



UNIVERSITY OF OTTAWA
HEART INSTITUTE
INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

REVASCULARIZATION REGISTRY PROGRAM
PATIENT REGISTRY

Unique number _____
Name _____
SURNAME FIRST NAME INITIAL
 Male Female DOB ____/____/____ Age ____
Ontario Health # _____
OR Other Province Other Country Not Available

FOR OFFICE USE ONLY: CLINICAL URGENCY =
 Calculated Requested Estimated

Address _____
STREET ADDRESS MUNICIPALITY
Postal Code _____ Phone _____

REASON(S) FOR REFERRAL

- Cath RHC PCI Surgery TAVI
 Coronary Disease (CAD) Aortic Stenosis CHF/Cardiomyopathy
 Elective Stable CAD Valve area _____ cm² Congenital
 Unstable Angina Gradient _____ mmHg Arrhythmia
 NSTEMI Other:
 STEMI Other Valvular

DATE year month day
Referral _____
Admission _____
Transfer _____
Referring MD _____
Cardiologist _____
Surgeon _____
Location: Home UOHI
 Other:

OTHER FACTORS AFFECTING URGENCY

- Employment Re-entry into system Non-cardiac Surgery
 Cardiac admission within 3 months Restenosis

PRIMARY DIAGNOSIS

CLINICAL HISTORY / PHYSICAL EXAM

CCS/ACS ANGINA CLASS

- Stable CAD
 0 I II III IV
Acute Coronary Syndrome
 IV-A Low Risk IV-B Intermediate Risk
 IV-C High Risk * IV-D Emergent

- ↓
* If CCS/ACS Class IV-C High Risk:
 Hemodynamically Stable
 Hemodynamically Unstable
(i.e. requires inotropic or vasopressor or balloon pump)

PAST HISTORY

Procedure	No	Yes	Date (yyyy/mm/dd)	Institution
Cath				INSTITUTION
Recent or Previous MI	<input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	If "Yes", specify time from date of request: <input type="checkbox"/> <1 week <input type="checkbox"/> ≤ 3 months <input type="checkbox"/> > 3 months <input type="checkbox"/> Unknown	
Previous PCI				VESSELS INVOLVED
Previous Open Heart Surgery				PROCEDURE
LIMA				

Preferred Language: English French

HEART FAILURE CLASS (NYHA)

- I II III IV

REST ECG

- Ischemic changes at rest?
 Yes* No Uninterpretable

- ↓
If "yes", describe: Persistent
 Transient without pain
 Transient with pain

EXERCISE ECG

- Done Not done Unknown
Risk:
 High Low Uninterpretable

FUNCTIONAL IMAGING

- Done* Not done Unknown
↓
*If "Done", please specify:
 Low Risk High Risk

COMORBIDITY ASSESSMENT

- Allergy No Yes Dye Latex Other: _____
Anticoagulant No Yes Name: _____
Varicose Veins No Yes
Hypertension No Yes
Peripheral Vascular Disease No Yes
Cerebrovascular Disease No Yes CVA: No Yes TIA: No Yes
Carotid Stenosis (>70%) None Unilateral Bilateral Previous Endarterectomy
Renal Failure No Yes Creatinine _____ μmol/L Date ____/____/____
Smoking Never Yes Dialysis: No Yes yyyy mm dd
COPD No Yes
Diabetes No Yes Diet Insulin Oral Medication Not Treated
Active Infective Endocarditis No Yes
Hyperlipidemia No Yes
On IIb/IIa Inhibitors No Yes
Possible LV Thrombus No Yes
History of CHF No Yes

Check box if you (physician) have discussed with this patient (and/or significant other) timely access to care options for this procedure.
Signature _____ Date (yyyy/mm/dd)

PATIENT NAME

UNIQUE NUMBER

DATE OF CATH (YY/MM/DD)

CINE #

CORONARY ANGIOGRAM / HEMODYNAMICS

LM _____ % LAD prox _____ % CCX prox _____ % RCA _____ % Grafts _____ %
mid _____ % distal _____ % PIV _____ %
diagonal _____ % marginal _____ %
diagonal _____ %

LV FUNCTION
Method: Echo MUGA Other Not done
Findings: I (≥ 50%) II (35-49%) III (20-34%) IV (< 20%) Unknown

PAP _____ / _____

Aortic Valve _____ Stenosis: Mild Mod Severe Regurg: 0 1 2 3 4 Symptomatic Asymptomatic
Gradient _____ Area _____

Mitral Valve _____ Stenosis: Mild Mod Severe Regurg: 0 1 2 3 4 Symptomatic Asymptomatic
Gradient _____ Area _____

Tricuspid Valve _____ Stenosis: Mild Mod Severe Regurg: 0 1 2 3 4 Symptomatic Asymptomatic
Gradient _____ Area _____

DISPOSITION OF PATIENT REGISTRY FORM

Medical Treatment: Place on chart PCI: Send to Wait List Management Office Surgery: Send to Wait List Management Office

PCI ROUNDS

Date (yyyy/mm/dd): _____ / _____ / _____

1 **Accept** Vessel _____ A B1 B2 C1 C2 _____ A B1 B2 C1 C2 _____ A B1 B2 C1 C2
Priority: Board Soonest Elective MD _____

2 **Reject** Unsuitable anatomy Lack of evidence of ischemia
Recommend _____

3 **Defer** To await evidence of ischemia Office visit with _____ Purpose _____

Reviewed by Group Dr. _____

Comments

SURGERY ROUNDS RECOMMENDATION

Date (yyyy/mm/dd): _____ / _____ / _____

Procedure: CABG AVR MVR
Autologous Blood: Yes No
Procedural Risk: Low Med High

Comments

Reviewed by:

SURGICAL URGENCY

Emergent Urgent (1-14 days) Semi-urgent (15-42 days) Elective (43-180 days)

Patient/Family sent the CCN brochure Date (yyyy/mm/dd): _____ / _____ / _____
 Letter sent to the patient re: options for timely access Date (yyyy/mm/dd): _____ / _____ / _____

Date off listed (YYYY/MM/DD)	Reason off listed	Discharge date (YYYY/MM/DD)	Cancellation date - most recent (YYYY/MM/DD)	
Date deferred (YYYY/MM/DD)	Reason deferred	Reinstatement date (YYYY/MM/DD)	Calculated triage score	Max. recommended waiting time

PLEASE ADVISE OF ANY CHANGES TO AFOREMENTIONED DATA AS THIS MAY HAVE AN IMPACT ON THE PATIENT'S URGENCY RATING SCORE.

Please forward Patient Registry form to the Wait List Management Office, H1, University of Ottawa Heart Institute

Surgery: Tel: 613-696-7000 ext. 15444 | Fax: 613-696-7144 | Cardiology: Tel: 613-696-7000 ext. 19733 | Fax: 613-696-7144