

DEMOGRAPHICS

Last Name ²⁰⁰⁰ :	First Name ²⁰¹⁰ :	Middle Name ²⁰²⁰ :
Birth Date ²⁰⁵⁰ : mm / dd / yyyy	Patient ID ²⁰⁴⁰ :	Other ID ²⁰⁴⁵ :

EPISODE OF CARE

Arrival Date/Time ³⁰⁰¹ : mm / dd / yyyy / hh:mm	Discharge Date/Time ¹⁰¹⁰¹ : mm / dd / yyyy / hh:mm
CathPCI DCT Unique Patient Identifier ¹⁴⁶²⁷ :	Chest Pain-MI DCT Unique Patient Identifier ¹⁴⁶²⁷ :
COVID-19 Status ¹⁴⁵⁹⁹ : <input type="radio"/> COVID-19 Data Not Collected <input type="radio"/> COVID-19 Suspected <input type="radio"/> COVID-19 Negative <input type="radio"/> Other <input type="radio"/> COVID-19 Positive <input type="radio"/> COVID-19 Recovered <input type="radio"/> COVID-19 Testing Not Performed → If COVID-19 Status = Positive or Suspected complete the following	

LABS (HIGHEST VALUE FROM FIRST MEDICAL CONTACT TO DISCHARGE)

Troponin ¹⁴⁶⁰⁰ : <input type="radio"/> Troponin I <input type="radio"/> Troponin T <input type="checkbox"/> Not Drawn ¹⁴⁶⁰¹ → If Troponin Drawn, Test Location ¹⁴⁶⁰² : <input type="radio"/> Lab <input type="radio"/> POC → If Lab, Troponin Assay, URL ¹⁴⁶⁰³ : _____ <i>Lab Assay, URL</i> → If POC, Troponin Assay, URL ¹⁴⁶⁰⁴ : _____ <i>Lab Assay, URL</i> → Troponin Value ¹⁴⁶⁰⁵ : _____ <input type="radio"/> ng/mL <input type="radio"/> ng/L <input type="radio"/> µg/L
Brain Natriuretic Peptide (BNP) ¹⁴⁶⁰⁷ : _____ (pg/mL) <input type="checkbox"/> Not Drawn ¹⁴⁶⁰⁸
N-Terminal Pro B-type Natriuretic Peptide (NT-proBNP) ¹⁴⁶¹¹ : _____ (pg/mL) <input type="checkbox"/> Not Drawn ¹⁴⁶¹²
C-Reactive Protein (CRP) ¹⁴⁶⁰⁹ : _____ (mg/L) <input type="checkbox"/> Not Drawn ¹⁴⁶¹⁰
D-Dimer ¹⁴⁶¹³ : _____ <input type="radio"/> ng/mL <input type="radio"/> µg/L <input type="checkbox"/> Not Drawn ¹⁴⁶¹⁵
Lactate Dehydrogenase (LDH) ¹⁴⁶¹⁹ : _____ <input type="radio"/> IU/L <input type="radio"/> U/L <input type="checkbox"/> Not Drawn ¹⁴⁶²⁰

HOSPITAL COURSE

COVID-19 Therapies ¹⁴⁶¹⁶ : (select all that apply) <input type="checkbox"/> Aviptadil <input type="checkbox"/> Bevacizumab <input type="checkbox"/> Eculizumab <input type="checkbox"/> Fibrinolysis <input type="checkbox"/> Intravenous Immunoglobulin <input type="checkbox"/> Sarilumab <input type="checkbox"/> Bamlanivimab <input type="checkbox"/> Convalescent Plasma <input type="checkbox"/> Etesevimab <input type="checkbox"/> Fingolimod <input type="checkbox"/> Pirfenidone <input type="checkbox"/> Tocilizumab <input type="checkbox"/> Baricitinib <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Famotidine <input type="checkbox"/> Interferon <input type="checkbox"/> Remdesivir <input type="checkbox"/> Clinical Drug/Treatment Trial <input type="checkbox"/> None Administered ¹⁴⁶²¹
Patient Enrolled in Clinical Trial ¹⁴⁶²² : <input type="radio"/> No <input type="radio"/> Yes → If Yes, COVID-19 Clinical Trial Identification ¹⁴⁶²⁸ : _____, _____
Episode Events ¹⁴⁶¹⁷ : (select all that apply) <input type="checkbox"/> None Documented ¹⁴⁶¹⁸

CATEGORY	EPISODE EVENTS	CATEGORY	EPISODE EVENTS
Arrhythmias	<input type="checkbox"/> Atrial Fibrillation	Respiratory Support	<input type="checkbox"/> High-Flow Nasal Cannula Oxygen
	<input type="checkbox"/> Ventricular Fibrillation		<input type="checkbox"/> Invasive Mechanical Ventilation
	<input type="checkbox"/> Ventricular Tachycardia		<input type="checkbox"/> Noninvasive Positive Pressure Ventilation
<input type="checkbox"/> Ventricular Tachycardia	<input type="checkbox"/> V-V Extracorporeal Membrane Oxygenation		
Cardiac Involvement	<input type="checkbox"/> Heart Failure	Renal Therapy	<input type="checkbox"/> Renal Replacement Therapy
	<input type="checkbox"/> Myocarditis	Acute Stroke	<input type="checkbox"/> Embolic Stroke
	<input type="checkbox"/> Pericarditis		<input type="checkbox"/> Hemorrhagic Stroke
<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Ischemic Stroke		
Hemodynamic Support	<input type="checkbox"/> Intravenous Inotrope(s)	<input type="checkbox"/> Undetermined Stroke	<input type="checkbox"/> Deep Venous Thrombosis
	<input type="checkbox"/> Intravenous Vasopressor(s)	Thrombotic Events	<input type="checkbox"/> Disseminated Intravascular Coagulation
	<input type="checkbox"/> Mechanical Ventricular Support		<input type="checkbox"/> Pulmonary Embolus
<input type="checkbox"/> Mechanical Ventricular Support	<input type="checkbox"/> Other Thrombotic Event		
<input type="checkbox"/> Mechanical Ventricular Support			
Respiratory Involvement	<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Acute Respiratory Distress Syndrome		

 → If Invasive Mechanical Ventilation, **Number of Days Mechanically Ventilated**¹⁴⁶²⁵: _____ days

 → If Mechanical Ventricular Support, **Device(s)**¹⁴⁶²⁶: (select all that apply) _____