



GWTG-AFib Case Record Form (CRF)

June 2023

Patient ID:		_____	
DEMOGRAPHICS			
Was patient admitted as an inpatient?		<input type="radio"/> Yes <input type="radio"/> No	
Please select reason patient was not admitted:		<input type="radio"/> Outpatient planned ablation procedure episode <input type="radio"/> Discharge from Observation Status <input type="radio"/> Discharged from ED	
Date of Birth:	___/___/___		
Sex:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		
Patient Gender Identity:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="radio"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="radio"/> Genderqueer, Neither Exclusively Male nor Female <input type="radio"/> Additional Gender Category or Other <input type="radio"/> Did not Disclose		
Other Patient Gender Identity	_____		
Patient-Identified Sexual Orientation:	<input type="radio"/> Straight or heterosexual <input type="radio"/> Lesbian or gay <input type="radio"/> Bisexual <input type="radio"/> Queer, pansexual, and/or questioning <input type="radio"/> Something else; please specify <input type="radio"/> Don't know <input type="radio"/> Declined to answer		
Other Patient-Identified Sexual Orientation:	_____		
Homeless:	<input type="checkbox"/>		
Patient Zip Code	_____		
Payment source:	<input type="checkbox"/> Medicare Title 18 <input type="checkbox"/> Medicaid Title 19 <input type="checkbox"/> Medicare – Private/HMO/PPO/Other <input type="checkbox"/> Medicaid – Private/HMO/PPO/Other <input type="checkbox"/> Private/HMO/PPO/Other <input type="checkbox"/> VA/CHAMPVA/Tricare <input type="checkbox"/> Self-Pay/No Insurance <input type="checkbox"/> Other/Not Documented/UTD		
Race and Ethnicity			
Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> UTD <input type="checkbox"/> Japanese <input type="checkbox"/> Korean		

	<input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian
Hispanic Ethnicity:	<input type="radio"/> Yes <input type="radio"/> No/Unable to Determine (UTD)
If Yes Hispanic Ethnicity:	<input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino or Spanish Origin

ADMISSION

Arrival and Admission Information

Internal Tracking ID:	
Physician/Provider NPI:	
Arrival Date and Time:	MM/DD/YYYY HH: MM or MM/DD/YYYY format
Admission Date:	MM/DD/YYYY format

Point of Origin for Admission or Visit:	<input type="radio"/> 1 Non-Health Care Facility Point of Origin <input type="radio"/> 2 Clinic <input type="radio"/> 4 Transfer from a Hospital (Different Facility) <input type="radio"/> 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) <input type="radio"/> 6 Transfer from another Health Care Facility <input type="radio"/> 7 Emergency Room <input type="radio"/> 9 Information not available <input type="radio"/> F Transfer from Hospice and is under a Hospice Plan of Care or enrolled in a Hospice Program
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MEDICAL HISTORY

Medical History (Select all that apply):	<input type="checkbox"/> No medical history reported <input type="checkbox"/> Alcohol use/dependence > 20 units/week <input type="checkbox"/> Anemia <input type="checkbox"/> Bioprosthetic valve <input type="checkbox"/> Bleeding Diathesis <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac Transplantation <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Ischemic <input type="checkbox"/> Non-ischemic <input type="checkbox"/> Carotid Disease (clinically diagnosed) <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> CRT-D (cardiac resynchronization therapy w/ICD) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> ICH <input type="checkbox"/> TIA <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other infectious respiratory pathogen	<input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension History <input type="checkbox"/> Uncontrolled > 160 mmHg systolic <input type="checkbox"/> ICD only <input type="checkbox"/> Illicit Drug Use <input type="checkbox"/> Left Ventricular Hypertrophy <input type="checkbox"/> Liver Disease (Cirrhosis, Bilirubin > 2x Normal, AST/ALT/AP > 3x Normal) <input type="checkbox"/> Mechanical Prosthetic Heart Valve <input type="checkbox"/> Mitral Stenosis <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> CPAP <input type="checkbox"/> Pacemaker <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prior Hemorrhage <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Other <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Bare metal stent <input type="checkbox"/> Drug eluting stent <input type="checkbox"/> Renal Disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Sinus Node Dysfunction / Sick Sinus Syndrome <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism
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		<input type="checkbox"/> Familial Hypercholesterolemia <input type="checkbox"/> Family History of AF	
History of cigarette smoking in the past 12 months		<input type="radio"/> Yes <input type="radio"/> No	
History of vaping or e-cigarette use in the past 12 months		<input type="radio"/> Yes <input type="radio"/> No	
Other Risk Factor	Labile INR (Unstable/high INRs or time in therapeutic range <60%)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to determine from the information available in the medical record		
Prior AF Procedures	<input type="checkbox"/> None <input type="checkbox"/> Cardioversion <input type="checkbox"/> Ablation Month/Year of prior ablation ____/____/____ <input type="radio"/> AF Surgery (Surgical MAZE)		<input type="checkbox"/> LAA Occlusion Device <input type="radio"/> Lariat <input type="radio"/> Surgical closure (clip or oversew) <input type="radio"/> Watchman <input type="radio"/> Other
	DIAGNOSIS		
Atrial Arrhythmia Type:	<input type="checkbox"/> Atrial Fibrillation If Atrial Fibrillation: <input type="radio"/> First Detected Atrial Fibrillation <input type="radio"/> Paroxysmal Atrial Fibrillation <input type="radio"/> Persistent Atrial Fibrillation <input type="checkbox"/> Permanent/long standing Persistent Atrial Fibrillation <input type="radio"/> Unable to Determine		<input type="checkbox"/> Atrial Flutter If Atrial Flutter: <input type="radio"/> Typical Atrial Flutter <input type="radio"/> Atypical Atrial Flutter <input type="radio"/> Unable to Determine
Was Atrial Fibrillation/Flutter the patient's primary diagnosis?		<input type="radio"/> Yes <input type="radio"/> No	
If no, what was the patient's primary diagnosis?		<input type="radio"/> Acute MI <input type="radio"/> COPD <input type="radio"/> CVA/TIA	<input type="radio"/> Heart Failure <input type="radio"/> Surgery <input type="radio"/> Other
Were any of the following first detected on this admission?	<input type="checkbox"/> None <input type="checkbox"/> Acute MI <input type="checkbox"/> Atherosclerotic Vascular Disease <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Liver Disease		
Active bacterial or viral infection at admission or during hospitalization	<input type="checkbox"/> None/ND <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other emerging infectious disease		<input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal Cold <input type="checkbox"/> Other viral infection
Medications Used Prior to Admission <i>Select all that apply</i>	<input type="checkbox"/> Patient on no meds prior to admission <input type="checkbox"/> ACE inhibitor <input type="checkbox"/> Aldosterone Antagonist <input type="checkbox"/> Alpha Blockers <input type="checkbox"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Antiarrhythmic		
	<input type="checkbox"/> Antiplatelet agent <input type="checkbox"/> aspirin <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> dipyridamole/aspirin (Aggrenox) <input type="checkbox"/> effient (Prasugrel) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid) <input type="checkbox"/> Other <input type="checkbox"/> Beta Blocker		

	<input type="checkbox"/> amiodarone (Cordarone) <input type="checkbox"/> disopyramide (Norpace, Norpace CR) <input type="checkbox"/> dofetilide (Tikosyn) <input type="checkbox"/> dronedarone (Multaq) <input type="checkbox"/> flecainide (Tambocor) <input type="checkbox"/> propafenone (Rythmol, Rythmol SR) <input type="checkbox"/> quinidine <input type="checkbox"/> sotalol (Betapace, Betapace AF) <input type="checkbox"/> Other <input type="checkbox"/> Anticoagulation Therapy <input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> fondaparinux (Atrixa) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> warfarin (Coumadin) <input type="checkbox"/> Other Anticoagulant	<input type="checkbox"/> Ca channel blocker <input type="checkbox"/> dihydropyridine (nifedipine) (nicardipine) <input type="checkbox"/> non-dihydropyridine (verapamil) (diltiazem) <input type="checkbox"/> Digoxin <input type="checkbox"/> Diuretic <input type="checkbox"/> Hydralazine Nitrate <input type="checkbox"/> NSAIDS/COX-2 Inhibitor <input type="checkbox"/> Statin
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EXAM/ LABS AT ADMISSION

Presenting symptoms related to AF <i>Select all that apply</i>		<input type="checkbox"/> No reported symptoms <input type="checkbox"/> Chest pain/tightness/discomfort <input type="checkbox"/> Dyspnea at exertion <input type="checkbox"/> Dyspnea at rest <input type="checkbox"/> Exercise intolerance	<input type="checkbox"/> Fatigue <input type="checkbox"/> Lightheadedness/dizziness <input type="checkbox"/> Palpitations <input type="checkbox"/> Syncope <input type="checkbox"/> Weakness
Initial Vital Signs	Height _____ Weight _____ Heart Rate _____ bpm BP-Supine _____/_____ mmHG	<input type="checkbox"/> inches <input type="checkbox"/> cm <input type="checkbox"/> lbs <input type="checkbox"/> kg <input type="checkbox"/> Not documented <input type="checkbox"/> Not documented <input type="checkbox"/> Not documented <input type="checkbox"/> Not documented	
Initial Presenting Rhythm(s) <i>Select all that apply</i>		<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atrial Tachycardia	<input type="checkbox"/> Sinus Rhythm <input type="checkbox"/> Paced (6) <input type="checkbox"/> Other
If paced, underlying Atrial Rhythm		<input type="radio"/> Sinus Rhythm <input type="radio"/> Atrial fib/flutter <input type="radio"/> Sinus arrest <input type="radio"/> Unknown	
If paced, pacing type:		<input type="radio"/> Atrial Pacing <input type="radio"/> Ventricular Pacing <input type="radio"/> Atrioventricular	
Automated ECG Interpretation :		<input type="radio"/> Yes <input type="radio"/> No	
Initial ECG Findings:	Resting Heart Rate (bpm) _____ <input type="checkbox"/> Not Available QRS duration (ms) _____ <input type="checkbox"/> Not Available QTc (ms) _____ <input type="checkbox"/> Not Available PR interval (ms) _____ <input type="checkbox"/> Not Available		

Labs: (closest to arrival)	Platelet Count	_____ μL	<input type="checkbox"/> Not Available
	SCr	_____ o mg/dL o μmol/L	<input type="checkbox"/> Not Available
	Estimated Creatinine Clearance	[auto calculated] mL/min	
	PT/INR	_____	<input type="checkbox"/> Not Available
	Hematocrit	_____ %	<input type="checkbox"/> Not Available
	Hemoglobin	_____ g/dl	<input type="checkbox"/> Not Available
	TSH	_____ μIU/ML	<input type="checkbox"/> Not Available
	K	_____ o mEq/L o mmol/L o mg/dL	<input type="checkbox"/> Not Available
	Mg	_____ mg/dL	<input type="checkbox"/> Not Available
	BUN	_____ o mg/dL o μmol/L	<input type="checkbox"/> Not Available
	NT-BNP	_____ (pg/mL)	<input type="checkbox"/> Not Available
	BNP	_____ o pg/mL o pmol/L o ng/L	<input type="checkbox"/> Not Available

IN-HOSPITAL

Cardiac Procedures this hospitalization (select all that apply)	<input type="checkbox"/> No Procedures <input type="checkbox"/> A-Fib Ablation <input type="checkbox"/> A-Flutter Ablation <input type="checkbox"/> Bioprosthetic valve <input type="checkbox"/> Cardioversion <input type="checkbox"/> Chemical <input type="checkbox"/> Electrical <input type="checkbox"/> TEE Guided <input type="checkbox"/> CRT-D (cardiac resynchronization therapy/ICD) <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only)	<input type="checkbox"/> ICD only <input type="checkbox"/> LAA Occlusion Device <input type="checkbox"/> Lariat <input type="checkbox"/> Watchman <input type="checkbox"/> Surgical closure (clip or oversew) <input type="checkbox"/> Other <input type="checkbox"/> Mechanical Prosthetic Heart Valve <input type="checkbox"/> Pacemaker <input type="checkbox"/> PCI/Cardiac Catheterization <input type="checkbox"/> Bare metal stent <input type="checkbox"/> Drug eluting stent
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Cardiac Function and Structural Assessment

Echocardiogram Date for left atrial assessment	___/___/___ MM/DD/YYYY
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EF - Quantitative	_____ % <input type="checkbox"/> Not available	Obtained:	<input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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EF - Qualitative	<input type="checkbox"/> Not applicable <input type="checkbox"/> Normal or mild dysfunction <input type="checkbox"/> Qualitative moderate/severe dysfunction <input type="checkbox"/> Performed/results not available <input type="checkbox"/> Planned after discharge <input type="checkbox"/> Not performed (6)	Obtained:	<input type="radio"/> This Admission <input type="radio"/> W/in the last year <input type="radio"/> > 1 year ago
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Left atrial diameter _____(cm) o ND
Left atrial volume _____ (cm) o ND
Left atrial volume index (mL/m2) _____ o ND

If Left atrial diameter ND, how was the atrial enlargement described?	<input type="radio"/> Normal
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	<ul style="list-style-type: none"> <input type="radio"/> Mild enlargement <input type="radio"/> Moderate enlargement <input type="radio"/> Severe enlargement <input type="radio"/> Unknown 	
Oral Medications during hospitalization (Select all that apply)	<ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Antiarrhythmic <ul style="list-style-type: none"> <input type="checkbox"/> amiodarone (Cordarone) <input type="checkbox"/> disopyramide <input type="checkbox"/> dofetilide (Tikosyn) <input type="checkbox"/> dronedarone (Multaq) <input type="checkbox"/> flecainide (Tambocor) <input type="checkbox"/> propafenone (Rythmol, Rythmol SR) <input type="checkbox"/> quinidine <input type="checkbox"/> sotalol (Betapace, Betapace AF) <input type="checkbox"/> Other <input type="checkbox"/> Anticoagulant <ul style="list-style-type: none"> <input type="checkbox"/> apixaban (Eliquis) <input type="checkbox"/> dabigatran (Pradaxa) <input type="checkbox"/> edoxaban (Savaysa) <input type="checkbox"/> rivaroxaban (Xarelto) <input type="checkbox"/> warfarin (Coumadin) 	<ul style="list-style-type: none"> <input type="checkbox"/> Antiplatelet agent <ul style="list-style-type: none"> <input type="checkbox"/> aspirin <input type="checkbox"/> clopidogrel (Plavix) <input type="checkbox"/> dipyridamole/aspirin (Aggrenox) <input type="checkbox"/> effient (Prasugrel) <input type="checkbox"/> ticagrelor (Brilinta) <input type="checkbox"/> ticlopidine (Ticlid) <input type="checkbox"/> Other <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Digoxin
Parenteral In-Hospital Anticoagulation	<ul style="list-style-type: none"> <input type="radio"/> Unfractionated Heparin IV <input type="radio"/> full dose LMW Heparin <input type="radio"/> Other IV Anticoagulant <input type="radio"/> None 	
Health Related Social Needs Assessment		
During this admission, was a standardized health related social needs form or assessment completed?	<input type="radio"/> Yes <input type="radio"/> No/ND	
If yes, identify the areas of unmet social need. (Select all that apply)	<ul style="list-style-type: none"> <input type="checkbox"/> None of the areas of unmet social need listed <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Financial Strain <input type="checkbox"/> Food <input type="checkbox"/> Living Situation / Housing <input type="checkbox"/> Mental Health <input type="checkbox"/> Personal Safety <input type="checkbox"/> Substance Use <input type="checkbox"/> Transportation Barriers <input type="checkbox"/> Utilities 	
CHA2DS2-VASc reported?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA	
CHA2DS2-VASc Total reported score:		
Medical reason(s) documented by a physician, nurse practitioner, or physician assistant for not assessing risk factors:	<input type="radio"/> Yes <input type="radio"/> No	
ABLATION		
Pre-Ablation Diagnosis and Evaluation		
Indication for ablation:	<ul style="list-style-type: none"> <input type="radio"/> First-line therapy for longstanding persistent AF <input type="radio"/> First-line therapy in paroxysmal AF before antiarrhythmic therapy <input type="radio"/> First-line therapy in persistent AF before antiarrhythmic therapy <input type="radio"/> Long-standing persistent AF that has failed ≥ 1 antiarrhythmic drug <input type="radio"/> Paroxysmal AF that is refractory or intolerant to ≥ 1 antiarrhythmic drugs <input type="radio"/> Persistent AF that is refractory or intolerant to ≥ 1 antiarrhythmic drug <input type="radio"/> Other (left atrial flutter, left atrial tachycardia, etc.) 	
Modified EHRA Symptoms Score:	<ul style="list-style-type: none"> <input type="radio"/> I – No symptoms <input type="radio"/> IIA – Mild symptoms (Normal daily activity not affected and symptoms not considered troublesome by patient) 	

	<ul style="list-style-type: none"> ○ IIB – Moderate symptoms (Normal daily activity not affected but patient troubled by symptoms) ○ III - Severe symptoms (Normal daily activity affected) ○ IV – Disabling symptoms (Normal daily activity discontinued) ○ ND
Baseline Rhythm	<ul style="list-style-type: none"> ○ Atrial fibrillation ○ Atrial flutter, typical right ○ Atrial flutter, atypical ○ Sinus rhythm ○ Other (specify) _ ○ Unknown/ND
Did the patient have prior ablations for atrial fibrillation (do not count ablations for other arrhythmias):	<ul style="list-style-type: none"> ○ 0 (no prior AF ablation) ○ 1 ○ 2 ○ ≥ 3
What was the peri-procedural anticoagulation strategy?	<ul style="list-style-type: none"> ○ Bridging anticoagulation strategy <ul style="list-style-type: none"> ○ bivalirudin ○ LMWH ○ Unfractionated heparin ○ Other ○ Uninterrupted anticoagulation strategy <ul style="list-style-type: none"> ○ apixaban ○ dabigatran ○ edoxaban ○ rivaroxaban ○ warfarin pre-procedure INR _____ ○ Interrupted anticoagulation strategy <ul style="list-style-type: none"> ○ apixaban <ul style="list-style-type: none"> ○ More than one dose held ○ dabigatran <ul style="list-style-type: none"> ○ More than one dose held ○ edoxaban <ul style="list-style-type: none"> ○ More than one dose held ○ rivaroxaban <ul style="list-style-type: none"> ○ More than one dose held ○ warfarin <ul style="list-style-type: none"> ○ More than one dose held ○ None
What was the primary intraprocedural parenteral anticoagulant used?	<ul style="list-style-type: none"> ○ Bivalirudin ○ Heparin ○ Other _____ ○ None, Reason for not prescribing (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Major bleeding event <input type="checkbox"/> Minor bleeding event <input type="checkbox"/> Risk of bleeding
Anesthesia used during the procedure:	<ul style="list-style-type: none"> ○ General anesthesia with endotracheal tube intubation ○ General anesthesia with JET or high frequency ventilation ○ General anesthesia with laryngeal mask airway ○ IV conscious sedation without intubation or mechanical airway ○ Other ○ Unable to determine
Type of Ablation Procedure	<ul style="list-style-type: none"> ○ Percutaneous catheter ablation ○ Surgical ablation ○ Hybrid approach (surgical and percutaneous) ○ Other _____
Epicardial access was attempted:	<input type="checkbox"/>
Imaging/mapping used: (check all that apply):	<ul style="list-style-type: none"> <input type="checkbox"/> 3D electroanatomic mapping <input type="checkbox"/> Intracardiac echocardiography (ICE) <input type="checkbox"/> Intraoperative TEE

	<input type="checkbox"/> Preprocedure CT <input type="checkbox"/> Preprocedure MRI <input type="checkbox"/> Preprocedure TEE <input type="checkbox"/> Rotational angiography
Trans-septal approach used for the ablation procedure:	<input type="radio"/> Brockenbrough/mechanical needle <input type="radio"/> Radiofrequency needle <input type="radio"/> SafeSept (wire needle) <input type="radio"/> Other, such as entry through patent foramen ovale <input type="radio"/> Trans-septal method not utilized
Was an Atrial Septal Closure Device Present	<input type="radio"/> Yes <input type="radio"/> No
Procedure Date and Time:	Date (MM/DD/YYYY): ___/___/_____
	Total Procedure Time __:__(MM:SS)
	Total Ablation time: __:__(MM:SS)
	Total Fluoroscopy time: __:__(MM:SS)
	Total Fluoroscopy Dose: _____ o mGy/cm ² o mGy
Procedure Operator NPI	
Energy and catheter type used (check all that apply):	<input type="checkbox"/> A-Fib Ablation <input type="checkbox"/> Cryoablation balloon <input type="checkbox"/> Electroporation <input type="checkbox"/> Irrigated RFA with contact force sensing <input type="checkbox"/> Irrigated RFA without contact force sensing <input type="checkbox"/> Laser balloon <input type="checkbox"/> Radiofrequency balloon <input type="checkbox"/> Other _____ <input type="checkbox"/> A-Flutter Ablation <input type="checkbox"/> Cryoablation balloon <input type="checkbox"/> Electroporation <input type="checkbox"/> Irrigated RFA with contact force sensing <input type="checkbox"/> Irrigated RFA without contact force sensing <input type="checkbox"/> Laser balloon <input type="checkbox"/> Radiofrequency balloon <input type="checkbox"/> Other _____
Ablation Approach (Check all that apply)	<input type="checkbox"/> Left superior PV isolation attempted Technique: <input type="radio"/> Circumferential <input type="radio"/> Segmental Outcome: <input type="checkbox"/> Entrance Block <input type="checkbox"/> Exit Block <input type="checkbox"/> First Pass Isolation <input type="checkbox"/> Left inferior PV isolation attempted Technique: <input type="radio"/> Circumferential <input type="radio"/> Segmental Outcome: <input type="checkbox"/> Entrance Block <input type="checkbox"/> Exit Block <input type="checkbox"/> First Pass Isolation <input type="checkbox"/> Right superior PV isolation was attempted Technique: <input type="radio"/> Circumferential <input type="radio"/> Segmental Outcome: <input type="checkbox"/> Entrance Block <input type="checkbox"/> Exit Block <input type="checkbox"/> First Pass Isolation <input type="checkbox"/> Right inferior PV isolation was attempted Technique: <input type="radio"/> Circumferential <input type="radio"/> Segmental Outcome: <input type="checkbox"/> Entrance Block <input type="checkbox"/> Exit Block <input type="checkbox"/> First Pass Isolation <input type="checkbox"/> Right Middle PV isolation was attempted Technique: <input type="radio"/> Circumferential <input type="radio"/> Segmental Outcome: <input type="checkbox"/> Entrance Block <input type="checkbox"/> Exit Block <input type="checkbox"/> First Pass Isolation
Lines and Additional Strategies (Check all that apply):	<input type="checkbox"/> Anterior Lateral Mitral Isthmus Line (Left Superior to Mitral Annulus) Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> A-Flutter induced and mapped <input type="checkbox"/> History of A-Flutter Outcome: <input type="radio"/> Block achieved or demonstrated <input type="radio"/> Block not achieved <input type="checkbox"/> Complex Fractionated Atrial Electrogram (CFAE Ablation)

Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 CTI
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 Inferolateral Mitral Isthmus Line (left Inferior to Mitral Annulus)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 LA Appendage Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 LA Floor (low posterior line)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 LA Roofline
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 Posterior Wall Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 Superior Septal Mitral Isthmus Line (Right Superior to Mitral Annulus)
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 SVC Isolation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved
 Targeted Ganglia Ablation
Indication: Empiric A-Flutter induced and mapped
 History of A-Flutter
Outcome: Block achieved or demonstrated Block not achieved

Non-Pulmonary Vein Triggers
(Check all that apply):

Accessory Pathway
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
 AVNRT
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
 Coronary Sinus
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
 Crista Terminalis
Indication: Empiric Triggers AF Frequent APDs
 Atrial Tachycardia
Trigger Eliminated: Yes No Not tested
 Eustachian Ridge
Indication: Empiric Triggers AF Frequent APDs

<input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> LA appendage Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Left side of intra atrial septum Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Ligament of Marshall Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Mitral Valve Annulus Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Posterior Wall Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Right Atrial Appendage Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Right side of intra atrial septum Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Superior Vena Cava Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Tricuspid Valve annulus Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested <input type="checkbox"/> Other (specify) _____ Indication: <input type="checkbox"/> Empiric <input type="checkbox"/> Triggers AF <input type="checkbox"/> Frequent APDs <input type="checkbox"/> Atrial Tachycardia Trigger Eliminated: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not tested	
Phrenic Nerve Strategy	<input type="radio"/> Phrenic Nerve Pacing Not Done <input type="radio"/> Course of Phrenic Nerve Delineated with Pacing <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 50
Phrenic Nerve Outcome:	<input type="radio"/> No Capture <input type="radio"/> Capture <input type="radio"/> Phrenic Nerve Sites of Capture Avoided <input type="radio"/> Lesions placed at sites of capture during phrenic pacing
Radiofrequency delivery strategy	<input type="radio"/> Point by Point <input type="radio"/> Drag Technique <input type="radio"/> Other
Energy	High Power Anterior (watts) _____ High power duration (seconds) _____ Low Power Posterior (watts) _____ Low power duration (seconds) _____
Lesion Index Used	Anterior Target _____ Posterior Target _____ <input type="checkbox"/> N/A
Esophageal Protection Strategies	<input type="checkbox"/> Esophageal Cooling <input type="checkbox"/> Esophageal Deviation Performed

(select all that apply)	<input type="checkbox"/> Esophageal Temp Probe <input type="radio"/> One sensor <input type="radio"/> Multi-sensor <input type="checkbox"/> No Strategy Utilized
Scar Assessment:	<input type="radio"/> Not assessed <input type="radio"/> Assessed <input type="radio"/> Voltage cutoff <input type="radio"/> 0.2 <input type="radio"/> 0.5 <input type="radio"/> Not noted <input type="radio"/> Scar not present <input type="radio"/> Scar present (select all locations that apply) Location: <input type="checkbox"/> LA posterior wall <input type="checkbox"/> LA Roofline <input type="checkbox"/> LA Septum <input type="checkbox"/> RA Free Wall <input type="checkbox"/> RA Septum <input type="checkbox"/> Other
Provocation testing (Check all that apply):	<input type="checkbox"/> Adenosine <input type="radio"/> Heart Block not achieved <input type="radio"/> Heart Block achieved <input type="radio"/> Left pulmonary vein reconnection <input type="radio"/> Right pulmonary vein reconnection <input type="radio"/> Triggers noted (NPV) <input type="radio"/> No reconnection or triggers noted <input type="checkbox"/> Burst pacing <input type="radio"/> AF induced <input type="radio"/> AF not induced <input type="checkbox"/> Isoproterenol <input type="radio"/> A-Fib NPVT noted <input type="radio"/> APDs observed <input type="radio"/> A-Tach or A-Flutter induced <input type="radio"/> Left pulmonary vein reconnection <input type="radio"/> Right pulmonary vein reconnection Maximum Dose: _____
Did cardioversion occur?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Electrical <input type="radio"/> Pharmacological <input type="radio"/> During ablation lesion delivery
Post ablation rhythm:	<input type="radio"/> Atrial fibrillation <input type="radio"/> Atrial flutter, typical right <input type="radio"/> Atrial flutter, atypical <input type="radio"/> Sinus rhythm <input type="radio"/> Other (specify) _____ <input type="radio"/> Unknown/ND
Complications noted during and post-procedure:	<input type="radio"/> Yes <input type="radio"/> No
If yes, Check all that apply:	<input type="checkbox"/> Air embolus <input type="checkbox"/> Hemorrhage requiring transfusion <input type="checkbox"/> Atrioesophageal fistula <input type="checkbox"/> Phrenic nerve injury

	Aspiration <input type="checkbox"/> AV fistula <input type="checkbox"/> Requiring surgical repair <input type="checkbox"/> Complication from anesthesia <input type="checkbox"/> Death <input type="checkbox"/> Deep venous thrombosis <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Hematoma <input type="checkbox"/> Hemopericardium (check all that apply): <input type="checkbox"/> Tamponade <input type="checkbox"/> Pericardiocentesis <input type="checkbox"/> Requiring surgical drainage and/or repair	<input type="checkbox"/> Pseudo aneurysm <input type="checkbox"/> Requiring surgical repair <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> PV stenosis <input type="checkbox"/> Retroperitoneal bleed <input type="checkbox"/> Stiff LA Syndrome <input type="checkbox"/> Stroke <input type="checkbox"/> Transient ischemic attack <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Volume overload/pulmonary edema <input type="checkbox"/> Other (specify) _____
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DISCHARGE

Discharge Information

Discharge Date/Time	___/___/___ __:___ MM/DD/YYYY or MM/DD/YYYY HH:MM
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What was the patient's discharge disposition on the day of discharge?	<input type="radio"/> 1 – Home <input type="radio"/> 2 – Hospice – Home <input type="radio"/> 3 – Hospice – Health Care Facility <input type="radio"/> 4 – Acute Care Facility <input type="radio"/> 5 – Other Health Care Facility <input type="radio"/> 6 – Expired <input type="radio"/> 7 – Left Against Medical Advice/AMA <input type="radio"/> 8 – Not Documented or Unable to Determine (UTD)
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If Other Health Care Facility	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Long Term Care Hospital (LTCH) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Other
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When is the earliest physician/APN/PA documentation of comfort measures only?	<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented/UTD
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Patient is currently enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AFib, STK, VTE)?	<input type="radio"/> Yes <input type="radio"/> No
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Vital Signs (closest to discharge)	BP-Supine	___ / ___ mmHg (systolic/diastolic) <input type="radio"/> Not documented
	Heart Rate	___ bpm <input type="radio"/> Not documented

Reason documented by a physician, nurse practitioner, or physician assistant for discharging patient with heart rate >110 bpm?	<input type="radio"/> Yes <input type="radio"/> No
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Discharge Rhythm(s) (closest to discharge)	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atrial Tachycardia <input type="radio"/> Sinus Rhythm <input type="radio"/> Paced <input type="radio"/> Other
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ECG findings (closest to discharge):	Resting Heart Rate (bpm) ___ <input type="checkbox"/> Not Available QRS duration (ms) ___ <input type="checkbox"/> Not Available QTc (ms) ___ <input type="checkbox"/> Not Available PR interval (ms) ___ <input type="radio"/> Not Available
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Discharge ECG QRS Morphology	<input type="radio"/> Normal <input type="radio"/> RBBB <input type="radio"/> LBBB <input type="radio"/> NS-IVCD <input type="radio"/> Not Available
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Labs	Platelet Count	___ mL <input type="radio"/> Not Available
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(closest to discharge)	SCr	_____ O mg/dL O μmol/L O Not Available
	Estimated Creatinine Clearance	_____ mL/min O Not Available
	INR	_____ O Not Available
Discharge Medications		
ACEI Prescribed?	O Yes O No O NC	
	If Yes	Medication: Dosage: Frequency:
ARB Prescribed?	O Yes O No O NC	
	If Yes	Medication: Dosage: Frequency:
Aldosterone Antagonist Prescribed?	O Yes O No O NC	
	If Yes	Medication: Dosage: Frequency:
Antiarrhythmic Prescribed?	O Yes O No O NC	
	If Yes	Medication : Dosage: Frequency: Medication : Dosage: Frequency:
ARNI Prescribed?	O Yes O No O NC	
	If Yes	Medication: Dosage: Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ARNI:	<input type="checkbox"/> ACE inhibitor use within the prior 36 hours <input type="checkbox"/> Allergy <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hypotension <input type="checkbox"/> Other medical reasons <input type="checkbox"/> Patient Reason <input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women <input type="checkbox"/> System Reason	
Reasons for not switching to ARNI at discharge	O Yes O No O ARNI was prescribed at discharge	
Reason ARNI not prescribed:	<input type="checkbox"/> New onset heart failure <input type="checkbox"/> NYHA Class I <input type="checkbox"/> NYHA Class IV <input type="checkbox"/> Not previously tolerating ACEI or ARB	
Anticoagulation Therapy Prescribed?	O Yes O No O NC Yes O No O NC	
	If Yes	Class: Medication:

	Dosage: Frequency:
Are there any relative or absolute contraindications to oral anticoagulant therapy? (Check all that apply)	<input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Comorbid illness (e.g. renal/liver) <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Frequent falls/frailty <input type="checkbox"/> High bleeding risk <input type="checkbox"/> Need for dual antiplatelet therapy <input type="checkbox"/> Occupational risk <input type="checkbox"/> Patient refusal/preference <input type="checkbox"/> Physician preference <input type="checkbox"/> Prior intracranial hemorrhage <input type="checkbox"/> Recent operation <input type="checkbox"/> Transient or reversible causes of atrial fibrillation <input type="checkbox"/> Unable to adhere/monitor
Antiplatelet(s) Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
If Yes	Medication : Dosage: Frequency: Medication : Dosage: Frequency:
Are there any relative or absolute contraindications to oral antiplatelet therapy? (Check all that apply)	<input type="checkbox"/> Allergy <input type="checkbox"/> Bleeding Event <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Comorbid illness (e.g. renal/liver) <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Frequent falls/frailty <input type="checkbox"/> High bleeding risk <input type="checkbox"/> Occupational risk <input type="checkbox"/> Patient refusal/preference <input type="checkbox"/> Physician preference <input type="checkbox"/> Prior intracranial hemorrhage <input type="checkbox"/> Recent operation <input type="checkbox"/> Transient or reversible causes of atrial fibrillation <input type="checkbox"/> Unable to adhere/monitor
Beta Blocker Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
If Yes	Medication: Dosage: Frequency:
Ca Channel Blocker Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
If Yes	Medication: Dosage: Frequency:
Digoxin Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
If Yes	Dosage: Frequency:
Statin Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Hydralazine Nitrate Prescribed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Other Medications at Discharge	<input type="checkbox"/> Diuretic <input type="checkbox"/> NSAIDS/COX-2 Inhibitor <input type="checkbox"/> PCSK-9 Inhibitor
Discharge Instructions	
Smoking Cessation Counseling Given	<input type="radio"/> Yes <input type="radio"/> No
Rhythm Control/Rate Control Strategy Planned/Intended	<input type="checkbox"/> Rhythm Control Strategy Planned <input type="checkbox"/> Rate Control Strategy Planned <input type="checkbox"/> No Documentation of Strategy

Patient and/or caregiver received education and/or resource materials regarding all the following:	Risk factors	<input type="radio"/> Yes	<input type="radio"/> No
	Stroke Risk	<input type="radio"/> Yes	<input type="radio"/> No
	Management	<input type="radio"/> Yes	<input type="radio"/> No
	Medication	<input type="radio"/> Yes	<input type="radio"/> No
	Adherence	<input type="radio"/> Yes	<input type="radio"/> No
	Follow-up	<input type="radio"/> Yes	<input type="radio"/> No
When to call provider		<input type="radio"/> Yes	<input type="radio"/> No
Anticoagulation Therapy Education Given:		<input type="radio"/> Yes	<input type="radio"/> No
PT/INR Planned Follow-up		<input type="radio"/> Yes	<input type="radio"/> No
Who will be following patients PT/INR?		<input type="radio"/> Home INR Monitoring <input type="radio"/> Anticoagulation Warfarin Clinic <input type="radio"/> Managed by Physician associated with hospital <input type="radio"/> Managed by outside physician <input type="radio"/> Not documented	
Date of PT/INR test planned post discharge:		___/___/___	<input type="radio"/> Not documented
System Reason for no PT/INR Planned Follow-up?		<input type="radio"/> Yes	<input type="radio"/> No
Risk Interventions			
TLC (Therapeutic Lifestyle Change) Diet		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
Obesity Weight Management		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
Activity Level/Recommendation		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
Screening for obstructive sleep apnea		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
Referral for evaluation of obstructive sleep apnea if positive screen		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
Discharge medication instruction provided		<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Not Documented <input type="radio"/> Not Applicable
CLINICAL CODES AND RISK SCORES			
ICD-10-CM Principal Diagnosis Code			
ICD-10-CM Other Diagnoses Codes			
ICD-10-PCS Principal Procedure Code			
ICD-10-PCS Other Procedure Codes			
CPT Code			
CPT Code Date			