16381]=Yes, **Hospitalization Event**

EVENT(S)[11011]	EVENT(S) OCCURRED[11012]	EVENT DATE[16496]
Hypertensive crisis	O No O Yes	mm / dd / yyyy
Heart failure	O No O Yes	mm / dd / yyyy
Myocardial infarction	O No O Yes	mm / dd / yyyy
Renal artery denervation reintervention	O No O Yes	mm / dd / yyyy
Renal failure	O No O Yes	mm / dd / yyyy
Stroke	O No O Yes	mm / dd / yyyy
Transient ischemic attack	O No O Yes	mm / dd / yyyy
Other	O No O Yes	mm / dd / yyyy

NEW DIAGNOSES

NEW DIAGNOSES[16410]	DX(S) OCCURRED[16411]	DATE OF DIAGNOSIS[16414]	IF YES
Atrial fibrillation/atrial flutter	O No O Yes	mm / dd / yyyy	
New requirement for dialysis	O No O Yes	mm / dd / yyyy	
New renal artery stenosis of >50%	O No O Yes	mm / dd / yyyy	**Method of Diagnosis**[16412]: *(select all that apply)* ☐ CT angiography ☐ Duplex ultrasound ☐ Invasive angiogram ☐ Magnetic resonance angiogram **Stenting Required**[16413]: O No O Yes

LABS

Hemoglobin[13775]: _____ g/dL	☐ Not Drawn[14326]
Potassium[16390]: _____ mEq/L	☐ Not Drawn[16391]
Creatinine[13310]: _____ mg/dL	☐ Not Drawn[13311]
Glucose[16392]: _____ mg/dL	☐ Not Drawn[16393]
Albumin[16415] _____ g/dL	☐ Not Drawn[14211]

ANTIHYPERTENSIVE MEDICATIONS (CODE ALL ANTIHYPERTENSIVE MEDS THE PATIENT WAS TAKING AT HOME AT THE FOLLOW-UP ASSESSMENT DATE)

1	**Antihypertensive Medication**[16426]:	Select the medication	**Frequency**[16428]: O Daily O BID O TID O QID O Weekly O Other
2	**Antihypertensive Medication**[16426]:	Select the medication	**Frequency**[16428]: O Daily O BID O TID O QID O Weekly O Other

FOLLOW-UP – BLOOD PRESSURE *(Note: Blood pressure measurements should be reflective of the patient's current medication regimen)*

BLOOD PRESSURE

24 Hour Ambulatory BP Monitor Available[16475]**:** O No O Yes

→ **If** Yes, **Date When Monitoring Began**[16481]**:** mm / dd / yyyy

→ **If** Yes, **Average Daytime BP**[16469/16470]**:** ___/___ mmHg

→ **If** Yes, **Average Nocturnal BP**[16471/16472]**:** ___/___ mmHg

→ **If** Yes, **Average Overall BP**[16473/16474]**:** ___/___ mmHg

Office BP and HR Data Available[16476]**:** O No O Yes

→ **If** Yes, **Office BP Date**[16477]**:** mm / dd / yyyy

→ **If** Yes, **Office BP**[16478/16479]**:** ___/___ mmHg

→ **If** Yes, **AOBP**[16509]**:** O No O Yes

→ **If** Yes, **Office Heart Rate**[16482]**:** _____ bpm

HOME BLOOD PRESSURE MEASUREMENTS

Home Blood Pressure Available[16447]**:** O No O Yes

PROVIDE THE AVERAGE BLOOD PRESSURE PER DAY FOR AS MANY DAYS AS AVAILABLE (UP TO 7 CONSECUTIVE DAYS) PRIOR TO FOLLOW-UP. IF ONLY ONE BP WAS AVAILABLE FOR THAT DAY, CODE THAT BP. IF LESS THAN 7 DAYS ARE AVAILABLE, LEAVE THE MISSED DAYS BLANK.

→ **If** Yes, **Home BP Measurement Day**[16484]	**Average Home Systolic and Diastolic BP**[16491/16493]
Day 1	___/___ mmHg
Day 2	___/___ mmHg
Day 3	___/___ mmHg
Day 4	___/___ mmHg
Day 5	___/___ mmHg
Day 6	___/___ mmHg
Day 7	___/___ mmHg