Cardiac Care Network

CCN Software Application

Data Definitions & Data Dictionary

2009

Background

The Cardiac Care Network of Ontario (CCN) was established in the early 1990's. A key part of our mandate at that time was to establish a provincial system of active cardiac access management for the province of Ontario – this system continues to be maintained today. The CCN system includes standardized referral, triage, and data collection processes for selected advanced cardiac procedures in the province of Ontario. CCN holds Prescribed Registry status in the Province of Ontario for the purpose of facilitating and/or improving the provision of health care (section 39(1)(c) of PHIPA).

To achieve the requirements of this mandate, a software application was developed in the 1990s (***CARDIACCESS***) to serve as a patient management and waitlist registry system for advanced cardiac services. The purpose of the software was to do the following:

- Facilitate active monitoring and management of patients requiring access to advanced cardiac procedures through the use of standardized referral processes, risk stratification and clinical triage tools;
- Collect information to monitor clinical events and reasons for delay while waiting for advanced cardiac procedures;
- Provide data and reports to the Ontario Ministry of Health and Long-Term Care (MOHLTC) and hospitals to support health services planning and decision making;
- Collect the data required to develop hospital-based outcomes report cards and other health services research activities pertaining to quality and performance metrics;
- Support approved research studies and projects sponsored by CCN and other partners

The software application ***CARDIACCESS*** was developed incrementally over time, with an initial focus on Coronary Artery Bypass Graft (CABG) surgery in early 1990's, and diagnostic cardiac catheterization (cath), percutaneous coronary intervention (PCI) and other open heart surgery procedures added to the application by 2000. By early 2000, it was determined that the CCN software application required upgrading to meet standards established for health informatics and to improve the functionality of the software application based on technology, including web access, and enhanced security features. In addition, new fields were required to reflect the current standards of cardiac care, including data fields relevant to primary PCI, electrophysiology, ablation and implantable cardioverter defibrillator procedures, discharge and repatriation. Redevelopment of the application was undertaken, and in October 2008, the new CCN software application was implemented in all 18 member hospitals of the Cardiac Care Network in Ontario.

Data Definitions

With the redevelopment of the software application, a process was undertaken to validate the data fields and data definitions in ***CARDIACCESS***, and to determine what additional data variables would be required to support contemporary cardiac care standards. Prior to developing the new CCN application and data model, the CCN data dictionary underwent an extensive and systematic review of all data fields and definitions.

The purpose of the review was to ensure the new data model and software application would achieve the following:

- Support accurate and timely data collection and reporting;
- Ensure relevant and contemporary data definitions;
- Support standard application of the data definitions across all cardiac centres and procedures;
- Optimize data quality;
- Align with CCN standards established for access management best practices.

The review was completed in October 2005, and the process engaged a broad contingent of stakeholders representing Ontario and other jurisdictions and cardiac registries across Canada. This included multidisciplinary groups representing the users of the system from Ontario hospitals; cardiologists, interventional cardiologists, and cardiac Surgeons from Ontario and other parts of Canada; researchers from the Institute for Clinical and Evaluative Studies (ICES); and policy/decision makers from the Ontario MOHLTC. In addition, the review panels included participants representing other jurisdictions and organizations including: the Canadian Cardiovascular Society Access to Care Initiative, the Ontario Provincial Wait Times Strategy, Alberta Provincial Projects for Outcome Assessment in Coronary Heart Disease (APPROACH), the Système de Gestion de l'Accès aux Services (Quebec Cardiac Registry), and Improving Cardiovascular Outcomes in Nova Scotia (ICONS). Other affiliations included the American College of Cardiology – National Cardiovascular Data Registry and the Canadian Cardiovascular Outcomes Research Team (CCORT). We acknowledge the efforts of these representatives, and thank them for their significant contributions to inform this work.

Moving Forward

Our next steps will include ongoing review of these data variables and their definitions, with a continued effort to enhance and augment the software application and its relevance to collect the data required to render information on system performance and quality of care. We welcome your comments, feedback and participation to inform this process.

Yours truly,

Kori Kingsbury
Chief Executive Officer
April 1, 2009

	Field Name	Data Definition	Screen	Screen Section
1.	Health Card Number	The Patient's Health Care Number for THIS ENCOUNTER	Patient Profile	Demographics
2.	Version	Version number of the patient's most recent provincial health card, if the health card has a version code	Patient Profile	Demographics
3.	Authority Issuing	The province/agency that issued the health number given for this encounter: • Ontario • Alberta • British • Columbia • Manitoba • New Brunswick • Newfoundland • and Labrador • Northwest • Territories • Nova Scotia • Nunavut • Prince Edward • Island • Quebec • Saskatchewan • Yukon • RCMP, OPP, • Military, • Mennonite, • Refugee	Patient Profile	Demographics
4.	Last Name	Patient's Surname.	Patient Profile	Demographics
5.	First Name	Patient's First Name	Patient Profile	Demographics
6.	Middle Name	Patient's Middle Name	Patient Profile	Demographics
7.	Sex	Male Female Undifferentiated	Patient Profile	Demographics
8.	Date of Birth	Patient's Date of Birth YYYY MM DD	Patient Profile	Address
9.	Address Type	Home : The current residence, not necessarily the official permanent residence Mailing: The address specified for mailing materials to the patient Temporary: A temporary address where the patient or patient's family can be reached.	Patient Profile	Address
10.	Address1	Patient's Address. Line 1: Goes with the address where the patient or patient's family can be reached.	Patient Profile	Address
11.	Address2	Patient's Address. Line 2: Goes with the address where the patient or patient's family can be reached.	Patient Profile	Address
12.	City	City of the Address Specified: Goes with the address where the patient or patient's family can be reached.	Patient Profile	Address
13.	Country	Country code of the address specified: country code that	Patient Profile	Address

	Field Name	Data Definition	Screen	Screen Section
		goes with the address where the patient or patient's family can be reached. List of values: (ISO 3166 with Canada and USA being the first two countries in the list)		
14.	Province/State	Province code of patient's residence Use official Canada Post letter abbreviation. This province code goes with the address where the patient or patient's family can be reached. List of Values: • Alberta • British • Columbia • Manitoba • New Brunswick • Newfoundland • and Labrador • Nova Scotia • Northwest • Territory • Nunavut • Ontario • Prince Edward • Island • Quebec • Saskatchewan • Yukon Territory • Alaska • Alabama • Arkansas • Arizona • California • Colorado • Connecticut • Canal Zone • District of • Columbia • Delaware • Florida • Georgia • Guam • Hawaii • Iowa • Idaho • Illinois • Indiana • Kansas • Kentucky • Louisiana • Massachusetts • Maryland • Maine	Patient Profile	Address

	Field Name	Data Definition	Screen	Screen Section
		• Michigan • Minnesota • Missouri • Mississippi • Montana • North Carolina • North Dakota • Nebraska • New Hampshire • New Jersey • New Mexico • Nunavut • Nevada • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Puerto Rico • Rhode Island • South Carolina • South Dakota • Tennessee • Texas • Utah • Virginia • Virgin Islands • Vermont • Washington • Wisconsin • West Virginia • Wyoming • OTHER		
15.	Postal / Zip Code	A postal code is a series of letters and/or digits appended to a postal address for the purpose of sorting mail. This code goes with the address where the patient or patient's family can be reached.	Patient Profile	Address
16.	Phone Number Type	Type of patient phone numbers where patient and or significant other can be reached: PRN = Home: Phone number of current residence, not necessarily official permanent residence WPN = Work: Phone number of place of work of patient or patient's family/significant other EMR = Emergency: Phone number to be used in event of an emergency.	Patient Profile	Phone
17.	Phone Number	The Phone number associated with the phone type which is home, work or emergency.	Patient Profile	Phone
18.	Waitlist Category	Cardiac Procedures: The service category associated with the procedural wait list.	Wait List Category	Step1: Select the Wait List

	Field Name	Data Definition	Screen	Screen Section
				Category
19.	Service Area	Cardiac for CCN - associated with user access rights	Wait List Category	Step 2: Service Selection
20.	Service Detail 1	Primary Access to Care Service Categories for CCN. List of values: • **CATH Lab Diagnostic**: Any cardiac diagnostic catheter based procedure done in the CATH lab excluding EP diagnostic procedures. In the case of a same sitting (ad hoc) PCI including primary, facilitated or rescue PCI, the waitlist entry is created for a CATH lab diagnostic coronary angiogram and off-listed with the granular detail of all procedures completed • **CATH Lab Intervention**: Any interventional catheter based procedure done in the CATH lab, excluding EP procedures • **Surgical**: Any cardiac procedure done in the operating room • **Electrophysiology**: Any diagnostic or interventional EP procedure	Wait List Category	Step 2: Service Selection
21.	Service Detail 2	The procedure for which the patient is accepted to a waiting list. This includes: **For Service Detail 1 - CATH Lab - Diagnostic:** • Coronary Angiogram • Other **For Service Detail 1 - CATH Lab - Intervention:** • [Scheduled] PCI • Congenital/Structural • Valve Intervention • Other **For Service Detail 1 - Surgical:** • Aortic Operation • CABG • CABG + Valve • Congenital/Structural • Other • Other Valve • Valve only (AS,AR,MR) **For Service Detail 1 - Electrophysiology:** • Diagnostic Study • Ablation • Implant ICD • Implant Pacemaker	Wait List Category	Step 2: Service Selection
22.	Which Valvular Lesion(s)? AS	This field is selected for a cardiac valve surgery procedure for a narrowing, blockage or obstruction of the aortic valve. The field is activated by selecting Service Detail 1: Surgery and Service Detail 2 CABG+VALVE or VALVE Only [AS, AR, MR] procedure.	Wait List Category	Step 2: Service Selection

	Field Name	Data Definition	Screen	Screen Section
23.	Which Valvular Lesion(s)? AR	This field is selected for a cardiac valve surgery procedure for AR = Aortic Regurgitation/Insufficiency defined as the backward flow of blood into the left ventricle. The field is activated by selecting Service Detail 1:Surgery and Service Detail 2 CABG+VALVE or VALVE Only [AS, AR, MR] procedure.	Wait List Category	Step 2: Service Selection
24.	Which Valvular Lesion(s)? MR	This field is selected for a cardiac valve surgery procedure MR = Mitral Regurgitation defined as backward flow of blood into the left atrium. The field is activated by selecting Service Detail 1: Surgery and Service Detail 2 CABG+VALVE or VALVE Only [AS, AR, MR] procedure.	Wait List Category	Step 2: Service Selection
25.	Planned Service Location	The hospital location in which the procedure will be completed. Displays the unique identification number of the hospital site, associated with the waitlist entry	Wait List Category	Step 3: Planned Service Location
26.	CERO Referral	A referral originating from the Central East Regional Office in Toronto	Referral Form	General Referral Information
27.	Unassigned Priority	The priority override when required data to risk stratify patients waiting is not available	Referral Form	General Referral Information
28.	Reason	The reason the data required to risk stratify the patient is not available List of responses: INC: Incomplete URS data in referral form OUT: Case done outside of triage office hours NTR: Referral not triaged by RCCC OTH: Other	Referral Form	General Referral Information
29.	Date of Clinical Status Change	The date on which a Patient's clinical condition changed while on the wait list. If patient's symptoms change, or the patient undergoes a new or repeat diagnostic test, that results in a change in the patient's clinical status. A change in clinical status can be a worsening or improvement in condition resulting in an increase or decrease in priority.	Referral Form	General Referral Information
30.	Date on Form	The date written on the form by the referring physician (cath referral form or other form requesting procedure) on which the request was made. The date is next to the physician signature line on the CCN standard referral form.	Referral Form	General Referral Information
31.	Referral Date	Date the coordinator or triage office (regular business hours) or the physician-on-call (evenings and weekends) becomes aware of the referral for CATH, PCI, SURGERY or EP services.	Referral Form	General Referral Information
32.	Referring Physician 1	Physician who referred Patient for procedure selected from a look up list associated with the provincial CPSO index.	Referral Form	General Referral Information
33.	Referring Physician 2	This field is activated when "**HCP not found"** is selected in the	Referral Form	General Referral

	Field Name	Data Definition	Screen	Screen Section
		CPSO index lookup. This is a free text field to enter the name of the Physician who referred Patient for procedure when they are not found in the CPSO index look up. Do not include Dr. or other salutation; Use last name, first name only.		Information
34.	Out of Province Referring Physician	Check if the referral was received from a Out of Province Physician, then specify the name in the text box provided. Do not include Dr. or other salutation; Use last name, first name only.	Referral Form	General Referral Information
35.	Requested Procedural Physician 1	Referral specifies a request for a specific procedural physician.	Referral Form	General Referral Information
36.	Requested Procedural Physician 2	This field is activated when "**HCP is not found"** is selected in the CPSO index lookup. This is a free text field to enter the name of the requested procedural physician when they are not found in the CPSO index look up. Do not include Dr. or other salutation; Use last name, first name only.	Referral Form	General Referral Information
37.	First Available Procedural Physician	The referral requests the procedure can be done by the first available procedural physician.	Referral Form	General Referral Information
38.	Family Physician 1	The name of the patient's family physician, if available.	Referral Form	General Referral Information
39.	Family Physician 2	This field is activated when "**HCP is not found"** is selected in the CPSO index lookup. This is a free text field to enter the name of the patient's family physician, when they are not found in the CPSO index look up. Do not include Dr. or other salutation; Use last name, first name only.	Referral Form	General Referral Information
40.	Patient Wait Location	Location of Patient at time of referral, including home. List of values: • All Ontario hospital sites +'Home'	Referral Form	General Referral Information
41.	If Patient Wait Location is Other	Free text field to specify the location of the patient at the time of referral when Patient wait location is OTHER	Referral Form	General Referral Information
42.	Reason(s) for Referral - Primary Reason	Primary Reason for Referral • Coronary disease (D) • Aortic stenosis (S) • Other valvular (V) • Congestive heart failure (including cardiomyopathy) (H) • Congenital (C) • Other (O) • Arrhythmia (A)	Referral Form	General Referral Information
43.	Primary Reason - Type	If Primary Reason for Referral = Coronary disease Describe type of 'Coronary Disease: • elective, • stable coronary disease • unstable angina/ non-ST elevation MI (NSTEMI) • ST elevation MI (STEMI) If Primary Reason for Referral = OTHER describe type: • protocol (research or employment) • cardiac biopsy (cath for purpose of biopsy) • donor cathed as donor for transplant • transplant recipient	Referral Form	General Referral Information

	Field Name	Data Definition	Screen	Screen Section
		• heart disease of other aetiology		
44.	Reasons for Referral - Secondary Reason	Secondary Reason for Referral • Coronary disease (D) • Aortic stenosis (S) • Other valvular (V) • Congestive heart failure (including cardiomyopathy) (H) • Congenital (C) • Other (O) • Arrhythmia (A)	Referral Form	General Referral Information
45.	Secondary Reason - Type	If Secondary reason for Referral = Coronary disease Describe type of 'Coronary Disease: • elective, • stable coronary disease • unstable angina/ non-ST elevation MI (NSTEMI) • ST elevation MI (STEMI) If Secondary Reason for Referral = OTHER describe type: • protocol (research or employment) • cardiac biopsy (cath for purpose of biopsy) • donor cathed as donor for transplant • transplant recipient • heart disease of other aetiology	Referral Form	General Referral Information
46.	Aortic Valve Area (Echo)	A record of the area of the aortic valve (measured in squared centimetres) from the findings of a specific echocardiography investigation. By selecting either primary or secondary reason for referral as Aortic Stenosis resulting in the aortic valve area field being activated.	Referral Form	General Referral Information
47.	Aortic Valve Gradient (Echo)	By selecting either primary or secondary reason for referral as Aortic Stenosis, the aortic valve gradient field is then activated. First use peak if available, otherwise use mean The aortic gradient is used in the estimation in severity of Aortic Stenosis. Aortic Mean Gradient as derived by the echo or planimetry of cath gradient measured in mmHg. If both echo and cath available then order of priority is (1) echo (2) cath.	Referral Form	General Referral Information
48.	Request Type	This field is for CATH only. For CATH referral specify if: • Referral for CATH and consultation regarding subsequent management • No consult required - CATH only If referring healthcare provider completing the referral does not complete this field, user should leave this field blank as it is not a required field	Referral Form	General Referral Information
49.	Referring MDs Estimate of Urgency	Referring Physician's estimate of urgency: • 1: Emergent • 2: Urgent (while still in hospital)	Referral Form	General Referral Information

	Field Name	Data Definition	Screen	Screen Section
		• 3: Urgent (within 2 weeks) • 4: Elective • U: Unknown		
50.	Patient Email	Patient's current email address	Referral Form	General Referral Information
51.	Patient Letter Sent	Check if the patient was sent/provided a letter as per CCN Best Practice Guidelines. Value yes if checked. No if not checked.	Referral Form	General Referral Information
52.	Date Patient Letter Sent	Date the letter was sent/provided to the patient. By default it is today's date.	Referral Form	General Referral Information
53.	Patient Brochure Sent	Check if the patient was sent or given a CCN brochure. Yes value if checked, no value if not checked.	Referral Form	General Referral Information
54.	Date Patient Brochure Sent	Date when brochure was sent or given to patient. Defaults to today's date when checked,	Referral Form	General Referral Information
55.	MD Discussed Options	The referring MD has discussed access options with the patient as specified by the check box on the referral form. Value yes if checked. No= not checked.	Referral	General Referral Information
56.	Comment	Free text comment field related to the provision of the Brochure - 255 characters maximum	Referral Form	General Referral Information
57.	Translator Required?	Whether a translator is needed Y: Yes N: No U: Unknown	Referral Form	General Referral Information
58.	If so what Language	Language for which a translator is needed	Referral Form	General Referral Information
59.	Special Instructions	Additional Instructions that have been provided on the referral form. Maximum length 300 characters.	Referral Form	General Referral Information
60.	Cath Done outside Ontario	Check the box if the patient was cathed outside of Ontario.	Referral Form	Cath Lab Diagnostic
61.	History of MI	History of MI is an MI > 30 days from the referral date Select Yes or NO If 'Service Detail 2' = CABG, or CABG + Valve and if current referral date of most recent coronary angiogram procedure < 6 months then default History of MI value is from the Referral Form page of most recent coronary angiogram procedure If 'Service Detail 2' = Coronary Angiogram, and if current referral date of most recent CABG procedure < 6 months then default History of MI value from Referral Form page of most recent CABG procedure Otherwise Default is : No Value	Referral Form	Cath Lab Diagnostic
62.	Recent MI	Patient has had an MI within 30 days of (Prior to) referral Date. Enter Yes or No. (If 'Service Detail 2' ='CABG', or 'CABG +Valve' and if current date – referral date of most recent coronary angiogram procedure <6 months) 'Recent MI' value from Referral Form page of most recent coronary angiogram procedure	Referral Form	Cath Lab Diagnostic

	Field Name	Data Definition	Screen	Screen Section
		(If 'Service Detail 2' = 'Coronary Angiogram', and if current date – referral date of most recent CABG procedure < 6 months) 'Recent MI' value from Referral Form page of most recent CABG procedure Otherwise default is : No Value		
63.	Recent MI Date	Date if Recent MI < or = to 30 days before referral date. If MI date is uncertain then use Admission date as a default. Refer to ACC definition of MI When recent MI = (Y) yes, date of recent MI becomes a required field.	Referral Form	Cath Lab Diagnostic
64.	CCS/ACS Class	Select - Class 0, 1, 2, 3, 4, ACS low risk, ACS intermediate risk, ACS high risk, emergent 0,1,2,3,4 to be used for stable angina. 0: Class 0, Asymptomatic, 1: Class I: Ordinary physical activity such as walking or climbing stairs does not cause angina. Angina with strenuous, rapid, or prolonged exertion at work or recreation. 2: Class II: Slight limitation of ordinary activity. Walking or climbing stairs. rapidly, walking uphill, walking or stair climbing after meals, or in cold, or in wind. or under emotional stress, or during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of stairs at a normal pace and in normal conditions.3: Class III: Marked limitation of ordinary physical activity. Walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace. 4: Class IV: Inability to carry out any physical activity without discomfort – anginal syndrome may be present at rest. Low risk, intermediate risk, high risk and emergent to be used with acute coronary symptoms (ACS), STEMI not treated with primary PCI and Emergent Patient Categories. Low risk (includes ACS and STEMI not treated by primary PCI low risk) 1. ACS low risk: a: TIMI Risk Score for unstable angina and non-ST segment elevation myocardial infarction (see table 1) = 0-2 – OR any of the following b: Age < 65 years (note: age is not to be used alone to determine risk category) c: No or minimum troponin rise (<1.0 ng/ml) (note: Troponin T levels are universal due to a single system of standards.) d: No further Chest Pain e: Inducible ischemia <= 7 MET's workload 2. STEMI not treated by primary PCI low risk:a: TIMI risk score after STEMI (see table 2) = 0-3 – OR b: ACC/AHA guidelines after STEMI (Gibbons, 2002) : i) LVEF >= 40%; ii) low risk on non-invasive assessment such as: Duke treadmill score >=5. Intermediate risk (includes ACS and STEMI not treated by primary PCI intermediate risk) 3. ACS intermediate risk: a: TIMI Risk Score for unstable angina non-ST segment elevation myocardial infarction (see table 1) = 3-4 – OR any of the following b: NSTEMI with small troponin rise (>= 1 < 5 ng/ml) c: Worst ECG T wave inversion or flattening. d: Significant LV	Referral Form	Cath Lab Diagnostic

	Field Name	Data Definition	Screen	Screen Section
		dysfunction (EF < 40%) e: Previous documented CAD, MI or CABG, PCI 4. STEMI not treated by primary PC intermediate risk: a: TIMI risk score after STEMI (see table 2) = 4-5 OR b: ACC/AHA guidelines after STEMI (Gibbons, 2002): i) absence of high risk predictors; ii) LVEF < 40%; iii) high or intermediate risk on non-invasive assessment such as: Duke treadmill score < 5, stress-induced large anterior or multiple perfusion defects. High risk (includes ACS and STEMI not treated by primary PCI high risk): 3. ACS high risk a: TIMI Risk Score for unstable angina and non-ST segment elevation myocardial infarction (see table 1) = 5-7 OR any of the following: b: Persistent or recurrent chest pain c: Dynamic ECG changes with chest pain (e.g. transient ischemic ST segment changes with chest pain.) d: CHF, hypotension, arrhythmias with C/P e: Moderate or high (>5 ng/ml) Troponin Rise f: Age > 75 years (note: age is not to be used alone to determine risk category) 4. STEMI not treated by primary PCI high risk (clinical predictors): a: TIMI risk score after STEMI (see table 2) > 5 OR- b: ACC/AHA guidelines after STEMI ((high risk predictors) Gibbons, 2002): i)failed reperfusion (recurrent chest pain, persistent ECG findings of infarction), ii) mechanical complications (sudden heart failure, new murmur), iii) change in clinical status (shock) Emergent (URS = 1)= shock, and primary PCI, salvage/rescue PCI, facilitated PCI for STEMI Note: if clinical parameters result in patient falling into two classifications (e.g. High Risk and Emergent for shock) the higher classification takes precedence.		
65.	CCS Class Date	Date associated with the last CCS Class value before the Patient came off the wait list, if different from first. If changing the CCS/ACS class based on a change in patient status then you must also enter the date in the Status Change Date field in the General Information section at the top of the page. Recalculate the priority (by clicking on 'assess priority' button) after entering in new information	Referral Form	Cath Lab Diagnostic
66.	From Hx, if CCS/ACS Class = High Risk	If Angina Class = High Risk, select the most appropriate category: 1: hemodynamically stable 2: hemodynamically unstable (requires inotropic or vasopressor support or balloon pump) N: Not applicable – not 4C The classification of the patient as hemodynamically stable or unstable is independent of whether the patient is or is not being treated with IV nitro or IIaIIIb inhibitors.	Referral Form	Cath Lab Diagnostic
67.	NYHA	The New York Heart Association (NYHA) Functional	Referral Form	Cath Lab

	Field Name	Data Definition	Screen	Screen Section
		Classification • 1 : No symptoms with ordinary physical activity. • 2 : Symptoms with ordinary activity. Slight limitations of activity. • 3 : Symptoms with less than ordinary activity. Marked limitation of activity. • 4 : Symptoms with any physical activity or even at rest. • N: Not applicable The New York Heart Association (NYHA) Functional Classification provides a simple way of classifying the extent of heart failure. It places patients in one of four categories based on how much they are limited during physical activity. Not applicable applies to patients without known HF		Diagnostic
68.	Ischemic Changes at Rest	Are there ischemic changes at rest? • Y: Yes • N: No • I: Uninterpretable • U: Unknown Uninterpretable: Significant resting ST segment depression, or Left Bundle Branch Block, or LVH, or Digoxin therapy, or paced ventricular rhythm or WPW.	Referral Form	Cath Lab Diagnostic
69.	Ischemic Change Type	If there are ischemic changes at rest, what type? • Persistent (fixed) • Transient without pain • Transient with pain • Not applicable • Unknown	Referral Form	Cath Lab Diagnostic
70.	Exercise ECG Done	Exercise ECG Test Done D: Done N: Not done U: Unknown	Referral Form	Cath Lab Diagnostic
71.	Exercise ECG Risk	Risk Assessment from Exercise ECG L: Low H: High risk U: Uninterpretable N: Not applicable High risk – patient demonstrates any of the following: a) >= 2.5mm ST depression or ST elevation > 1mm in leads without q waves at low workloads (heart rate < 120); or b) early onset ST segment changes or angina in 1st stage (3 min); or c) ST segment depression lasting longer than 8 minutes into recovery stage; or d) max HR < 120 on no cardio-inhibitory medication; or e) SBP lowered at least by 10mm Hg; or f) 3 or more beats of ventricular tachycardia; or g) Duke treadmill score <-10. Low risk – Absence of high risk criteria Uninterpretable – Significant resting ST segment depression,	Referral Form	Cath Lab Diagnostic

	Field Name	Data Definition	Screen	Screen Section
		or Left Bundle Branch Block, or LVH, or Digoxin therapy, or paced Ventricular rhythm or WPW.		
72.	Functional Imaging Done	D: Done N: Not Done U: Unknown Functional imaging includes exercise or pharmacological stress (either dipyridamole/Persantine or adensosine or dobutamin/Dobutrex) with either 1) nuclear/PET perfusion imaging (thallium, MIBI or rubidium) or 2) nuclear ventriculography (MUGA); or 3) echocardiography.	Referral Form	Cath Lab Diagnostic
73.	Functional Imaging Risk	High risk scans showed clear evidence of a) multi-vessel disease, or b) of single vessel disease involving a large segment of the anterior wall; or c) summed stress score > 12 segments or d) transient ischemia LV cavity dilation. Low risk tests are those that do not meet the high risk criteria L: Low H: High N: Not applicable U: Unknown High risk scans showed clear evidence of a) multi-vessel disease, or b) of single vessel disease involving a large segment of the anterior wall; or c) summed stress score > 12 segments or d) transient ischemia LV cavity dilation. Low risk tests are those that do not meet the high risk criteria. Used with exercise_ecg_risk to determine ischemic risk for urs_cabg_	Referral Form	Cath Lab Diagnostic
74.	LV Method	a: MUGA b: Ventriculogram c: Echo d: Other e: Not Done Hierarchical order (non-valve) in the event of results from multiple tests = MUGA, left ventriculogram, echo, other Hierarchical order (valve) in the event of results from multiple tests = MUGA, echo, left ventriculogram, other. Note: If no intervening MI and multiple tests, MUGA takes precedent. If there has been an intervening MI between the dates of any two assessments, the most recent assessment post-MI takes precedent.	Referral Form	Cath Lab Diagnostic
75.	LV Function	1: >=50%, 2: 35%-49%, 3: 20%-34%, 4: <20%, U: Unknown N: Not Applicable	Referral Form	Cath Lab Diagnostic

	Field Name	Data Definition	Screen	Screen Section
		If LV assessment is completed but the results are not yet available, then user should enter LV function of "unknown"		
76.	Other Factors Affecting Prioritization	Other Factors considered in setting prioritization other than those captured in the URS if any. • Other clinical factors (e.g. chemotherapy, other non-cardiac surgery required) • Non-clinical factors. List any relevant information in the history section below this field	Referral Form	Cath Lab Diagnostic
77.	Brief History	History documented on the cath referral form. Maximum length is 300 characters.	Referral Form	Cath Lab Diagnostic
78.	Fax Catheterization Report to Person/Organization	Contact Person or Organization information for Faxing the Cath Report.	Referral Form	Cath Lab Diagnostic
79.	Fax Catheterization Fax Number	Contact Person or Organization FAX number for Faxing the Cath Report.	Referral Form	Cath Lab Diagnostic
80.	Email	Contact Person or Organization email information for sending the Cath Report via email.	Referral Form	Cath Lab Diagnostic
81.	Creatinine	The Status of the patient's most recent Serum Creatinine test before procedure P: Pending N: Not Done U: Unknown	Referral Form	Co-Morbidity
82.	Creatinine u/mol	The value of the **most recent** serum creatinine **prior to procedure, entered at the time of offlisting.** Numeric creatinine value #### umol/L	Referral Form	Co-Morbidity
83.	Dialysis	History of dialysis. On any form of dialysis at time of referral (peritoneal, hemodialysis, CRT) Y: Yes N: No	Referral Form	Co-Morbidity
84.	Diabetes	Y: Yes Patient has history of diabetes mellitus diagnosed and /or treated by a physician as documented in chart and/or referral/ triage form. N: No	Referral Form	Co-Morbidity
85.	Diabetes Control	Choose one of the following: D: Managed by diet only O: on Oral Hypoglycemics includes oral agent with/ without diet treatment I: Insulin treatment includes any combination with insulin U: Unknown N: No treatment	Referral Form	Co-Morbidity
86.	History of Smoking	• N: Never = no history of any form of tobacco. • C: Current = use of any form of tobacco (cigarettes, cigar, pipe) within one month of referral date. • F: Former: Former = use of any form of tobacco > one month of referral date.	Referral Form	Co-Morbidity

	Field Name	Data Definition	Screen	Screen Section
87.	Hypertension	• Y: Yes = Documented history of hypertension diagnosed and treated with medication, diet and/or exercise. • N: No	Referral Form	Co-Morbidity
88.	Hyperlipidemia	• Y: Yes = Documented history of dyslipidemia diagnosed and/or treated by a physician. • N: No	Referral Form	Co-Morbidity
89.	CVD	Cerebral Vascular Disease = history of Cerebral Vascular disease as any history of stroke TIA previous carotid endarterectomy/stent or any known carotid stenosis > = 70% • Y: Yes • N: No • U: Unknown	Referral Form	Co-Morbidity
90.	PVD	Indicate if the patient has a history of peripheral vascular disease. This can include: 1. Claudication either with exertion or at rest. 2. Amputation for arterial vascular insufficiency. 3. Prior vascular surgery or angioplasty (to extremities or intra-abdominal viscera). 4. Positive non-invasive/invasive vascular test. [Footnote – a)AAA > 4cm; b) ABI < 70%; and/or c)PVD (excluding CVD) with a luminal diameter > 50%]. This does not include procedures such as vein stripping or carotid disease. Choose one of the following: Y: Yes N: No U: Unknown [Footnote – examples may include a) aorto-iliac occlusive disease reconstruction, b) peripheral vascular (excluding carotids) bypass surgery, angioplasty or stent; c) percutaneous intervention to the extremities or intra-abdominal viscera, or d) AAA repair or stent.]	Referral Form	Co-Morbidity
91.	Varicose Veins	History of varicose vein surgery or injection. Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
92.	COPD	Chronic lung disease: The patient must have a documented history of obstructive or restrictive lung disease (e.g. COPD, asthma, bronchitis, emphysema, pulmonary fibrosis) and be on pharmacological therapy. Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
93.	Previous CABG Proced	Y: Patient has had a previous CABG procedure, N: Patient does not have such a history U: Unknown	Referral Form	Co-Morbidity
94.	LIMA	Left internal mammary artery previously used? Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
95.	Previous PCI	Whether there were any previous PCIs prior to this procedure	Referral Form	Co-Morbidity

	Field Name	Data Definition	Screen	Screen Section
		Y: Yes N: No U: Unknown		
96.	On Coumadin	Whether Patient is currently on Coumadin Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
97.	On IIb/IIIa Inhibitors	Whether Patient is currently on IIb/IIIa Inhibitors Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
98.	Dye Allergy	Whether Patient has previously had an allergic reaction to the dye Y: Yes N: No U: Unknown	Referral Form	Co-Morbidity
99.	Possible LV Thrombus	Possible Left Ventricle Thrombus Y: Yes - if echo, ventriculogram or other imaging modality reports a definite or possible left ventricular thrombus. N: No - if echo, ventriculogram or other imaging modality does not report a definite or possible left ventricular thrombus U: Unknown	Referral Form	Co-Morbidity
100.	Infective Endocarditis	Y: Infective Endocarditis is active (i.e., under active treatment of antiobiotics and has not had a negative blood count.) N: No active Infective Endocarditis as defined above	Referral Form	Co-Morbidity
101.	Active Endocarditis	If Infective Endocarditis is YES (active (i.e., under active treatment of antiobiotics and has not had a negative blood count.) then Active is defined as patient is currently being treated for endocarditis, the disease is active. If no antibiotic medication (other than prophylactic medication) is being given, then the infection is considered treated. List of values: • Y: Yes • N: No	Referral Form	Co-Morbidity
102.	History of CHF	Enter YES if patient has history of congestive heart failure diagnosed and/or treated by a physician. There must be a history of one or more of the following: exertional dyspnea, orthopnea, paroxysmal nocturnal dsypnea (PND), and either cardiac rales, or pulmonary congestion on x-ray. Neither pedal edema nor dyspnea alone are diagnostic. List of values: • Y: Yes • N: No • U: Unknown If CHF on referral form indicated to be 'no' or 'unknown', user should enter 'no'	Referral Form	Co-Morbidity
103.	Height	Patient Height (in cm) no decimals	Referral Form	Co-Morbidity

	Field Name	Data Definition	Screen	Screen Section
104.	Weight	Patient Weight (in kg) - no decimals	Referral Form	Co-Morbidity
105.	Unprotected LM	No patent bypass grafts to LAD or circumflex territory List of values: • Y: Yes • N: No	Referral Form	PCI
106.	3 Vessel Disease with Proximal LAD	>=70% stenosis in three other vessels and .=70% stenosis of proximal LAD - the segment before any branch of the LAD, based on most recent Cath. Applies to native circulation only List of values: • Y: Yes • N: No.	Referral Form	PCI
107.	Vein Graft Lesion	Any severity, if vein graft is the target (or one of the targets) for PCI List of values: • Y: Yes • N: No	Referral Form	PCI
108.	Survival Dependent Vessel	Any one artery supplying a sufficient amount of myocardium, such that (in the opinion of the cardiologist) closure of this vessel would be fatal List of values: • Y: Yes • N: No	Referral Form	PCI
109.	High Grade	Default to YES if any one or more of the 4 PCI fields (unprotected left main, 3VD with Proximal LAD, vein graft lesion, survival vessel) are YES List of values: • Y: Yes • N: No	Referral Form	PCI
110.	Implant Indication	Indication for implant: • New • Replacement • Other	Referral Form	Electrophysiology
111.	If Implant Indication = Replacement	Field is activated when implant indication is a replacement: • Advisory, recall • ERI/EOL • Device upgrade single to dual chamber • Device upgrade ICD to CRT-ICD or PPM to CRT-PPM • Replacement infection/erosion • Device upgrade other • Other	Referral Form	Electrophysiology
112.	Priority	If Service Detail 2 = ICD Implant and Implant Indication ='N: New' List of values: • Secondary Indication • Primary Indication If Service Detail 2 = Pacemaker Implant and Implant Indication = N: NEW List of values • Single and dual chamber PPM, urgent/semi-urgent with TTVP	Referral Form	Electrophysiology

	Field Name	Data Definition	Screen	Screen Section
		• Single and dual chamber PPM, urgent/semi urgent with no TTVP • Single and dual chamber PPM, non-urgent, with high risk of Syncope • Single and dual chamber PPM, non-urgent, with lower risk of Syncope • Resynchronization (Biventricular PPM), without Defibrillator If Service Detail 2 = 'Diagnostic Study List of values: • Priority 1 • Priority 2 If Service Detail 2 = 'Ablation' List of values: • Priority 1 • Priority 2		
113.	Aortic Prosthetic Valve Failure	Failure of an existing prosthetic valve in the aortic position. Examples of prosthetic valve failure include moderate or severe dysfunction due to peri-valvular regurgitation, cusp tearing or degeneration, valve dehiscence, or destruction by infection. List of values: • Y: Yes • N: No	Referral Form	Surgery
114.	Atrial Fibrillation	Sustained or paroxysmal atrial fibrillation or flutter. List of values: • Y: Yes • N: No	Referral Form	Surgery
115.	Pulmonary Artery Pressure mmHg	Pulmonary artery pressure as measured directly (via right heart catheterization), or estimated (via echo-Doppler or other method) in mmHg. Range of valid data is > 0 and < 999. Order of priority for source (1) direct measure by right heart cath (2) PAP estimated by RVSP on echo NOTE - if RVSP on echo is reported as normal enter 15 mmHg	Referral Form	Surgery
116.	Aortic Valve Area cm sq	Aortic Valve Area in centimetres squared, one decimal place. Value greater than or equal to zero.	Referral Form	Surgery
117.	Atrial Arrythmia	Atrial fibrillation or flutter, either paroxysmal or sustained. List of values: • Y: Yes • N: No	Referral Form	Surgery
118.	LVEF %	Enter specific numeric value if available or if provided as a LVEF grade, enter the midpoint of the grade. Grade1 = enter 55% Grade 2 = enter 42% (middle of range) Grade 3 = enter 27% (middle of range) Grade 4 = enter 15% (middle of range) If a range is provided then, Grade 1-2 enter 50%, Grade 2-3 enter 35% Grade 3-4 enter 20%	Referral Form	Surgery

	Field Name	Data Definition	Screen	Screen Section
		Hierarchical order for NON-VALVE in the event of multiple test results = (1) MUGA(2) Left ventriculogram (3) Ech o (4) Other Hierarchical order for VALVE in the event of multiple test results (1) MUGA (2) Echo (3) Left ventriculogram (4) other Note: If no intervening MI and multiple tests, MUGA takes precedent. If there has been an intervening MI between the dates of any two assessments, the most recent assessment post-MI takes precedent.		
119.	Aortic Mean Gradient mmHg	The aortic peak or mean gradient is used in the estimation in severity of Aortic Stenosis. Aortic Mean Gradient as derived by the Echo or Planimetry of cath gradient measured in mmHg. If both echo and cath available then order of priority is (1) echo (2) cath. Value must be greater than or equal to Maximum length = 3 digits no decimal.	Referral Form	Surgery
120.	Syncope	Presence of transient loss (syncope) or imminent loss (presyncope) of consciousness associated with the loss of postural tone related to transient and inadequate cerebral blood flow. Symptoms include severe dizziness, fainting.	Referral Form	Surgery
121.	LVESD mm	Left ventricular end systolic diameter: measure in mm.	Referral Form	Surgery
122.	Aortic Peak Instant Gradient mmHg	Aortic Peak Instantaneous Gradient as derived by the Echo measured in mmHg used to determine the severity of Aortic Stenosis	Referral Form	Surgery
123.	Medically Unstable	Unrelenting cardiac compromise unresponsive to all therapy except surgery. Example: cardiogenic shock, valvular complications of endocarditis, aortic dissection, catastrophic prosthetic valvular failure, chordal rupture, myocardial infarction and trauma.	Referral Form	Surgery
124.	LVEDD mm	Left ventricular end diastolic diameter, in mm	Referral Form	Surgery
125.	Mitral Prosthetic Valve Failure	Failure of an existing prosthetic valve in the mitral position. Examples of prosthetic valve failure include moderate or severe dysfunction due to peri-valvular regurgitation, cusp tearing or degeneration, valve dehiscence, or destruction by infection.	Referral Form	Surgery
126.	Prior Sternotomy	Any prior operative procedure involving a sternotomy	Referral Form	Surgery
127.	LM	Stenosis of Left Main CAD based on most recent Cath. Applies to native circulation only. Y: Yes >=50% N: No U: Unknown	Referral Form	Surgery
128.	Prox LAD	Stenosis of Proximal LAD = the segment before any branch of the LAD, based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown	Referral Form	Surgery
129.	Mid/Distal LAD	Stenosis of Mid/Distal LAD = any segment beyond the first branch of the LAD, based on most recent Cath. Applies to	Referral Form	Surgery

	Field Name	Data Definition	Screen	Screen Section
		native circulation only. Y: Yes >=70% N: No U: Unknown		
130.	Circumflex	Stenosis of Circumflex and any branches (including ramus and obtuse marginal branches), based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown	Referral Form	Surgery
131.	RCA	Stenosis of Right Coronary Artery and any branches, based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown	Referral Form	Surgery
132.	Graft Patency LAD	Read-only field unless Previous CABG Proced (Procedure) field = Y: Yes' then Specify if LAD GRAFT is patent using the following list of values: • Y: Yes • N: No • U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded. Graft LAD = LAD and all branches (i.e. septals and diagonals)	Referral Form	Surgery
133.	Graft Patency Circumflex	Read-only field unless Previous CABG Proced (Procedure) field = Y: Yes' then Specify if CIRCUMFLEX GRAFT is patent using the following list of values: • Y: Yes • N: No • U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded Graft Circumflex = Circumflex and all branches (i.e. obtuse marginals)	Referral Form	Surgery
134.	Graft Patency RCA	Read-only field unless Previous CABG Proced (Procedure) field = Y: Yes' then Specify if RCA GRAFT is patent using the following list of values: • Y: Yes • N: No • U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded. Graft RCA = RCA and all branches (i.e. AM, PL, PDA)	Referral Form	Surgery
135.	Acceptance Date	Date the HCP accepts the patient for a procedure i.e. surgery PCI or angiography. If patient is triaged direct to angiography by the RCCC, the acceptance date is same as referral date.	Wait Times Data	Acceptance

	Field Name	Data Definition	Screen	Screen Section
		Acceptance date is required when removal reason is any of: • procedure started • procedure cancelled: physician decision		
136.	Acceptance Healthcare Professional	The physician who accepted the patient referral for a cardiac procedure.	Wait Times Data	Acceptance
137.	Planned Service Location	The location where the procedure is planned to be done.	Wait Times Data	Acceptance
138.	Patient Wait Location	Location of Patient while waiting for the referred procedure, can include Home.	Wait Times Data	Acceptance
139.	Funding Source	The Billing Source for the procedure based on the following list Values: Provincial Health Insurance Other insurance • DND (military) • RCMP • Federal Refugee • Federal Prison • Prov. Prison • Self • None (hospital absorbs) • Unknown	Wait Times Data	Acceptance
140.	Override	Override of patient postal code and patient province. Changing address details on the wait times data page through this override function will not change the address information contained within the EMPI database.	Wait Times Data	Acceptance
141.	Patient Postal Code/Zip Code	Patient's postal code associated with the address type home and is the location where the patient or patient's family can be reached. A postal code is a series of letters and/or digits appended to a postal address for the purpose of sorting mail. Read-only field if override checkbox is blank. Must be a valid format Postal code: A#A#A# Zip code: ##### or #####-#### Saving Wait Time Data page executes validation to ensure that postal code/zip code is valid.	Wait Times Data	Acceptance
142.	Patient Province	Province code of patient's residence Use official Canada Post letter abbreviation. This province code goes with the address where the patient or patient's family can be reached: • List of Values: • Alberta • British • Columbia • Manitoba • New Brunswick • Newfoundland • and Labrador • Nova Scotia	Wait Times Data	Acceptance

	Field Name	Data Definition	Screen	Screen Section
		• Northwest • Territory • Nunavut • Ontario • Prince Edward • Island • Quebec • Saskatchewan • Yukon Territory • Alaska • Alabama • Arkansas • Arizona • California • Colorado • Connecticut • Canal Zone • District of • Columbia • Delaware • Florida • Georgia • Guam • Hawaii • Iowa • Idaho • Illinois • Indiana • Kansas • Kentucky • Louisiana • Massachusetts • Maryland • Maine • Michigan • Minnesota • Missouri • Mississippi • Montana • North Carolina • North Dakota • Nebraska • New Hampshire • New Jersey • New Mexico • Nunavut • Nevada • New York • Ohio • Oklahoma • Oregon		

	Field Name	Data Definition	Screen	Screen Section
		• Pennsylvania • Puerto Rico • Rhode Island • South Carolina • South Dakota • Tennessee • Texas • Utah • Virginia • Virgin Islands • Vermont • Washington • Wisconsin • West Virginia • Wyoming • OTHER		
143.	Admission Date	Date of admission to originating hospital. This is the date Patient admitted to the originating hospital i.e., either the hospital where the procedure is performed if Patient is coming from home, or the peripheral hospital if the Patient is a transfer. In the latter case, the Transfer Date is entered as the date the Patient is transferred to the hospital where the procedure is performed from the peripheral hospital.	Wait Times Data	Scheduling
144.	Transfer Date	Transfer Date is entered as the date the Patient is transferred from the peripheral hospital to the hospital where the procedure is performed. Left blank if the Patient came from home to the hospital where the procedure is performed.	Wait Times Data	Scheduling
145.	Admission Location	The hospital location where patient was initially admitted to. Can be either the hospital where the procedure is performed if Patient is coming from home, or the peripheral hospital if the Patient is a transfer.	Wait Times Data	Scheduling
146.	Booking Date	Original date the Patient was booked/scheduled for the procedure. May or may not be the date Patient actually had procedure.	Wait Times Data	Scheduling
147.	Removal Date	Date Patient removed from Active Wait list.	Wait Times Data	Off Listing
148.	Removal Reason	The Reason the patient is removed from the Active Wait List based on the following values: • Patient Died Prior to Procedure • Procedure Cancelled Patient Decision • Procedure Cancelled Physician Decision • Procedure Completed • Waitlist Entry Created in Error • Re-referral: Patient Choice • Re-referral: Waitlist Related • Re-referral: Clinical Complexity	Wait Times Data	Off Listing
149.	Date of Death	The date the patient died while waiting for their procedure	Wait Times	Off Listing

	Field Name	Data Definition	Screen	Screen Section
			Data	
150.	Re-referral Destination	The name of the hospital to which the patient was re-referred or re-directed for the procedure. Select from the hospital code list. List of values: • All Ontario hospital sites	Wait Times Data	Off Listing
151.	Discharge /Transfer Date	Date Patient is discharged/transferred from the institution where the procedure was performed. Discharge section to be completed only for patients with removal reason of procedure started.	Wait Times Data	Discharge
152.	Patient Status at Discharge	The Status of the patient at discharge or transfer based on the following values: A: Alive - Patient discharged home D: Deceased - patient died prior to discharge from facility that performed the procedure T: Transferred - transfer to another facility	Wait Times Data	Discharge
153.	Patient Repatriation	Specify if patient was transferred on discharge to the original referring facility Y: Yes N: No	Wait Times Data	Discharge
154.	Post Procedure Care Location	The facility that a patient is transferred to upon discharge from the cardiac centre post procedure. This field is only to be completed if patient is repatriated.	Wait Times Data	Discharge
155.	Dates Affecting Readiness to Treat From	Dates affecting readiness to treat (DART) allow users to enter dates during which time a procedure is unable to take place for reasons solely related to a PATIENT's DECISION not to be available. A DART is subtracted from the total wait time DART FROM is the beginning date of the period for which the patient, by their own decision, is not available for procedure. This stops the wait time clock. Dates affecting readiness to treat allow users to enter dates during which time a procedure is unable to take place for reasons solely related to a PATIENT's DECISION not to be available. To ensure that the removal date has not fallen between the dates affecting readiness to treat, users should verify and edit dates affecting readiness to treat as required prior to entering the removal date. Once the removal date is entered the Dates affecting readiness to treat (DART) cannot be edited.	Scheduling Details	Dates Affecting Readiness to Treat
156.	Dates Affecting Readiness to Treat To	DART TO: is the beginning date of the period for which the patient, by their own decision, is not available for procedure. This stops the wait time clock. If the user is not aware of the 'to' date at the time of the entry, they should enter December 31, 9999. To ensure that	Scheduling Details	Dates Affecting Readiness to Treat

	Field Name	Data Definition	Screen	Screen Section
		the removal date has not fallen between the dates affecting readiness to treat, users should verify and edit dates affecting readiness to treat as required prior to entering the removal date. Once the removal date is entered the Dates affecting readiness to treat (DART) cannot be edited.		
157.	Dates Affecting Readiness to Treat Reason	A patient may not be available for a procedure during a specific time period as per the following • patient requested procedure deferral • patient not available	Scheduling Details	Dates Affecting Readiness to Treat
158.	Cancellations Cancellation Date/Hour	Date on which cancellation occurred. (Not necessarily the date for which the cancelled procedure was scheduled) The hour is part of the date in case there is more than one cancellation on the same day.	Scheduling Details	Cancellation
159.	Cancellation Reason	Reason for cancelling and rescheduling an already scheduled procedure. Cancelling a procedure does not stop the wait time clock • No bed - ward • No bed - stepdown • No bed - ICU • No nurse - ward • No nurse OR/lab • No nurse - ICU • More urgent/emergent Patient • Patient not ready - medical • No physician • No anaesthetist • No OR/lab assistant • No perfusionist • No blood products • Transplants • No OR/lab time • OR/lab equipment failure • No medical transportation • Physician Preference • Other	Scheduling Details	Cancellation
160.	Delays Date Logged	The procedure is delayed due to any reason except a patient's decision to defer or cancel. The start date the patient was deferred for this encounter. The wait time clock does not stop during this delay period.	Scheduling Details	Delays
161.	Delays Reason	A procedure can only be delayed based on the following reasons: • medical specialty consult or tests • non cardiac medical complications/reasons (e.g. non-cardiac admissions, non-cardiac surgery or treatment, acute illness) • lack of bed availability • lack of available staff • transfer delays • medications (plavix, IIa/IIIb inhibitors, coumadin)	Scheduling Details	Delays

	Field Name	Data Definition	Screen	Screen Section
		• physician preference • disaster / emergency • other - other medical reasons		
162.	Treating Healthcare Professional CATH	Code identifying cath lab health care professional who actually performed the procedure. Must be a valid physician code. Each procedure can have only one provider.	Offlisting Details	Catheterization Lab Environment
163.	Coronary Angiogram	Selective injection of x-ray contrast into one or more coronary arteries or coronary bypass graft. If physician fails to gain access to a peripheral artery it is not a coronary angiogram however, if the physician does gain access but unable to advance a catheter or engage a catheter in the coronary arteries then the coronary angiogram tick box should be checked. User should then indicate that all applicable native and graft anatomy fields are 'unknown'.	Offlisting Details	Catheterization Lab Environment
164.	Left Ventricular Pressure	Cath lab procedure: Catheter was inserted into the left ventricle and pressure was recorded. Also known as LVEDP or systolic pressure	Offlisting Details	Catheterization Lab Environment
165.	Contrast Ventriculogram	Cath lab procedure: Contrast injection into left or right ventricle was performed and recorded by cine-angiogram.	Offlisting Details	Catheterization Lab Environment
166.	Aortogram	Cath lab procedure: Contrast injection into aorta was performed and recorded by cine-angiogram.	Offlisting Details	Catheterization Lab Environment
167.	Other Angiogram	Cath lab procedure: Contrast injection into a chamber or vessel other than left or right ventricle or aorta was performed and recorded by cine-angiogram.	Offlisting Details	Catheterization Lab Environment
168.	Right Heart Catheterization	Cath lab procedure: Catheter inserted into Rt. Atrium and or Rt. Ventricular and or Pulmonary Artery, and pressure was recorded.	Offlisting Details	Catheterization Lab Environment
169.	Myocardial Biopsy	Cath lab procedure: Catheter inserted into Rt. or Lt. Ventricle to excise a sample of myocardial tissue.	Offlisting Details	Catheterization Lab Environment
170.	Coronary Angiogram Native Stenosis LM	Cath lab procedure: Stenosis of Left Main CAD based on most recent Cath. Applies to native circulation only. Y: Yes >=50% N: No U: Unknown: unable to determine as part of the diagnostic test	Offlisting Details	Catheterization Lab Environment
171.	Coronary Angiogram Native Stenosis Proc LAD	Cath lab procedure: Stenosis of Proximal LAD = the segment before any branch of the LAD, based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown: unable to determine as part of the diagnostic test	Offlisting Details	Catheterization Lab Environment
172.	Coronary Angiogram Native Stenosis Mid/distal LAD	Cath lab procedure: Stenosis of Mid/Distal LAD = any segment beyond the first branch of the LAD, based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown: unable to determine as part of the diagnostic	Offlisting Details	Catheterization Lab Environment

	Field Name	Data Definition	Screen	Screen Section
		test		
173.	Coronary Angiogram Native Stenosis Circumflex	Cath lab procedure: Stenosis of Circumflex and any branches (including ramus and obtuse marginal branches), based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown: unable to determine as part of the diagnostic test	Offlisting Details	Catheterization Lab Environment
174.	Coronary Angiogram Native Stenosis RCA	Cath lab procedure: Stenosis of Right Coronary Artery and any branches, based on most recent Cath. Applies to native circulation only. Y: Yes >=70% N: No U: Unknown: unable to determine as part of the diagnostic test	Offlisting Details	Catheterization Lab Environment
175.	Coronary Angiogram Graft Patency LAD	Cath lab procedure: Read-only field unless Previous CABG Proced field = Y: Yes' then Specify if LAD GRAFT is patent using the following list of values: Y: Yes N: No - >= 70% stenosis U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded WTIS-96 graft LAD = LAD and all branches (i.e. septals and diagonals) graft Circumflex = Circumflex and all branches (i.e. obtuse marginals)graft RCA = RCA and all branches (i.e. AM, PL, PDA).	Offlisting Details	Catheterization Lab Environment
176.	Coronary Angiogram Graft Patency Circumflex	Cath lab procedure: Read-only field unless Previous CABG Proced field = Y: Yes' then Specify if CIRCUMFLEX GRAFT is patent using the following list of values: Y: Yes N: No >= 70% stenosis U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded WTIS-96 graft LAD = LAD and all branches (i.e. septals and diagonals) graft Circumflex = Circumflex and all branches (i.e. obtuse marginals)graft RCA = RCA and all branches (i.e. AM, PL, PDA).	Offlisting Details	Catheterization Lab Environment
177.	Coronary Angiogram Graft Patency RCA	Cath lab procedure: Read-only field unless Previous CABG Proced field = Y: Yes' then Specify if RCA GRAFT is patent using the following list of values: Y: Yes N: No >= 70% stenosis U: Unknown A graft is considered NOT Patent if Stenosis >= 70% OR is totally occluded WTIS-96 graft LAD = LAD and all branches (i.e. septals and diagonals) graft Circumflex = Circumflex and all branches (i.e. obtuse marginals)graft RCA = RCA and all branches (i.e. AM, PL, PDA).	Offlisting Details	Catheterization Lab Environment
178.	Vein Graft Target Lesion	Cath lab procedure vein graft lesion = any severity, if the vein	Offlisting	Catheterization

	Field Name	Data Definition	Screen	Screen Section
		graft is the target (or one of the targets) for PCI Y: Yes N: No	Details	Lab Environment
179.	Survival Dependent Vessel	Cath lab procedure: Any one artery supplying a sufficient amount of myocardium, such that (in the opinion of the cardiologist) closure of this vessel would be fatal.	Offlisting Details	Catheterization Lab Environment
180.	LV Function	Cath lab procedure: Grade based on Cath data (radiology report or cath lab report) when a cath with left ventriculogram was performed. Order of priority for sources : (1) MUGA (2) Left Ventriculogram; (3) Echo; (4) Thalliam; (5) Estimate in OR (direct vision) (U) Unknown. List of values: 1: >=50% 2: 35%-49%, 3: 20%-34%, 4: <20%, U: Unknown	Offlisting Details	Catheterization Lab Environment
181.	PCI	Cath lab procedure: PCI= Angioplasty	Offlisting Details	Catheterization Lab Environment
182.	Number of Bare Metal Stents	For Cath lab procedure: number of bare metal stents used for a PCI procedure	Offlisting Details	Catheterization Lab Environment
183.	Number of Drug Eluting Stents	Cath lab procedure: Number of DES or Drug Eluting Stents used for PCI procedure.	Offlisting Details	Catheterization Lab Environment
184.	Atherectomy/Thrombectomy	Cath lab procedure: Atherectomy: Includes Directional Coronary Atherectomy (DCA) or Rotational Atherectomy (Rotablator) Thrombectomy: Includes suction, catheter, or other device to remove clot/thrombus from a coronary artery	Offlisting Details	Catheterization Lab Environment
185.	Aortic Valve Gradient	Cath lab procedure: Record peak gradient, however if this is not available record the mean gradient in mm Hg.	Offlisting Details	Catheterization Lab Environment
186.	Aortic Valve Area	Cath lab procedure: In centimetres squared, two decimal places.	Offlisting Details	Catheterization Lab Environment
187.	Lesion Location	Cath Lab procedure requiring a stent: Location of lesion: 1 Proximal right coronary artery 2 Mid right coronary artery 3 Distal right coronary artery 4 Posterior inter-ventricular (dominant RCA) 5 Left ventricular continuation of RCA 6 Postero-lateral 1 (of RCA) 7 Postero-lateral 2 (of RCA) 8 Postero-lateral 3 (of RCA) 9 Right ventricular branch 10 Acute marginal branch 11 Left main 12 Proximal left anterior descending 13 Mid left anterior descending 14 Distal left anterior descending 15 First diagonal branch 16 Second diagonal branch 17 First septal perforator 18 Proximal circumflex	Offlisting Details	Catheterization Lab Environment Stent Table

	Field Name	Data Definition	Screen	Screen Section
		19 Mid circumflex 20 First obtuse marginal 21 Second obtuse marginal 22 Third obtuse marginal 23 Ongoing A-V groove portion (dominant circumflex) 24 Postero-lateral 1 of circumflex 25 Postero-lateral 2 of circumflex 26 Postero-lateral 3 of circumflex 27 Posterior inter-ventricular (dominant Cx) 28 Ramus intermediate 29 30 31 Graft to RCA (aorto-coronary graft) 32 Graft to LAD (aorto-coronary graft) 33 Graft to diagonal (aorto-coronary graft) 34 Graft to obtuse marginal (aorto-coronary graft) 35 Left internal thoracic (mammary) graft (regardless of target) 36 Right internal thoracic (mammary) graft (regardless of target)		
188.	Lesion Type	Cath Lab procedure requiring a stent: Type A: • concentric, no calcification • No ostia or branches involved • No thrombus or total occlusion Type B1: one of the following: • Eccentric, calcification • Ostia or branch involved • Thrombus = total occlusion 10-20 mm long or 49-90 degrees Type B2: • two or more of type B1 criteria Type C: • >2 cm long, very tortuous • 90 degree bend, old vein graft • total occlusion > 3 months	Offlisting Details	Catheterization Lab Environment Stent Table
189.	Survival Dependent Vessel	Cath Lab procedure requiring a stent: Any one artery supplying a sufficient amount of myocardium, such that (in the opinion of the cardiologist) closure of this vessel would be fatal Yes No	Offlisting Details	Catheterization Lab Environment Stent Table
190.	Stent Type	Cath Lab procedure requiring a stent 1= Drug Eluting 2= Bare Metal	Offlisting Details	Catheterization Lab Environment Stent Table
191.	Drug Eluting Stent Type	Cath Lab procedure requiring a stent 1= Cypher (sirolimus) 2= Taxus (paclitaxel) 3= Other (Other DES not covered by 1 or 2)	Offlisting Details	Catheterization Lab Environment Stent Table
192.	Stent Size	Cath Lab procedure requiring a stent	Offlisting	Catheterization

	Field Name	Data Definition	Screen	Screen Section
		Mm to 2 decimal places (2.00, 2.25, 2.50, 2.75, 3.00, 3,25, 3.50, 3.75, 4.00, 4.25, 4.50, 4.75, 5.00)(millimetres)	Details	Lab Environment Stent Table
193.	Stent Length	Cath Lab procedure requiring a stent mm to no decimal place The range from 6, 7, 8, 9, 10,…23, 24, 25, 26, 28, 30, 32, 33, 38, 40,45. (millimetres)	Offlisting Details	Catheterization Lab Environment Stent Table
194.	Due to Restenosis	Cath Lab procedure requiring a stent: Yes No Unknown	Offlisting Details	Catheterization Lab Environment Stent Table
195.	Procedure done for Primary PCI	The use of PCI as the initial mode of reperfusion with STEMI. Does not include rescue or facilitated PCI. Primary PCI procedures must also capture coronary angiogram. Enter as cath referral, same sitting PCI and primary PCI	Offlisting Details	Catheterization Lab Environment PPCI
196.	Where did patient present from	The Location of the patient prior admission to the CATH lab. List of responses: • Transferred In - from other ED/Hospital • Own Emergency Department • Field - EMS directly to CATH lab	Offlisting Details	Catheterization Lab Environment PPCI
197.	Fibrinolysis Contraindicated	Patient is not a candidate for fibrinolysis	Offlisting Details	Catheterization Lab Environment PPCI
198.	Cardiogenic Shock	Patient shows signs and symptoms of cardiogenic shock	Offlisting Details	Catheterization Lab Environment PPCI
199.	Date and Time of Onset of Chest Pain/Symptom	The date and time the patient reported chest pain/symptoms started obtained from Emergency Department (ED) or ambulance record.	Offlisting Details	Catheterization Lab Environment PPCI
200.	Time of Contact First contact - Was Ambulance Involved	Was an Ambulance involved YES NO Does not have anything to do with ED - supports time of first medical contact.	Offlisting Details	Catheterization Lab Environment PPCI
201.	First Contact in ED	If arrival to Ed is walk in or not by ambulance, then first contact is ED. First contact is the earliest recorded time on the ED record.	Offlisting Details	Catheterization Lab Environment PPCI
202.	First Contact with Paramedics	If an ambulance is involved, then first medical contact is the first patient contact time with paramedics. Date and time of First Contact with Paramedics.	Offlisting Details	Catheterization Lab Environment PPCI
203.	Time of first ECG Diagnostic of STEMI	Date and time of First ECG diagnostic of STEMI	Offlisting Details	Catheterization Lab Environment PPCI
204.	Time of First Balloon Inflation	Record date and time the FIRST balloon inflation occurred in the cath lab.	Offlisting Details	Catheterization Lab Environment PPCI
205.	Time of Arrival in First	Record date and time of arrival in the first ED.	Offlisting	Catheterization

	Field Name	Data Definition	Screen	Screen Section
	ED		Details	Lab Environment PPCI
206.	Time PCI Centre Called	Date and time PCI Centre Called.	Offlisting Details	Catheterization Lab Environment PPCI
207.	Time of EMS Arrival in first ED for PPCI Transfer	Date and time of EMS arrival in first ED for PPCI transfer.	Offlisting Details	Catheterization Lab Environment PPCI
208.	Time Left First ER	Date and time Patient left first ED.	Offlisting Details	Catheterization Lab Environment PPCI
209.	Time of Arrival in PCI CATH Lab	Date and time of Arrival in PCI Cath Lab. The data is obtained from the CATH Lab record.	Offlisting Details	Catheterization Lab Environment PPCI
210.	Procedure done for Facilitated Intervention	A planned PCI after fibrinolytic therapy. Direct transfer to the cath lab is already planned at the time the fibrinolytic therapy is administered. The transfer to the cath lab is not dependent on the response to the fibrinolytic therapy.	Offlisting Details	Catheterization Lab Environment
211.	Procedure done for Rescue Intervention	PCI done as soon as possible for perceived failure of fibrinolytic treatment for STEMI.	Offlisting Details	Catheterization Lab Environment
212.	Peripheral Intervention	Non-Coronary catheter-based therapeutic vascular procedure performed in a cath lab on a peripheral artery. Typically this would involve dilation and/or stenting.	Offlisting Details	Catheterization Lab Environment
213.	Catheter Based Valve Procedure	A procedure that is performed via percutaneous access and making use of one or more catheters for valve repair.	Offlisting Details	Catheterization Lab Environment
214.	Catheter Based Congenital /Structural Intervention	A procedure that is performed via percutaneous access and making use of one or more catheters to treat a congenital or structural cardiac lesion other than a valvular lesion (valve lesions are captured under a separate valve intervention field).	Offlisting Details	Catheterization Lab Environment
215.	Referral	The patient is being referred for a subsequent cardiac procedure following an initial procedure in the cath lab a: PCI b: CABG c: CABG + Valve d: Valve e: Diagnostic Study f: Ablation g: Implant ICD h: Implant Pacemaker	Offlisting Details	Catheterization Lab Environment
216.	Which Valvular Lesion AS	This field is selected for a cardiac valve surgery procedure for a narrowing, blockage or obstruction of the aortic valve. The field is activated by selecting Service Detail 1: Surgery and Service Detail 2 CABG+VALVE or VALVE Only procedure. Only applies to cardiac valve surgery and not percutaneous valve interventions.	Offlisting Details	Catheterization Lab Environment
217.	Which Valvular Lesion AR	This field is selected for a cardiac valve surgery procedure for AR = Aortic Regurgitation/Insufficiency defined as the backward flow of blood into the left ventricle. The field is	Offlisting Details	Catheterization Lab Environment

	Field Name	Data Definition	Screen	Screen Section
		activated by selecting Service Detail 1:Surgery and Service Detail 2 CABG+VALVE or VALVE Only procedure.		
218.	Which Valvular Lesion MR	This field is selected for a cardiac valve surgery procedure MR = Mitral Regurgitation defined as backward flow of blood into the left atrium. The field is activated by selecting Service Detail 1:Surgery and Service Detail 2 CABG+VALVE or VALVE Only procedure.	Offlisting Details	Catheterization Lab Environment
219.	Referral Destination	The centre the patient is re-referred to.	Offlisting Details	Catheterization Lab Environment
220.	Treating Healthcare Professional Surgery	Code identifying Cardiac Surgery/OR health care professional who actually performed the procedure. Must be a valid physician code.	Offlisting Details	Surgery
221.	Bypass Surgery	A cardiac surgical procedure in which one or more anastomoses are constructed between a conduit vessel and a coronary artery.	Offlisting Details	Surgery
222.	Off Pump	A cardiac surgery procedure performed without use of extracorporreal cardio pulmonary bypass.	Offlisting Details	Surgery
223.	Aortic Valve Surgery	Aortic Valve repair or replacement When done in conjunction with aortic valve replacement this is called a Bentall procedure. Off list such procedures as both aortic valve surgery and aortic surgery	Offlisting Details	Surgery
224.	Mitral Valve Surgery	Mitral Valve repair or replacement	Offlisting Details	Surgery
225.	Other Valve Surgery	Tricuspid and Pulmonic valve repair or replacement. Most of this will be tricuspid annuloplasty although occasionally other operations will also be included here.	Offlisting Details	Surgery
226.	Aneurysmectomy	Surgical resection or repair or exclusion of left ventricular aneurysm.	Offlisting Details	Surgery
227.	Cardiac Tumour	Excision (partial or complete), or biopsy, of a known or suspected cardiac tumour.	Offlisting Details	Surgery
228.	Myectomy	Excision of a portion of ventricular myocardium (typically septum but could include free wall resection in volume reduction surgery).	Offlisting Details	Surgery
229.	ASD Closure	Surgical patching or other of an Atrial Septal Defect.	Offlisting Details	Surgery
230.	VSD Closure	Surgical patching or other of a Ventricular Septal Defect.	Offlisting Details	Surgery
231.	Aortic Surgery	Surgical repair or replacement of ascending aorta When done in conjunction with aortic valve replacement this is called a Bentall procedure. Please off list such procedures as both aortic valve surgery and aortic surgery.	Offlisting Details	Surgery
232.	Pericardectomy	Excision of pericardium.	Offlisting Details	Surgery
233.	Arrythmia Surgery	Surgical procedures to treat cardiac rhythm disturbances. The primary example is a surgical maze procedure for atrial fibrillation. Pacemaker and ICD implants are not included here - they are recorded elsewhere.	Offlisting Details	Surgery
234.	Other	Any other surgical procedure on the heart or aortic arch for the time being this also includes complex congenital repair.	Offlisting Details	Surgery

	Field Name	Data Definition	Screen	Screen Section
		This field should be used for time being to indicate complex congenital cardiac surgery in the future complex congenital will have its own field.		
235.	Comments	Comment regarding an off listed surgical procedure - Free Text.	Offlisting Details	Surgery
236.	Treating Health Care Professional EP	Code identifying EP health care professional who actually performed the procedure. Must be a valid physician code.	Offlisting Details	EP Environment
237.	Which Environment	The environment in which the procedure was completed. Catheterization environment is procedure completed in catheterization lab or other specialized suite Surgical environment = procedure completed in main hospital operating rooms.	Offlisting Details	EP Environment
238.	ICD Implant	Check if ICD device implanted	Offlisting Details	EP Environment
239.	ICD Type	Select the type of ICD device List of values: • VVI-ICD • DDD-ICD • CRT-ICD (RA, RV & LV leads) • CRT-ICD (RV & LV leads) • Other – Lead Insertion • Other – Lead Revision • Other – Pocket Revision • Other – Device Explant • Other – DFT Testing • Lead Extraction with Laser • Lead Extraction without Laser • Lead Extraction with Laser Standby and Intention to Treat	Offlisting Details	EP Environment
240.	Pacemaker Implant	Check if a pacemaker was implanted	Offlisting Details	EP Environment
241.	Pacemaker Type	Select the type of pacemaker device List of values: • S: Single • D: Dual • C: CRT • P: PPM Other • L: Laser Lead Extraction	Offlisting Details	EP Environment
242.	EP Diagnostic Procedure	Check if EP Diagnostic Procedure performed	Offlisting Details	EP Environment
243.	EP Ablation Procedure	Check if Ablation Procedure performed	Offlisting Details	EP Environment
244.	Advanced Mapping	Check if Advanced Mapping Procedure performed	Offlisting Details	EP Environment
245.	Advanced Mapping Reason	Select the type of advanced mapping procedure List of values: • For Afib • For other reasons	Offlisting Details	EP Environment

	Field Name	Data Definition	Screen	Screen Section
246.	Date Logged	Date of event including hour – read only field	Adverse Events	Adverse Events
247.	Event	Event while on the wait list. Only the following types of event are to be captured here (note deaths are captured in the removal code) a: Death b: MI c: Hospitalization (other than MI) d: In hospital event requiring a status change upgrade. e: VF, sustained, VT or cardiac, arrest	Adverse Events	Adverse Events
248.	CCS/ACS	Select - Class 0, 1, 2, 3, 4, ACS low risk, ACS intermediate risk, ACS high risk, emergent 0,1,2,3,4 to be used for stable angina. 0: Class 0, Asymptomatic, 1: Class I: Ordinary physical activity such as walking or climbing stairs does not cause angina. Angina with strenuous, rapid, or prolonged exertion at work or recreation. 2: Class II: Slight limitation of ordinary activity. Walking or climbing stairs. rapidly, walking uphill, walking or stair climbing after meals, or in cold, or in wind. or under emotional stress, or during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of stairs at a normal pace and in normal conditions.3: Class III: Marked limitation of ordinary physical activity. Walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace. 4: Class IV: Inability to carry out any physical activity without discomfort – anginal syndrome may be present at rest. Low risk, intermediate risk, high risk and emergent to be used with acute coronary symptoms (ACS), STEMI not treated with primary PCI and Emergent Patient Categories. Low risk (includes ACS and STEMI not treated by primary PCI low risk). 1. ACS low risk: a: TIMI Risk Score for unstable angina and non-ST segment elevation myocardial infarction (see table 1) = 0-2 – OR any of the following b: Age < 65 years (note: age is not to be used alone to determine risk category) c: No or minimum troponin rise (<1.0 ng/ml) (note:Troponin T levels are universal due to a single system of standards.) d: No further Chest Pain e: Inducible ischemia <= 7 MET's workload 2. STEMI not treated by primary PCI low risk:a: TIMI risk score after STEMI (see table 2) = 0-3 – OR b: ACC/AHA guidelines after STEMI (Gibbons, 2002) : i) LVEF >= 40%; ii) low risk on non-invasive assessment such as: Duke treadmill score >=5. Intermediate risk (includes ACS and STEMI not treated by primary PCI intermediate risk) 2. ACS intermediate risk: a: TIMI Risk Score for unstable angina non-ST segment elevation myocardial infarction (see	Adverse Events	Adverse Events

	Field Name	Data Definition	Screen	Screen Section
		table 1) = 3-4 – OR any of the following b: NSTEMI with small troponin rise (>= 1 < 5 ng/ml) c: Worst ECG T wave inversion or flattening: Significant LV dysfunction (EF < 40%) e: Previous documented CAD, MI or CABG, PCI 4. STEMI not treated by primary PC intermediate risk: a: TIMI risk score after STEMI (see table 2) = 4-5 OR b: ACC/AHA guidelines after STEMI (Gibbons, 2002): i) absence of high risk predictors; ii) LVEF < 40%; iii) high or intermediate risk on non-invasive assessment such as: Duke treadmill score < 5, stress-induced large anterior or multiple perfusion defects. High risk (includes ACS and STEMI not treated by primary PCI high risk): 3. ACS high risk a: TIMI Risk Score for unstable angina and non-ST segment elevation myocardial infarction (see table 1) = 5-7 OR any of the following: b: Persistent or recurrent chest pain c: Dynamic ECG changes with chest pain (e.g. transient ischemic ST segment changes with chest pain.) d: CHF, hypotension, arrhythmias with C/P e: Moderate or high (>5 ng/ml) Troponin Rise f: Age > 75 years (note: age is not to be used alone to determine risk category) 4. STEMI not treated by primary PCI high risk (clinical predictors): a: TIMI risk score after STEMI (see table 2) > 5 OR- b: ACC/AHA guidelines after STEMI ((high risk predictors) Gibbons, 2002): i)failed reperfusion (recurrent chest pain, persistent ECG findings of infarction), ii) mechanical complications (sudden heart failure, new murmur), iii) change in clinical status (shock) Emergent (URS = 1)= shock, and primary PCI, salvage/rescue PCI, facilitated PCI for STEMI Note: if clinical parameters result in patient falling into two classifications (e.g. High Risk and Emergent for shock) the higher classification takes precedence.		
249.	URS	The URS at time of this event. Applies to CATH and CABG procedures only	Adverse Events	Adverse Events
250.	Priority	Patient priority at the time of the event	Adverse Events	Adverse Events
251.	Contact Date	The date the contact occurred	Contacts	Add New Contact
252.	User	The Person who created the contact entry into the application	Contacts	Add New Contact
253.	To	The Person who had received the specific contact. List of responses: A: Home Coordinator B: Other Coordinator C: Cardiologist S: Surgeon P: Patient F: Family Member D: Family Doctor H: Other Health Professional O: Other N: CCN	Contacts	Add New Contact

	Field Name	Data Definition	Screen	Screen Section
		R: Referring Cardiologist T: Cathing Cardiologist G: Angioplaster K: Data Clerk		
254.	From	The Person who initiated the specific contact. A: Home Coordinator B: Other Coordinator C: Cardiologist S: Surgeon P: Patient F: Family Member D: Family Doctor H: Other Health Professional O: Other N: CCN	Contacts	Add New Contact
255.	Reason for Contact	Code indicating type of contact. A: Letter/Info Package B: Angina Change C: Timing of Surgery D: Anxiety/Concern E: M.I. F: CHF G: Patient/Family Delay H: Other Co-morbid Factors I: Meds J: Blood Products K: Cancellation L: O/P Class-Diet M: O/P Class-Support O: Other P: Procedure Q: Mortality R: Rehab U: Clinical update of patient status Z: W/L REPT SENT TO PHYS	Contacts	Add New Contact
256.	Contact Subject	A note relative to the given contact, up to 10000 characters in length.	Contacts	Add New Contact
257.	Date Logged	Date action item was logged.	Action Items	Action Items
258.	User	User who logged the action item	Action Items	Action Items
259.	Priority	Priority of the action item as per the following values: • High • Medium • Low	Action Items	Action Items
260.	Description	Description of the action item. System Generated Action items include: • complete surveillance form • lock wait list entry	Action Items	Action Items
261.	Date Logged	date a note was logged	Notes	Notes History

	Field Name	Data Definition	Screen	Screen Section
262.	Last Update Date	the last date a note was updated	Notes	Notes History
263.	User Name	The RCCC who generated the note to log documentation related to the waitlist entry	Notes	Notes History
264.	Subject	The subject of a note written by the RCCC to log documentation related to the waitlist entry	Notes	Add a New Note
265.	Numeric 1	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
266.	Numeric 2	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
267.	Numeric 3	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
268.	Numeric 4	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
269.	Numeric 5	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
270.	Numeric 6	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
271.	Numeric 7	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
272.	Numeric 8	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
273.	Numeric 9	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
274.	Numeric 10	Numeric Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
275.	Numeric 11	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
276.	Numeric 12	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
277.	Numeric 13	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
278.	Numeric 14	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
279.	Numeric 15	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
280.	Numeric 16	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
281.	Numeric 17	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
282.	Numeric 18	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
283.	Numeric 19	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
284.	Numeric 20	Numeric Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
285.	Dates 1	Date Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
286.	Dates 2	Date Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items

	Field Name	Data Definition	Screen	Screen Section
287.	Dates 3	Date Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
288.	Dates 4	Date Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
289.	Dates 5	Date Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
290.	Dates 6	Date Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
291.	Dates 7	Date Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
292.	Dates 8	Date Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
293.	Dates 9	Date Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
294.	Dates 10	Date Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
295.	Text 1	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
296.	Text 2	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
297.	Text 3	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
298.	Text 4	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
299.	Text 5	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
300.	Text 6	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
301.	Text 7	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
302.	Text 8	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
303.	Text 9	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
304.	Text 10	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
305.	Text 11	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
306.	Text 12	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
307.	Text 13	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
308.	Text 14	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
309.	Text 15	Text Field designated for hospital specific use	Hospital Defined Fields	Hospital Specific Items
310.	Text 16	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
311.	Text 17	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items

	Field Name	Data Definition	Screen	Screen Section
312.	Text 18	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
313.	Text 19	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
314.	Text 20	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
315.	Text 21	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
316.	Text 22	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
317.	Text 23	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
318.	Text 24	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items
319.	Text 25	Text Field designated for CCN specific use	Hospital Defined Fields	Hospital Specific Items