



Acute Coronary Syndrome Israeli Survey – 2018



This form should be completed for all patients with ACS (AMI or Unstable AP) or Troponin elevation admitted between 1/3/2018 and 30/4/2018

Center: |_|_|_|_| Ward: |_|_|_| Patient: |_|_|_|_|

Hospitalization #: |_|_| Initials: |_|_|_|
ID (last 4 digits, Without check digit - "Sifrat Bikoret"): |_|_|_|_|
Enrollment Date |_|_|_| / |_|_|_| / 2018
Date of Admission to Cardiology/CCU department |_|_|_| / |_|_|_| / 2018
Informed consent obtained: No Yes

1. Demographics, History and Risk Factors

Year of Birth: 19 |_|_| gender: Male Female
Origin: Israeli Jew Israeli Arab Other Israeli Tourist Other Unknown
Level of Education: Elementary High school Higher education / Academic
Marital Status: Single Married/Attached Divorced Widow

Kupat Holim: Clalit Maccabi Meuhedet Leumit Other: _____

Height: |_|_|_| cm Weight: |_|_|_| kg

Prior Cardiovascular History:

ACS..... No Yes
Prior AP ≥24 hours..... No Yes
CABG..... No Yes
PCI..... No Yes
Cardiomyopathy No Yes
If yes, ischemic
Non-ischemic
CHF..... No Yes
Chronic renal failure..... No Yes
PVD..... No Yes
Stroke/TIA..... No Yes
Biologic Valve..... No Yes
TAVR/TAVI..... No Yes
COPD..... No Yes
A.Fib/Flutter..... No Yes
If yes, CAF 1
PAF 2
AICD/CRT implant..... No Yes
Any Malignancy..... No Yes
Active malignancy..... No Yes
(Definition of active malignancy: receiving active antimitotic treatment; or diagnosed within the past 6 months; or recurrent or metastatic; or inoperable)
Thyroid disease..... No Yes
Hypo 1 Hyper 2
Other life limiting disease..... No Yes

Risk Factors for CAD:

Smoking: 0 Never 1 Past 2 Current
Family history of CAD..... No Yes
Dyslipidemia..... No Yes Newly diagnosed
Hypertension..... No Yes
Diabetes..... No Yes
 1 Type 1 2 Type 2
Menopause..... No Yes (Women younger 55y)
Cannabis use..... No Yes Illicit drug use No Yes
If yes: Use 1 hour before index chest pain/myocardial infarction onset
 Use 24 hour preceding index chest pain/myocardial infarction onset
 use during the last year at least once in month
History of Pregnancy complications (e.g diabetes, hypertension, pre/eclampsia) (Women younger 60y) No Yes
If yes: Diabetes HTN pre/eclampsia

Prior Chronic Treatment: See the table at the end of the CRF

Aspirin stopped within 2 weeks before the index admission: 0 Yes 1 No
Antiplatelets (clopidogrel/prasugrel/ticagrelor) stopped within 2 weeks before the index admission: 0 Yes 1 No

2. Onset, 1st Medical Contact Information & Pre-hospital Information

Symptom onset: |_|_|_|_| / |_|_|_|_| / 2018 ⊕ |_|_|_|_| : |_|_|_|_| △₂
Day Month Hours Minutes NA

Presenting Symptoms: ₁ Typical angina ₂ Dyspnea ₃ Atypical chest pain
₄ Syncope ₅ Palpitations ₆ Abdominal pain
₇ Aborted SCD
 If yes, ₁ CPR only ₂ DC shock

First Medical Contact: ₁ Home visit ₂ HMO Out-Pts. clinic/ "Moked" ₃ Regular Ambulance
₄ Mobile ICCU ₅ ER ₆ In-Patient
₇ Other Hospital

First Medical Contact Date: |_|_|_|_| / |_|_|_|_| / 2018 ⊕ |_|_|_|_| : |_|_|_|_| △₂
Day Month Hours Minutes NA

<p>Mode of Transportation:</p> <input type="checkbox"/> ₁ Mobile ICCU <input type="checkbox"/> ₂ Regular ambulance <input type="checkbox"/> ₃ Private car / independently <input type="checkbox"/> ₄ Not relevant (e.g. in-patient)	<p>Reason ambulance not used:</p> <input type="checkbox"/> ₁ Ambulance not available <input type="checkbox"/> ₂ Advice from medical staff <input type="checkbox"/> ₃ Patient's decision <input type="checkbox"/> ₄ Other
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Treatment before hospitalizations - MADA Intensive Care Unit (NATAN/ATAN):
check all drugs given from beginning of symptoms till admission to hospital not including chronic drugs

<input type="checkbox"/> Aspirin, dose ____mg	<input type="checkbox"/> Ticagrelor, dose ____mg	<input type="checkbox"/> Narcotics (Morphine, Fentanyl), dose ____mg
<input type="checkbox"/> Clopidogrel, dose ____mg	<input type="checkbox"/> Heparin, dose ____IU	
<input type="checkbox"/> Prasugrel, dose ____mg	<input type="checkbox"/> LMWH, dose ____mg	

Procedures before hospitalization: *check all procedures before admission to hospital*

<input type="checkbox"/> ECG - if ECG was performed, please indicate the time of performance and attach to completed CRF	<input type="checkbox"/> DC shock – manual*
<input type="checkbox"/> Oxygen mask	<input type="checkbox"/> External pacing
<input type="checkbox"/> Oxygen nasal	<input type="checkbox"/> Intubation/Ventilation
<input type="checkbox"/> Non-invasive ventilation (CPAP, BiPAP)	
<input type="checkbox"/> CPR (chest compression) *	
<input type="checkbox"/> DC shock – AED*	

*Please fill the *Out of Hospital Cardiac Arrest (OHCA)* form

First Arrival to: ₁ ER ₂ Directly to CCU ₃ Directly to cath laboratory
 |_|_|_|_| / |_|_|_|_| / 2018 ⊕ |_|_|_|_| : |_|_|_|_| △₄
Day Month Hours Minutes NA

ED Information: *check all drugs administered at ED*

<input type="checkbox"/> Aspirin, dose ____mg
<input type="checkbox"/> Clopidogrel, dose ____mg
<input type="checkbox"/> Prasugrel, dose ____mg
<input type="checkbox"/> Ticagrelor, dose ____mg
<input type="checkbox"/> Heparin, dose ____IU
<input type="checkbox"/> LMWH , dose ____mg
<input type="checkbox"/> Other Anticoagulants
<input type="checkbox"/> GP IIb/IIIa antagonists

Reason for not giving loading dose of aspirin:

<input type="checkbox"/> allergy	<input type="checkbox"/> gastric problems	<input type="checkbox"/> known side effects
<input type="checkbox"/> active bleeding	<input type="checkbox"/> contraindication	

Reason for not giving the loading dose of clopidogrel:

<input type="checkbox"/> allergy	<input type="checkbox"/> known side effects	<input type="checkbox"/> local protocol
<input type="checkbox"/> perception of candidacy for urgent CABG	<input type="checkbox"/> active bleeding	
<input type="checkbox"/> contraindication		

Reason for not giving effient/ticagrelor:

<input type="checkbox"/> allergy	<input type="checkbox"/> known side effects	<input type="checkbox"/> local protocol
<input type="checkbox"/> perception of candidacy for urgent CABG	<input type="checkbox"/> active bleeding	
<input type="checkbox"/> need for oral anticoagulation	<input type="checkbox"/> contraindication	

2. Onset, 1st Medical Contact Information & Pre-hospital Information – CONT.

ED procedures: *check all procedures performed at ED*

- | | |
|---|---|
| <input type="checkbox"/> ECG If it is a qualifying ECG, please provide with completed CRF | <input type="checkbox"/> External pacing |
| <input type="checkbox"/> CPR (chest compression) * | <input type="checkbox"/> Intubation/Ventilation |
| <input type="checkbox"/> DC shock* | <input type="checkbox"/> Echocardiography |

*Please fill the *Out of Hospital Cardiac Arrest (OHCA)* form

1st Hospitalized in: ₁ CCU ₂ Cardiology ₃ Chest pain unit ₄ Internal Medicine ₅ Other

|_|_|_| / |_|_|_| / 2018
Day Month

⊕ |_|_|_| : |_|_|_|
Hours Minutes

△₂
NA

If 1st ward was not CCU/Cardiology:

Date transferred to CCU / Cardiology: |_|_|_| / |_|_|_| / 2018

⊕ |_|_|_| : |_|_|_|

△₂
NA

3. Vital Signs on First Medical Contact

Killip class: 1 2 3 4

Heart Rate (beats/minute): |_|_|_|_|

Oxygen saturation (%): Room air saturation (%): |_|_|_|_| **Oxygen supplement (%):** |_|_|_|_|

Blood pressure (mmHg): Systolic |_|_|_|_| / Diastolic |_|_|_|_|

Measuring Ankle Brachial Index (ABI)*

Ankle Brachial Index measured

Systolic blood pressure at the arm (mmHg) Right |_|_|_|_| / |_|_|_|_| Left |_|_|_|_| / |_|_|_|_|

Systolic blood pressure at the ankle (mmHg) Right |_|_|_|_| / |_|_|_|_| Left |_|_|_|_| / |_|_|_|_|

*Measurements should be done after patient has been at rest in the supine position for 10 minute

First ECG recorded: |_|_|_|_| / |_|_|_|_| / 2018 ⊕ |_|_|_|_| : |_|_|_|_|
Day Month Hours Minutes

Performed at: ₁ Home ₂ Ambulance ₃ ED ₄ Hosp. Ward ₅ Primary clinic/"moked"

Rhythm: ₁ NSR ₂ AF ₃ S. tachy ₄ S. brady
₅ VT/VF ₆ Asystole ₇ 2-3° AV block ₈ Other: _____

ECG Pattern: tick only one

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> ₀ Normal | <input type="checkbox"/> ₁ No new ST- T changes | <input type="checkbox"/> ₂ ST-elevation | <input type="checkbox"/> ₃ New onset of LBBB | <input type="checkbox"/> ₄ ST-depression |
| <input type="checkbox"/> ₅ T inversion only | <input type="checkbox"/> ₆ Undetermined ECG findings (LBBB, Pacing, Severe LVH) | <input type="checkbox"/> ₇ RBBB | | |

In the case of infero-basal ST-segment elevation myocardial infarction:

V7-9 RV4 performed ₀ Yes ₁ No △₉ NA

4. Primary Reperfusion Therapy in STE-ACS (or presumably new BBB Patients)

Primary Reperfusion: ₀ No ₁ Yes (If YES, specify one below) |_|_|_|_| / |_|_|_|_| / 2018 ⊕ |_|_|_|_| : |_|_|_|_|

Type of Reperfusion: ₁ Thrombolysis Day Month Hours Minutes

₂ Angiography **Followed by:** ₁ Primary PCI ₂ Urgent CABG ₀ No intervention

4. Primary Reperfusion Therapy in STE-ACS (or presumably new BBB Patients) – CONT.**Reasons for not Performing Primary Reperfusion (TLx or PCI) for ST Elevation or New LBBB (check all that apply):**

- Spontaneous reperfusion
 Late arrival at hospital
 Died before decision
 Contraindication to TLx
 PPCI Considered not indicated/justified
(i.e: comorbidity, advanced dementia, cancer, age, frailty)
 Renal failure
 Bleeding risk
 Assessed by calculator ₁ Yes ₂ No
 Clinical judgement ₁ Yes ₂ No
 If calculator was used tick appropriate:
 CRUSADE TIMI HASBLED
 Known coronary anatomy
 Other
 Patient refusal
 Takotsubo syndrome *Please fill the **Takotsubo** form
 Normal Coronaries

I. Thrombolytic Therapy (TLx):TLx agent : ₁ STK ₂ tPATLx judged to be clinically successful ₀ No ₁ Yes

* Performed within 12 hours from symptom onset. If performed later (>12h) enter data on paragraph 5- section "Additional Cardiac Interventions"

Date of angiography/PCI (after thrombolysis): |_|_|_| / |_|_|_| /2018 Ⓡ |_|_|| : |_|_||
Day Month Hours Minutes**II. Primary PCI/ Angiography**Vascular access: ₁ Femoral ₂ Radial ₃ BothInfarct related artery (check one): ₁ LMCA ₂ LAD ₃ LCx ₄ RCA ₅ SVG ₆ Other graft ₇ UnknownLM stenosis > 50% or FFR less than 0.8 ₁ Yes ₂ NoIf Yes: unprotected
 protected by CABGNumber of diseased vessels (according to primary angiography): |_|_|_|
(0=None, 1, 2, 3, 99=Unknown)If Yes, please specify **the most relevant choice**: LMCA LAD Cx RCA SVGTIMI grade flow –before revascularization (First injection): 0 1 2 3PCI for additional non infarct related artery lesion(s): ₀ No ₁ Yes

4. Primary Reperfusion Therapy in STE-ACS (or presumably new BBB Patients) – CONT.

IIb/IIIa antagonist: No Yes NA

Oral anti-platelet therapy:

Aspirin before during/after PPCI Unknown
loading dose _____mg

Clopidogrel before during/after PPCI Unknown
loading dose _____mg

Prasugrel before during/after PPCI Unknown
loading dose _____mg

Ticagrelor before during/after PPCI Unknown
loading dose _____mg

Anticoagulants:

Heparin loading dose _____IU

LMWH loading dose _____mg

Bivalirudin (Angiomax) loading dose _____mg
Continuous Infusion Yes No

Reason for not giving loading dose of aspirin:

allergy gastric problems
 known side effects active bleeding
 contraindication

Reason for not giving the loading dose of clopidogrel:

allergy known side effects local protocol
 perception of candidacy for urgent CABG
 active bleeding contraindication
 other

Reason for not giving effient/ticagrelor:

allergy known side effects local protocol
 perception of candidacy for urgent CABG
 active bleeding contraindication
 need for oral anticoagulation
 other

Stent: Yes No *if Yes,* BMS DES MGUARD

Aspiration Device: Yes No

IABP use: Yes No *if Yes,* before during/after PPCI

Catechol amines: Yes No

ECMO: Yes No

Other hemodynamic support, Specify: _____

Angiographic Complications: No Yes *if Yes, please mark: (all that apply)*

Perforation Dissection
 Occlusion of significant side branch Vascular complication (excluded bleeding)
 Distal embolization

TIMI grade flow - following the procedure: 0 1 2 3

5. Additional Cardiac Interventions and Procedures in CCU/Cardiology

Coronary angiography (excluding primary PCI): No Yes

If yes, specify: Event Driven staged PCI **Date:** |_|_| / |_|_| / 2018 ⊕ |_|_| : |_|_|
Day Month Hours Minutes

Vascular access: Femoral Radial Both

Number of diseased vessels (according to any angiography): |_|_|
(0=None, 1, 2, 3, 99=Unknown)

Coronary angiography followed by PCI No Yes
if yes, specify **Date:** |_|_| / |_|_| / 2018

Coronary angiography followed by CABG No Yes
if yes, specify **Date:** |_|_| / |_|_| / 2018

If PCI performed, PCI to (check all): LM LAD LCX RCA SVG Arterial Graft Unknown

5. Additional Cardiac Interventions and Procedures in CCU/Cardiology - CONT.

IIb/IIIa antagonist: No Yes NA

Oral Anti-platelet therapy:

Aspirin before during/after PPCI Unknown
loading dose _____mg NA

Clopidogrel before during/after PPCI Unknown
loading dose _____mg NA

Prasugrel before during/after PPCI Unknown
loading dose _____mg NA

Ticagrelor before during/after PPCI Unknown
loading dose _____mg NA

Reason for not giving loading dose of aspirin:

allergy gastric problems
 known side effects active bleeding
 contraindication

Reason for not giving the loading dose of clopidogrel:

allergy known side effects local protocol
 perception of candidacy for urgent CABG
 active bleeding contraindication

Reason for not giving effient/ticagrelor:

allergy known side effects local protocol
 perception of candidacy for urgent CABG
 active bleeding contraindication
 need for oral anticoagulation

Anticoagulants:

Heparin Bivalirudin (Angiomax)
 LMWH Other, specify: _____

Stent: Yes No *if Yes,* BMS DES

Aspiration device: Yes No

IABP use: Yes No *if Yes,* before during/after PPCI

Angiographic Complications: No Yes *if Yes, please mark:(all that apply)*

Perforation Dissection
 Occlusion of significant side branch Vascular complication (excluded bleeding)
 Distal embolization

Other Procedures:

	No	Yes		No	Yes
DC shock.....	<input type="radio"/>	<input type="checkbox"/>	Stress test /SPECT.....	<input type="radio"/>	<input type="checkbox"/>
Resuscitation (chest compression).....	<input type="radio"/>	<input type="checkbox"/>	Cardiac CT.....	<input type="radio"/>	<input type="checkbox"/>
Ventilation.....	<input type="radio"/>	<input type="checkbox"/>	AICD/CRT.....	<input type="radio"/>	<input type="checkbox"/>
IA Balloon.....	<input type="radio"/>	<input type="checkbox"/>	Permanent pacemaker.....	<input type="radio"/>	<input type="checkbox"/>
Echo.....	<input type="radio"/>	<input type="checkbox"/>	Temporary pacemaker.....	<input type="radio"/>	<input type="checkbox"/>
Dialysis.....	<input type="radio"/>	<input type="checkbox"/>	Therapeutic Hypothermia.....	<input type="radio"/>	<input type="checkbox"/>
EPS.....	<input type="radio"/>	<input type="checkbox"/>			

Targeted Temperature Management (Formerly Mild Therapeutic Hypothermia):

Length of TTM: ___ hours Minimal temp: ___ °c

In patients undergoing PCI, MTH initiated:

before PCI during/ after PCI

None Yes, External cooling pads / blankets / wraps
 Yes, Femoral vein catheter Yes, Cooling caps
 Yes, Cold intravenous fluid
 Yes, Nasal

EF Determined No Yes NA

if Yes, specify: **Date:** |_|_| / |_|_| / 2018 ⊕ |_|_| : |_|_|
Day Month Hours Minutes

EF Determined by: Echo Ventriculography Radionuclear scan NA

EF value: |_|_| %

EF category: Normal (≥50%) Mild (40-49%) Moderate (30-39%) Severe (<30%)

6. In Hospital Complications

	No	Yes		No	Yes
CHF mild-moderate*(Killip-2)	<input type="radio"/> 0	<input type="checkbox"/> 1	High degree (2-3°) AVB	<input type="radio"/> 0	<input type="checkbox"/> 1
Pulmonary edema*(Killip-3)	<input type="radio"/> 0	<input type="checkbox"/> 1	Asystole	<input type="radio"/> 0	<input type="checkbox"/> 1
Cardiogenic shock*(Killip-4).....	<input type="radio"/> 0	<input type="checkbox"/> 1	TIA	<input type="radio"/> 0	<input type="checkbox"/> 1
Hemodynamically significant RVI.....	<input type="radio"/> 0	<input type="checkbox"/> 1	Stroke	<input type="radio"/> 0	<input type="checkbox"/> 1
Re-MI.....	<input type="radio"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> Hemorrhagic		
Post MI angina/re-ischemia.....	<input type="radio"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> Ischemic		
Stent thrombosis (definite/probable/possible)..	<input type="radio"/> 0	<input type="checkbox"/> 1	Acute renal failure.....	<input type="radio"/> 0	<input type="checkbox"/> 1
Free wall rupture	<input type="radio"/> 0	<input type="checkbox"/> 1	Sepsis.....	<input type="radio"/> 0	<input type="checkbox"/> 1
Tamponade	<input type="radio"/> 0	<input type="checkbox"/> 1	Bleeding.....	<input type="radio"/> 0	<input type="checkbox"/> 1
VSD.....	<input type="radio"/> 0	<input type="checkbox"/> 1	Most serious bleeding	<input type="radio"/> 0	<input type="checkbox"/> 1
MR Moderate-severe.....	<input type="radio"/> 0	<input type="checkbox"/> 1	<i>Choose one of the following types of the BARC definitions:</i>		
Pericarditis	<input type="radio"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3a <input type="checkbox"/> 3b <input type="checkbox"/> 3c <input type="checkbox"/> 4 <input type="checkbox"/> 5a <input type="checkbox"/> 5b		
Sustained VT (>125 bpm).....	<input type="radio"/> 0	<input type="checkbox"/> 1	Minor bleeding.....	<input type="radio"/> 0	<input type="checkbox"/> 1
Primary VF.....	<input type="radio"/> 0	<input type="checkbox"/> 1	Any transfusion.....	<input type="radio"/> 0	<input type="checkbox"/> 1
Secondary VF.....	<input type="radio"/> 0	<input type="checkbox"/> 1	Blood transfusions.....	<input type="radio"/> 0	<input type="checkbox"/> 1
New AF.....	<input type="radio"/> 0	<input type="checkbox"/> 1	Units: _ _ _		
<input type="checkbox"/> PAF			Bleeding Site:		
<input type="checkbox"/> Chronic/Persistent			<input type="checkbox"/> Access site <input type="checkbox"/> ICH <input type="checkbox"/> GIT <input type="checkbox"/> Other		
			Minor Bleeding.....	<input type="radio"/> 0	<input type="checkbox"/> 1

** Specify worst Killip Class*

7. Laboratory Tests (maximal values)

FIRST TROPONIN TIME AND LEVEL, REPEATED TROPONIN

*If your measurement units do not match the measurement units listed below, please convert by the conversion calculator link

Peak CK: |_|_|_|_|_| IU/L Elevated No Yes NA (Maximal values)

First troponin time and value: |_|_|_| / |_|_|_| / 2018 ⊕ |_|_|:|_|_| Type I/T _____ |_|_|_|_| Unit: _____
Day Month Hours Minutes

Elevated

Peak troponin I (max): |_|_|_|_|_| Unit: _____ Elevated? No Yes NA

Peak troponin T (max): |_|_|_|_|_| Unit: _____ Elevated? No Yes NA

First Measurements of:

Cholesterol: Total |_|_|_|_| Unit: _____ LDL |_|_|_|_| Unit: _____ HDL |_|_|_|. |_|_|_| Unit: _____

Triglycerides: |_|_|_|_| Unit: _____

Lipid profile: during hospitalization No Yes Unit: _____
 (If not checked in 1st 24h, please indicate the reason: 1.not available; 2.weekend; 3. other)

First glucose: |_|_|_|_| Unit: _____ First fasting glucose: |_|_|_|_| Unit: _____

Earliest Hb: |_|_|_|. |_|_|_| Unit: _____ Lowest Hb: |_|_|_|. |_|_|_| Unit: _____

HBA1C: |_|_|_|_| % Elevated? No Yes NA

First platelets : |_|_|_|_| Unit: _____ Last platelets: |_|_|_|_| Unit: _____

|_|_|_|
Center

|_|_|
Ward

|_|_|_|
Patient

Max. CRP: |_|_|_|_| Unit: ___

Earliest Creatinine: |_|_|_|_| mg/L Max. Creatinine: |_|_|_|_| Unit: ___ Discharge Creatinine: |_|_|_|_| Unit: ___

Earliest WBC: |_|_|_|_|_| Unit: ___ Max. WBC: |_|_|_|_|_| Unit: ___

8. Treatment – Chronic, Pre-Hospital, In-Hospital, Discharge

Medication	Chronic use before admission	Initiated during hospitalization	Discharged with
Anti-platelet			
Aspirin	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Clopidogrel	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Prasugrel	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Ticagrelor	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
GP IIb/IIIa ant.	<input type="checkbox"/> NA	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> NA

Medication	Chronic use before admission	Pre-hospital therapy	Initiated during hospitalization	Discharged with
Anticoagulants				
Warfarin	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Dabigatran	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Rivaroxaban	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Apixaban	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
LMWH	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Heparin (UFH)	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Bivalirudin	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____
Fondaparinux	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ____

Other				
ACE-I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARB's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aldactone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beta Blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digoxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CCB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amiodarone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Anti-Arrhythmic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPI's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2 Blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colchicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Treatment – Chronic, Pre-Hospital, In-Hospital, Discharge – CONT.

Medication	Chronic use before admission	Pre-hospital therapy	Initiated during hospitalization	Discharged with
Other – CONT.				
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PDE 5 Inh (Viagra, Cialis, Levitra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal replacement therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iv Inotropic Rx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes patient? <input type="radio"/> No <input type="checkbox"/> Yes				
Insulin SC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulphonylureas				
Glibenclamide (Gluben)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glipizide (Gluco-Rite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glimepiride (Amaryl)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biguanides				
Metformin (Glucophage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> DPP-IV Inh.				
Sitagliptine (Januvia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saxagliptine (Onglyza)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vidagliptine (Galvus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linagliptine (Trajenta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GLP-1 Agonists				
Exenatide (Byetta, Budyreon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liraglutide (Victoza)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SGLT2-Inh				
Dapagliflozine (Forxiga)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Empagliflozine (Jardiance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other				
Acarbose (prandase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meglitinides (Repaglinide, Novonorm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TZDs (Pioglitazone - actos, Rosiglitazone - Avandia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lipids lowering? <input type="radio"/> No <input type="checkbox"/> Yes				
Simvastatin	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Pravastatin	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Atorvastatin	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Rosuvastatin	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d	<input type="checkbox"/> ____ mg/d
Ezetimibe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Treatment – Chronic, Pre-Hospital, In-Hospital, Discharge – CONT.

Medication	Chronic use before admission	Pre-hospital therapy	Initiated during hospitalization	Discharged with
PCSK9 Inh				
Alirocumab (Praluent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evolocumab (Repatha)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Discharge from Reporting Department (CCU/Cardiology)

Status at Discharge from Reporting Department:

<input type="checkbox"/> ₀ Alive →	Discharge Date: _ _ / _ _ / 2018 Discharged to: <table style="width: 100%;"> <tr> <td><input type="checkbox"/> ₁ Home</td> <td><input type="checkbox"/> ₂ Internal Medicine</td> </tr> <tr> <td><input type="checkbox"/> ₃ Cardiothoracic Surgery</td> <td><input type="checkbox"/> ₄ Other Ward</td> </tr> <tr> <td><input type="checkbox"/> ₅ Convalescence facility/unit (hotel)</td> <td><input type="checkbox"/> ₆ Nursing Home</td> </tr> <tr> <td><input type="checkbox"/> ₇ Other</td> <td></td> </tr> </table> CPC (Cerebral Performance Category- for OHCA): <input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₃ <input type="checkbox"/> ₄ <input type="checkbox"/> ₅ <input type="checkbox"/> NA	<input type="checkbox"/> ₁ Home	<input type="checkbox"/> ₂ Internal Medicine	<input type="checkbox"/> ₃ Cardiothoracic Surgery	<input type="checkbox"/> ₄ Other Ward	<input type="checkbox"/> ₅ Convalescence facility/unit (hotel)	<input type="checkbox"/> ₆ Nursing Home	<input type="checkbox"/> ₇ Other	
<input type="checkbox"/> ₁ Home	<input type="checkbox"/> ₂ Internal Medicine								
<input type="checkbox"/> ₃ Cardiothoracic Surgery	<input type="checkbox"/> ₄ Other Ward								
<input type="checkbox"/> ₅ Convalescence facility/unit (hotel)	<input type="checkbox"/> ₆ Nursing Home								
<input type="checkbox"/> ₇ Other									
<input type="checkbox"/> ₁ Deceased →	Date of Death: _ _ / _ _ / 2018 Cause of Death: <input type="checkbox"/> ₀ Non-cardiac <input type="checkbox"/> ₁ Cardiac Death was <input type="checkbox"/> ₀ Non-sudden <input type="checkbox"/> ₁ Sudden								

Discharge Diagnosis: ₁ STE MI ₂ NSTEMI ₃ UAP ₄ Myocarditis ₅ Pericarditis
 ₆ Perimyocarditis ₇ Takotsubo syndrome (please, fill the attached CRF for Takotsubo)
 ₈ PE

If STEMI:
ECG Findings (check all that apply):
Location: ₁ Anterior ₂ Inferior ₃ Lateral ₄ Posterior ₅ Right ventricle ₆ Undetermined
Q-Waves: ₀ No ₁ Yes

If AMI:
Type of AMI: |_|_|

Type 1	Spontaneous MI related to ischemia due to primary coronary event such as plaque erosion and /or rupture, fissuring or dissection	Type 4a	MI associated with PCI
Type 2	Myocardial infarction secondary to an ischemic imbalance. e.g. coronary artery spasm, coronary embolism, anemia, arrhythmias, hypertension or hypotension	Type 4b	MI associated with stent thrombosis as documented by angiography or at autopsy
Type 3	Myocardial infarction resulting in death when biomarker values are unavailable	Type 5	MI associated with CABG

If (Peri)Myocarditis or Takotsubo syndrome:
Cardiac MRI performed: ₀ No ₁ Yes
Coronary angiography performed: ₀ No ₁ Yes
Cardiac CT angiography performed: ₀ No ₁ Yes

Comments _____

Name of physician: _____ **CRF completed by:** _____ **Date:** _____

Nurses questionnaire

באשפוז:

סטטוס הביצועים לפי Karnofsky:

- 1 נורמלי, ללא תלונות, ללא סימני מחלה - 100
- 2 יכולת לבצע פעילות נורמלית; קיימים סימנים או סימפטומים מינוריים למחלה- 90
- 3 פעילות נורמלית עם מאמץ; קיימים מעט סימנים או סימפטומים של מחלה- 80
- 4 מטפל בעצמו; לא מסוגל לבצע פעילות נורמלית או לעבוד עבודה אקטיבית- 70
- 5 דורש עזרה לעיתים; אך מסוגל לטפל ברוב הצרכים האישיים- 60
- 6 דורש עזרה משמעותית וטיפול רפואי לעיתים קרובות- 50
- 7 נכה; דורש עזרה וטיפול מיוחדים- 40
- 8 נכות קשה; זקוק לאשפוז אך אין חשש לחייו - 30
- 9 חולה מאד; חייב להתאשפז; דרושה תמיכה רפואית אקטיבית- 20
- 10 גוסס; תהליך המוות מתקדם במהירות - 10
- 11 מת - 0

רמת הלחץ, המצוקה או הדחק שחוויית בשבוע שעבר, כולל היום:

10	9	8	7	6	5	4	3	2	1	0
לחץ, מצוקה או דחק קיצוני										ללא לחץ, מצוקה או דחק

נא סמן/י אם אחד מבין הרשומים מטה גרם לך לבעיות בשבוע שעבר, כולל היום. הקפד/הקפידו לענות בכן או לא לכל השאלות.

לא	כן	בעיות רגשיות	לא	כן	בעיות במשפחה	לא	כן	בעיות פרקטיות
<input type="checkbox"/>	<input type="checkbox"/>	דיכאון	<input type="checkbox"/>	<input type="checkbox"/>	התמודדות עם הילדים	<input type="checkbox"/>	<input type="checkbox"/>	שמירת הילדים
<input type="checkbox"/>	<input type="checkbox"/>	פחדים	<input type="checkbox"/>	<input type="checkbox"/>	התמודדות עם בן/בת זוג	<input type="checkbox"/>	<input type="checkbox"/>	דיור
<input type="checkbox"/>	<input type="checkbox"/>	עצבנות	<input type="checkbox"/>	<input type="checkbox"/>	בעיות בריאות במשפחה	<input type="checkbox"/>	<input type="checkbox"/>	ביטוח בריאות/בעיה פיננסית
<input type="checkbox"/>	<input type="checkbox"/>	עצבות				<input type="checkbox"/>	<input type="checkbox"/>	עבודה/לימודים
<input type="checkbox"/>	<input type="checkbox"/>	דאגה						
<input type="checkbox"/>	<input type="checkbox"/>	חוסר עניין בפעילויות הרגילות						
לא	כן	בעיות פיזיות						
<input type="checkbox"/>	<input type="checkbox"/>	משבר רוחני או דתי	לא	כן	לא	כן		
			<input type="checkbox"/>	<input type="checkbox"/>	מיניות	<input type="checkbox"/>	<input type="checkbox"/>	נשימה
			<input type="checkbox"/>	<input type="checkbox"/>	הפרעות שינה	<input type="checkbox"/>	<input type="checkbox"/>	עייפות
			<input type="checkbox"/>	<input type="checkbox"/>	שימוש בסמים	<input type="checkbox"/>	<input type="checkbox"/>	נפיחות
			<input type="checkbox"/>	<input type="checkbox"/>	שימוש יתר באלכוהול	<input type="checkbox"/>	<input type="checkbox"/>	צרבת
			<input type="checkbox"/>	<input type="checkbox"/>	לחץ בחזה	<input type="checkbox"/>	<input type="checkbox"/>	קלקול קיבה
			<input type="checkbox"/>	<input type="checkbox"/>	אי-נוחות	<input type="checkbox"/>	<input type="checkbox"/>	בחילות
						<input type="checkbox"/>	<input type="checkbox"/>	כאב

בכל אחת מהשאלות הבאות, נא סמן את המספר המתאר בצורה הטובה ביותר את דעתך:

עד כמה יש למחלתך השפעה על חייך?

10	9	8	7	6	5	4	3	2	1
משפיעה מאוד על חיי									לא משפיעה

כמה זמן לדעתך תימשך מחלתך?

10	9	8	7	6	5	4	3	2	1
לתמיד									זמן קצר

Nurses questionnaire – CONT.

בכל אחת מהשאלות הבאות, נא סמן את המספר המתאר בצורה הטובה ביותר את דעתך (המשך):
באיזו מידה את/ה מרגישה שיש לך שליטה על מחלתך?

10	9	8	7	6	5	4	3	2	1
שליטה רבה מאוד									אין שליטה

עד כמה את/ה חושבת/ת שהטיפול שלך (תרופות וכד') יכול לעזור למצב המחלה שלך?

10	9	8	7	6	5	4	3	2	1
יעזור מאוד									לא יעזור

באיזו מידה את/ה חשה/ה סימפטומים הנגרמים על-ידי המחלה שלך?

10	9	8	7	6	5	4	3	2	1
סימפטומים רבים וחמורים									אין סימפטומים

באיזו מידה את/ה מודאג/ת ממחלתך?

10	9	8	7	6	5	4	3	2	1
מודאג/ת מאוד									בכלל לא

באיזו מידה את/ה מרגישה/ה שאת/ה מבין/ה את המחלה שלך?

10	9	8	7	6	5	4	3	2	1
מבין/ה בצורה ברורה ביותר									לא מבין/ה

באיזו מידה מחלתך משפיע עליך מבחינה רגשית? לדוגמה, עד כמה היא גורמת לך לכעוס, לפחד, להיות מדוכא/ת או מצוברח/ת?

10	9	8	7	6	5	4	3	2	1
השפעות רגשיות חזקות מאוד									אין כל השפעות

נא דרג את שלושת הגורמים החשובים ביותר שאת/ה מאמין/ה שגרמו למחלה שלך:

1. _____
2. _____
3. _____

Acute Coronary Syndrome Israeli Survey – 2018

30-Day Follow-up (from 1st day of admission)

Do not record on this form events/ procedures that took place during the index hospitalization and were already recorded on the main form

Date of contact: |_|_|_| / |_|_| / 2018
day month

At the time of contact patient was:

₁ Still in hospital ₃ Deceased in hospital ₂ Discharged from hospital (specify below)

Date hospital Discharge: |_|_|_| / |_|_| / 2018
day month

To: Home Nursing House Other Institution

Patient returned to work:

No partially return fully return NA

Re-hospitalization within 30 days from admission: ₀ No ₁ Yes (specify below)

Date of first re-hospitalization: |_|_|_| / |_|_| / 2018
day month

First re-hospitalization was: Scheduled ₀ No ₁ Yes
 Cardiac ₀ No ₁ Yes

Events and Procedures after Discharge from the Reporting Department

Events: (Check all that apply)	Re-Hospitalization		Procedures: (Check all that apply)									
	No	Yes	No	Yes	No	Yes	Scheduled					
							No	Yes	Day/Month	No	Yes	
UAP/NSTEMI	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	Cor. Angiography ..	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
STEMI	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	PCI	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
Stent thrombosis.....	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	CABG	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
Angina	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	Echo.....	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
Arrhythmia	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	EPS.....	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
<i>Specify:</i> _____												
New onset A.F	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	Pacemaker	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
Syncope	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	CRTD/AICD	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
Aborted SCD	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁							
Major (TIMI) bleeding	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁							
Minor bleeding.....	<input type="radio"/> ₀	<input type="checkbox"/> ₁	_ _ _ / _ _	<input type="radio"/> ₀	<input type="checkbox"/> ₁							

Rehabilitation

Referral to rehabilitation program: ₀ No ₁ Yes

Participating in a rehabilitation program: ₀ No ₁ Yes

Smoking cessation (among smokers only)

Smoking status: smoking quit smoking

Patient received explanation regarding smoking cessation: ₀ No ₁ Yes

If yes: In hospital post discharged

Patient referred to smoking cessation program: ₀ No ₁ Yes

If yes: In hospital post discharged

Patient is participating/ participated in a smoking cessation program: ₀ No ₁ Yes

If yes: initiated In hospital initiated post discharged

Treatment – Within 30-Day Follow-up

Anti-platelet

Aspirin	<input type="checkbox"/> ____ mg/d	Prasugrel	<input type="checkbox"/> ____ mg/d	GP IIb/IIIa ant.	<input type="checkbox"/>
Clopidogrel	<input type="checkbox"/> ____ mg/d	Ticagrelor	<input type="checkbox"/> ____ mg/d		

Anticoagulants

Warfarin	<input type="checkbox"/> ____ mg/d	Apixaban	<input type="checkbox"/> ____ mg/d	Bivalirudin	<input type="checkbox"/> NA
Dabigatran	<input type="checkbox"/> ____ mg/d	LMWH	<input type="checkbox"/> ____ mg/d	Fondaparinux	<input type="checkbox"/> ____ mg/d
Rivaroxaban	<input type="checkbox"/> ____ mg/d	Heparin (UFH)	<input type="checkbox"/> ____ mg/d		

Other

ACE-I	<input type="checkbox"/>	Amiodarone	<input type="checkbox"/>	NSAIDS	<input type="checkbox"/>
ARB's	<input type="checkbox"/>	Other Anti-Arrhythmic	<input type="checkbox"/>	Colchicine	<input type="checkbox"/>
Aldactone	<input type="checkbox"/>	Nitrates	<input type="checkbox"/>	Steroids	<input type="checkbox"/>
Beta Blockers	<input type="checkbox"/>	Diuretics	<input type="checkbox"/>	PDE 5 Inh (Viagra, Cialis, Levitra)	<input type="checkbox"/>
Digoxin	<input type="checkbox"/>	PPI's	<input type="checkbox"/>	Smoking cessation med	<input type="checkbox"/>
CCB	<input type="checkbox"/>	H2 Blockers	<input type="checkbox"/>	Hormonal replacement therapy	<input type="checkbox"/>

Diabetes

Insulin SC	<input type="checkbox"/>	<input type="checkbox"/> GLP-1 Agonists	
<input type="checkbox"/> Sulphonylureas		Exenatide (Byetta, Budyreon)	<input type="checkbox"/>
Glibenclamide (Gluben)	<input type="checkbox"/>	Liraglutide (Victoza)	<input type="checkbox"/>
Glipizide (Gluco-Rite)	<input type="checkbox"/>	<input type="checkbox"/> SGLT2-Inh	
Glimepiride (Amaryl)	<input type="checkbox"/>	Dapaglifozine (Forxiga)	<input type="checkbox"/>
<input type="checkbox"/> Biguanides		Empagliflozine(Jardiance)	<input type="checkbox"/>
Meformin (Glucoophage)	<input type="checkbox"/>	<input type="checkbox"/> Other	
<input type="checkbox"/> DPP-IV Inh.		Acrabose (prandase)	<input type="checkbox"/>
Sitagliptine (Januvia)	<input type="checkbox"/>	Meglitinides (Repaglinide, Novonorm)	<input type="checkbox"/>
Saxagliptine (Onglyza)	<input type="checkbox"/>	TZDs (Pioglitasonone - actos, Rosiglitazone - Avandia)	<input type="checkbox"/>
Vidagliptine (Galvus)	<input type="checkbox"/>		
Linagliptine (Trajenta)	<input type="checkbox"/>		

Lipids

Simvastatin	<input type="checkbox"/> ____ mg	Rosuvastatin	<input type="checkbox"/> ____ mg	PCSK9 Inh	
Pravastatin	<input type="checkbox"/> ____ mg	Ezetimibe	<input type="checkbox"/>	Alirocumab (Praluent)	<input type="checkbox"/>
Atorvastatin	<input type="checkbox"/> ____ mg	Fibrates	<input type="checkbox"/>	Evolocumab (Repatha)	<input type="checkbox"/>

Status at the End of 30 days from the First Day of Hospitalization:

₀ Alive ₁ Deceased specify: **Date of Death:** |_|_|_| / |_|_|_| / 2018
Cause of Death: ₁ Cardiac ₀ Non-cardiac Unknown
Death was: ₁ Sudden ₀ Non-sudden Unknown

Name of physician: _____ **Signature:** _____ **Date:** |_|_|_| / |_|_|_| / 2018