Patient ID:		
DEMOGRAPHICS		***Demographics Tab***
Sex	○ Male ○ Female ○ Unknown	
Patient Gender Identity	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other. _____ ○ Did not disclose.	
Patient-Identified Sexual Orientation	○ Straight or heterosexual ○ Lesbian or gay ○ Bisexual ○ Queer, pansexual, and/or questioning ○ Something else; please specify: _____ ○ Don't know ○ Declined to answer	
Date of Birth	___/___/_____ (MM/DD/YYYY)	
Patient Postal Code	_____ - _____	❑ Homeless
Payment Source	❑ Medicare ❑ Medicaid ❑ Medicare – Private/HMO/PPO/Other ❑ Medicaid – Private/HMO/PPO/Other	❑ Private/HMO/PPO/Other ❑ VA/CHAMPVA/Tricare ❑ Self-pay/No Insurance ❑ Other/Not Documented/UTD
RACE AND ETHNICITY		***Demographics Tab***
Race	❑ American Indian or Alaska Native ❑ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	❑ Black or African American ❑ Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ❑ White ❑ UTD
Hispanic Ethnicity	○ Yes ○ No/UTD	
If yes,	❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican	❑ Cuban ❑ Another Hispanic, Latino, or Spanish Origin
ARRIVAL AND ADMISSION INFORMATION		***Admission Tab***
Arrival Date/Time	___/___/_____ __:__	
Point of Origin for Admission	○ Home ○ Transfer from a Hospital (Different Facility) ○ Clinic ○ Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	○ Transfer from another Health Care Facility ○ Non-Healthcare Facility Point of Origin ○ Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program ○ Information not available
Referring hospital arrival Date/Time	___/___/_____ __:__	○ Unknown

Referring hospital discharge Date/Time	___/___/_____ __:__ ○ Unknown
Initial point of hospital arrival	○ Emergency Department ○ Direct to inpatient unit ○ Intensive Care ○ Non-ICU ○ Cath Lab/Operating Room ○ Other

MEDICAL HISTORY *Admission Tab*

Medical History (Select all that apply):

- ❑ None
- ❑ Atherosclerotic vascular disease (choose all that apply)
  - ☐ Cerebrovascular disease (including previous TIA/CVA)
  - ☐ Coronary Artery Disease (CAD)
  - ☐ Peripheral Arterial Disease
  - ☐ Prior CABG
  - ☐ Prior MI
  - ☐ Prior PCI
- ❑ Atrial fibrillation or flutter
- ❑ Chronic Kidney Disease
  - ○ Chronic hemodialysis
- ❑ Chronic pulmonary disease
- ❑ Chronic liver disease
- ❑ Smoking/Vaping
  - ❑ Cigarette use
  - ❑ e-cigarette use
  - ❑ Vaping
- ❑ Diabetes Mellitus
- ❑ Hypertension
- ❑ Unknown
- ❑ Heart Failure (HF)
  - ○ Reduced EF
    - ❑ Ischemic Cardiomyopathy
    - ❑ Nonischemic Cardiomyopathy
    - ❑ History of heart transplantation
    - ❑ Presence of durable left ventricular assist device (LVAD)
    - ❑ Presence of Implantable cardioverter-defibrillator (ICD)
    - ❑ Presence of biventricular pacemaker (CRT)
  - ○ Preserved EF
- ❑ Cardiac amyloidosis
- ❑ Congenital Heart Disease
- ❑ Hypertrophic cardiomyopathy
- ❑ Isolated right ventricular failure
- ❑ Pulmonary hypertension
- ❑ Valvular heart disease
- ❑ Emerging Infectious Disease
  - ❑ MERS
  - ❑ SARS-COV-1
  - ❑ SARS-COV-2 (COVID-19)
  - ❑ Other infectious respiratory pathogen

MEDICATIONS AT HOSPITAL ADMISSION *Admission Tab*

Medications Used Prior to Admission: *[Select all that apply]*

- ❑ No meds prior to admission
- ❑ ACE Inhibitor
- ❑ Angiotensin receptor blocker (ARB)
- ❑ Angiotensin Receptor Neprilysin Inhibitor (ARNI)
- ❑ Anticoagulation Therapy
  - ○ Direct oral anticoagulant
  - ○ Warfarin
  - ○ Other
- ❑ Anti-hyperglycemic medications:
  - ☐ Insulin
  - ☐ Oral
- ❑ Antiplatelet Medication:
  - ☐ Aspirin
  - ☐ P2Y12 Inhibitors
  - ☐ Other Antiplatelet
- ❑ Beta-Blocker
- ❑ Home IV Inotropes
- ❑ Loop Diuretic
- ❑ Mineralocorticoid Receptor Antagonist (MRA)
- ❑ SGLT2 Inhibitor
- ❑ GLP-1 agonist
- ❑ Unknown/Unable to Determine

EXAMS/LABS AT ADMISSION *Admission Tab*

Date/Time of vital signs		___/___/_____ __:__	❑ Not Documented
Initial Vital signs	Height	_____ ❍ inches ❍ cm	❑ Not Documented
	Weight	_____ ❍Lbs. ❍Kgs.	❑ Not Documented
	BMI	_____ (Automatically Calculated)	
	BSA	_____ (Automatically Calculated)	
	Heart Rate	_____ bpm	❑ Not Documented
	BP	___ / ___ mmHg (systolic/diastolic)	❑ Not Documented

	Temperature	_____ ❍ C ❍ F ❑ Not Documented
Admission Labs	Lactate	_____ (mmol/L) ❑ Unavailable
	Hgb	_____ ❍ g/dL ❍ g/L ❑ Unavailable
	NT-proBNP	_____ ❍ pg/mL ❍ ng/L ❑ Unavailable
	BNP	_____ ❍ pg/mL ❍ pmol/L ❍ ng/L ❑ Unavailable
	SCr	_____ ❍ mg/dL ❍ µmol/L ❑ Unavailable
	ALT	_____ ❍ IU/L ❑ Unavailable
	Platelet Count	_____ (mm^3) ❑ Unavailable
	Troponin	_____ ❍ng/L ❍ng/mL ❍ug/L ❍ T ❍ I ❍ Normal ❍ Abnormal
		❑ Troponin Unavailable ❑ Troponin below limit of detection
	Random Blood Glucose	_____ (mg/dL) ❑ Unavailable
Most favorable neurological status at admission		❍ Conscious without severe disability ❍ Conscious with severe disability ❍ Comatose ❍ Unable to assess due to sedation ❍ Unknown/Not Documented

SHOCK ONSET	***Shock Onset Tab***
Certainty of shock etiology	❍ Cardiogenic shock was a clear contributor to the shock state ❍ Cardiogenic shock was suspected but with some uncertainty
Where was the onset of Cardiogenic Shock present?	❍ Shock present on participating hospital arrival ❍ Shock onset while in-hospital ❍ Shock onset at referring hospital
Cardiac arrest prior to shock onset?	❍ Yes ❍ No ❍ Unknown/Not Documented
Most favorable neurological status after the arrest and <u>prior to hospital discharge</u>	❍ Conscious without severe disability ❍ Conscious with severe disability ❍ Comatose ❍ Unable to assess due to sedation ❍ Unknown/Not Documented
Onset of shock (Date/Time):	__/__/____ __:__ ❍ Unknown
Was a multidisciplinary shock team involved in patient management?	❍ Yes ❍ No ❍ Not documented
If multidisciplinary shock team was involved, select the timeframe	❍ Within 3hrs of shock onset ❍ >24hrs of shock onset ❍ Within 6hrs of shock onset ❍ Unknown/not documented ❍ Within 24hrs of shock onset

SCAI Shock Stage at Onset (first 6hrs)	❍ Deceased ❍ Stage B ❍ Stage C	❍ Stage D ❍ Stage E ❍ ND/Unable to Determine
SCAI Shock Stage Serial assessment (Assessed at 6h-12h)	❍ Deceased ❍ Stage B ❍ Stage C	❍ Stage D ❍ Stage E ❍ ND/Unable to Determine
Presenting Physiology	❍ Biventricular Failure ❍ Left Ventricular Failure ❍ Right Ventricular Failure	❍ Primary Other Cardiac (Arrhythmia, Valvular Stenosis, etc.) ❍ Not Documented
Cardiogenic shock category	❍ Acute, de novo HF ❍ Acute-on-chronic HF	❍ Unable to determine

Etiologies and Contributors to Cardiogenic Shock:	❑ None of the causes below
	❑ Acute Transplant Rejection
	❑ ACS/AMI
	  ☐ STEMI
	  ☐ NSTEMI
	❑ Arrhythmia
	  ❑ Bradyarrhythmia
	  ❑ Tachyarrhythmia
	❑ COVID-19 related complication
	❑ Isolated Right Heart Failure
	  ☐ Acute PE
	  ☐ Pulmonary HTN
	❑ LVAD complication
	❑ Mechanical complication of MI
	❑ Myocarditis
	❑ Peripartum
	❑ Post-cardiac arrest
	❑ Post-cardiopulmonary bypass
	❑ Takotsubo cardiomyopathy
	❑ Tamponade
	❑ Valvular dysfunction
	❑ Other (Specify): _____
	❑ Unknown

MEDICATIONS AT SHOCK ONSET *Shock Onset Tab*

Medications administered at Onset of Shock *(Select all that apply)*	❑ None
	❑ Anticoagulation Therapy
	  ☐ Direct oral anticoagulant
	  ☐ Warfarin
	  ☐ IV heparin
	  ☐ Other
	❑ Antiplatelet Medication:
	  ☐ Aspirin
	  ☐ P2Y12 Inhibitors
	  ☐ Other Antiplatelet
		❑ Vasoactive Medications (IV Continuous, during <u>first 6hrs</u> after shock onset)
		  ☐ Dobutamine
		  ☐ Dopamine
		  ☐ Epinephrine
		  ☐ Levosimendan
		  ☐ Milrinone
		  ☐ Nitroprusside
		  ☐ Norepinephrine
		  ☐ Phenylephrine
		  ☐ Vasopressin
		❑ Not Documented

EXAMS/LABS AT SHOCK ONSET *Shock Onset Tab*

*Enter parameters <u>closest to shock onset</u>. (**To be entered only if shock onset was <u>after</u> arrival**)*

Date/Time of vital signs (closest to shock onset)		___/___/_____ __:__ ❑ Not Documented
Vital signs (closest to shock onset)	**Height**	_____ ❍inches ❍cm ❑ Not Documented
	Weight	_____ ❍lbs ❍kg ❑ Not Documented
	BMI	_____ (Automatically Calculated)
	BSA	_____ (Automatically Calculated)
	Heart Rate	_____ bpm ❑ Not Documented
	BP	___ / ___ mmHg (systolic/diastolic) ❑ Not Documented
	Temperature	_____ ❍C ❍F ❑ Not Documented
Labs (Closest to shock onset)	**Lactate**	_____ (mmol/L) ❑ Unavailable
	Hgb	_____ ❍ g/dL ❍ g/L ❑ Unavailable
	NT-proBNP	_____ ❍ pg/mL ❍ ng/L ❑ Unavailable
	BNP	_____ ❍ pg/mL ❍ pmol/L ❍ ng/L ❑ Unavailable
	SCr	_____ ❍ mg/dL ❍ µmol/L ❑ Unavailable
	ALT	_____ ❍ IU/L ❑ Unavailable
	Platelet Count	_____ (mm^3) ❑ Unavailable
	Troponin (Peak related to shock onset)	_____ ❍ng/mL ❍ug/L ❍ng/L ☐ Unavailable ☐ Below limit of detection
	Random Blood Glucose	_____ (mg/dL) ❑ Unavailable

IN-HOSPITAL CARE *In-Hospital Tab*

Cardiovascular Procedures during this hospitalization	
❑ No Procedures ❑ Cardiac Cath/Coronary Angiography ❑ Cardiac Transplantation *Date/Time of transplantation*:__/__/_____ __:__ ❑ Coronary Artery Bypass Graft (CABG) *Date/Time of CABG:* __/__/_____ __:__ ❑ Electrophysiology (EP) procedure *Date/Time of EP:* __/__/_____ __:__ ❑ Percutaneous Cardiac Intervention (PCI) *Date/Time of PCI:* __/__/_____ __:__ ❑ Pulmonary embolectomy (surgical or transcatheter) ❑ Targeted temperature management ❑ Other Procedures/Advanced therapies (Specify): _____	❑ Mechanical Circulatory Support Device/VAD *Date/Time of FIRST MCS:* __/__/_____ __:__ Percutaneous Assist Devices ❑ IABP ❑ Impella ❑ TandemHeart ❑ VA ECMO ❑ iVAC ❑ Other VAD Surgical Assist Devices ❑ Temporary external device (e.g. CentriMag) ❑ Implanted surgical assist device ❑ Continuous-Flow Devices ❑ Pulsatile-Flow Devices *Date/Time of implantation*: __/__/_____ __:__
Was a right heart catheterization or pulmonary artery catheterization performed?	○ Yes ○ No ○ Unknown/Not Documented
Date/time of first RHC/PAC	__/__/_____ __:__ ○ Unknown
Was the PA catheter used for a period of hemodynamic monitoring outside the Cath Lab/OR?	○ Yes ○ No ○ Unknown/Not Documented
Was the patient managed with invasive mechanical ventilation at any time during the hospitalization?	○ Yes ○ No ○ Unknown/Not Documented
Primary indication for advanced respiratory therapy	○ Airway protection only (other than cardiac arrest) ○ Cardiac arrest without respiratory failure ○ Chronic dependence on mechanical ventilation ○ Procedural sedation / anesthesia and recovery ○ Respiratory insufficiency ○ Other
Date/Time of first intubation related to this hospitalization	__/__/_____ __:__ ○ Unknown
Was patient managed with renal replacement therapy at any time during the hospitalization?	○ Yes ○ No ○ Unknown/Not Documented
If Yes, Select type of renal replacement therapy used	○ Accelerated venovenous hemofiltration (AVVH) ○ Continuous venovenous hemofiltration (CVVH) ○ Emergent or urgent hemodialysis ○ Routine hemodialysis for patient with end-stage renal dialysis (ESRD) ○ Unknown/Not Documented
Primary Indications for advanced renal therapy (Select all that apply)	❑ Acidemia ❑ Hyperkalemia ❑ Severe uremia ❑ Volume overload causing hemodynamic or respiratory compromise ❑ Volume overload in the absence of any of the above ❑ Other (specify) _____ ❑ Unknown/Not Documented

Data for Patient transferred to ICU from any other floor in the hospital		
Was the patient admitted to ICU at any point during this hospitalization?	○ Yes	○ No
ICU Admission Date/Time	__/__/_____ __:__	○ Unknown
ICU discharge (transfer out) Date/Time	__/__/_____ __:__	○ Unknown
Number of days patient was in ICU (*auto-calc*.)	_____	

Clinical Outcomes	***In-Hospital Tab***	
*Record the Time/Date of the **FIRST** event of each type*		
Severe/Moderate GUSTO bleeding event:	○ Yes ○ No	
Date/Time GUSTO detected:	___/___/_____ __:__	○ Not Documented
Intracranial Hemorrhage	○ Yes ○ No	
Date/Time Intracranial Hemorrhage detected	___/___/_____ __:__	○ Not Documented
Cardiac Arrest	○ Yes ○ No	
Date/Time Cardiac Arrest detected	___/___/_____ __:__	○ Not Documented
Stroke	○ Yes ○ No	
Date/Time Stroke detected	___/___/_____ __:__	○ Not Documented
Complications from procedures during this admission:	☐ No complications from procedures ☐ Acute Limb ischemia ☐ Amputation ☐ Fasciotomy ☐ Arterial non-CNS thrombosis ☐ Bleeding – Vascular access site – MCS-Related	☐ Bleeding – Vascular access site – Other access site ☐ Bleeding – Other site ☐ Cardiac tamponade ☐ Vascular injury (any) ☐ Venous thromboembolism ☐ Other (Specify): _____

Mechanical Circulatory Support Form	***MCS Tab***		
Section to be completed for each device implanted			
Implanted Device – VA ECMO	☐ ECMO (VA)		
Date/Time of Implant Procedure – VA ECMO	__/__/_____ __:__ (MM/DD/YYYY HH:MM)	☐ Not Documented	
Device explant date/Time VA ECMO:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)		
Arterial Implant Site - VA ECMO:	❍ Right ❍ Left ❍ Central	○ Axillary ○ Femoral	
Venous Implant Site - VA ECMO:	❍ Right ❍ Left ❍ Central	○ Axillary ○ Femoral	
Receiving CPR at time of Implant – VA ECMO	❍ Yes	❍ No	❍ Unknown/ND
Reason for device implant – VA ECMO (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____		
Vascular closure applied – VA ECMO:	❑ Collagen-based plug with MANTA		

	❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____
Implanted Device – IABP	☐ IABP ○ 25 cc ○ 30 cc ○ 34 cc ○ 40 cc ○ 50 cc
Date/Time of Implant Procedure – IABP	__/__/_____ __:__ (MM/DD/YYYY HH:MM) ☐ Not Documented
Device explant date/Time IABP:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)
Arterial Implant Site - IABP:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Receiving CPR at time of Implant - IABP	❍ Yes ❍ No ❍ Unknown/ND
Reason for device implant – IABP (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____
Vascular closure applied – IABP:	❑ Collagen-based plug with MANTA ❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____
Implanted Device – Impella	☐ Impella ☐ Impella 2.5 ☐ Impella 5.0 ☐ Impella CP ☐ Impella 5.5 ☐ Impella ECP ☐ Impella RP
Date/Time of Implant Procedure – Impella	__/__/_____ __:__ (MM/DD/YYYY HH:MM) ☐ Not Documented
Device explant date/Time Impella:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)
Arterial Implant Site - Impella:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Receiving CPR at time of Implant - Impella	❍ Yes ❍ No ❍ Unknown/ND
Reason for device implant – Impella (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____
Vascular closure applied – Impella:	❑ Collagen-based plug with MANTA

	❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____
Implanted Device – iVAC	☐ iVAC
Date/Time of Implant Procedure – iVAC	__/__/_____ __:__ (MM/DD/YYYY HH:MM) ☐ Not Documented
Device explant date/Time iVAC:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)
Arterial Implant Site - iVAC:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Venous Implant Site - iVAC:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Receiving CPR at time of Implant – iVAC	❍ Yes ❍ No ❍ Unknown/ND
Reason for device implant – iVAC (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____
Vascular closure applied – iVAC:	❑ Collagen-based plug with MANTA ❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____
Implanted Device – TandemHeart	☐ TandemHeart
Date/Time of Implant Procedure – TandemHeart	__/__/_____ __:__ (MM/DD/YYYY HH:MM) ☐ Not Documented
Device explant date/Time TandemHeart:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)
Arterial Implant Site - TandemHeart:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Venous Implant Site - TandemHeart:	❍ Right ❍ Left ❍ Central ○ Axillary ○ Femoral
Receiving CPR at time of Implant – TandemHeart	❍ Yes ❍ No ❍ Unknown/ND
Reason for device implant – Tandemheart (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO

	❑ Other reason for device implant (Specify): _____		
Vascular closure applied – TandemHeart:	❑ Collagen-based plug with MANTA ❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____		
Implanted Device – Temporary surgical VAD (e.g. CentriMag)	☐ Temporary surgical VAD ☐ Temporary surgical VAD - Left ☐ Temporary surgical VAD - Right		
Date/Time of Implant Procedure – Temporary surgical VAD (e.g. CentriMag)	__/__/_____ __:__ (MM/DD/YYYY HH:MM)	☐ Not Documented	
Device explant date/Time -Temporary surgical VAD (e.g. CentriMag):	___/___/_____ __:__ (MM/DD/YYYY HH:MM)		
Arterial Implant Site - Temporary surgical VAD (e.g. CentriMag):	❍ Right ❍ Left ❍ Central	○ Axillary ○ Femoral	
Receiving CPR at time of Implant - Temporary surgical VAD (e.g. CentriMag)	❍ Yes	❍ No	❍ Unknown/ND
Reason for device implant – Temporary surgical VAD (e.g. CentriMag) (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia ❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____		
Vascular closure applied – Temporary surgical VAD (e.g. CentriMag):	❑ Collagen-based plug with MANTA ❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____		
Implanted Device – Other	☐ Other Device		
Specify other device:	_____		
Date/Time of Implant Procedure – Other	__/__/_____ __:__ (MM/DD/YYYY HH:MM)	☐ Not Documented	
Device explant date/Time Other:	___/___/_____ __:__ (MM/DD/YYYY HH:MM)		
Arterial Implant Site - Other:	❍ Right ❍ Left ❍ Central	○ Axillary ○ Femoral	
Venous Implant Site - Other:	❍ Right ❍ Left ❍ Central	○ Axillary ○ Femoral	
Receiving CPR at time of Implant – Other	❍ Yes	❍ No	❍ Unknown/ND
Reason for device implant – Other (*Select all that apply*)	❑ Critical Left Main/Severe CAD ❑ Incessant Arrhythmia ❑ Refractory Ischemia		

	❑ Shock ❑ Severe Heart Failure without Shock ❑ Severe Valvular Dysfunction ❑ Supported PCI ❑ Ventricular Septal Defect ❑ Left-ventricular venting during VA-ECMO ❑ Other reason for device implant (Specify): _____
Vascular closure applied – Other:	❑ Collagen-based plug with MANTA ❑ Dry-based ❑ Manuel compression (Femostop) ❑ Planned open surgical repair ❑ Suture-based (Proglide, Prostar XL) ❑ Other (Specify):_____

PRE-ECMO EVENTS	***ECMO TAB***
Select any current device(s) supporting patient pre-ECMO *[Device(s) already selected from the MCS tab will be auto-populated here]*	☐ None ☐ Intra-Aortic Balloon Pump (IABP) ☐ Impella (any) ☐ Tandem Heart ❑ Left ❑ Right ☐ Temporary surgical VAD (e.g. CentriMag) ❑ Left ❑ Right ☐ Other (Specify): _____
Circumstances of ECMO Cannulation (select all that apply):	☐ Planned for patient deterioration (Prophylactic) ☐ Emergent (ECPR or Salvage) ☐ Failure to Wean from CPB ☐ Progression of Illness Despite Established VAD/ Temporary Mechanical Circulatory Support / IABP
GCS Score *(if assessed immediately pre-ECMO)*	_____ ○ GCS not assessed
Is there an ELSO record for this patient?	○ Yes ○ No ○ Unknown/Not Documented
If yes, enter ELSO Patient Record Number (**optional**)	_____

VASCULAR ACCESS & INITIATION OF ECMO				***ECMO TAB***
Date/Time ECMO started	____/____/_____ ____:____ ○ Unknown			
Type of cannulation	○ Central ○ Peripheral ○ Unknown/Not Documented			
Purpose	○ Drainage ○ Reinfusion ○ Unknown/Not Documented			
Cannulation anatomical site (check all that apply) *[repeat for each cannula placed]*	**Cannulation anatomical Site**	**Cannula size (Fr)**	**Cannula manufacturer**	**Cannula Model**
	❑ Right internal jugular vein			
	❑ Right Femoral Artery			
	❑ Left Femoral Artery			
	❑ Right Femoral Vein			
	❑ Left Femoral Vein			
	❑ Other (Specify):_____			
	❑ Aorta (Central)			
	❑ Right Atrium (Central)			
	❑ Left Atrium (Central)			

	❑ Pulmonary Artery (Central)			
	❑ Unknown/Not Documented			
Date/Time of insertion	___/___/_____ ___:___		○ Unknown	
Was this cannula removed for a reason other than death?	○ Yes	○ No	○ Not Documented	
Date/Time of removal	___/___/_____ ___:___		○ Unknown	

LV Decompression ***ECMO Tab***

LV Decompression Procedures (select all that apply) and date/time of procedure, if known:	❑ None/Not Performed	
	❑ Atrial Septostomy	Date/Time: __/__/_____ ___:___
	❑ LA Vent	Date/Time: __/__/_____ ___:___
	❑ LV Vent	Date/Time: __/__/_____ ___:___
	❑ PA Vent	Date/Time: __/__/_____ ___:___
	❑ Intra-Aortic Balloon Pump	Date/Time: __/__/_____ ___:___
	❑ Transaortic Valve Impella	Date/Time: __/__/_____ ___:___
	❑ L-VAD	Date/Time: __/__/_____ ___:___
	❑ R-VAD	Date/Time: __/__/_____ ___:___
	❑ Other (Specify): _____	Date/Time: __/__/_____ ___:___
Rationale for Decompression on ECLS (select one):	○ Institutional routine ○ Progressive Pulmonary Edema on CXR ○ Lack of native ejection	○ Decreased pulse pressure on Arterial Waveform ○ Evidence of Ischemia ○ Other (Specify): _____

ECMO Cannulation Location (area) ***ECMO Tab***

ECMO Cannulation Location:	○ Another hospital (pre-transfer) ○ Ambulatory/Outpatient Area ○ Adult cardiac ICU (CICU) ○ Adult general ICU ○ Cardiac Catheterization Lab ○ Delivery Suite ○ Diagnostic/Intervention. Area (excluding Cath Lab)	○ Emergency Department (ED) ○ Operating Room (OR) ○ Post-Anesthesia Recovery Unit (PACU) ○ Same-day Surgical Area ○ Telemetry unit or Step-down unit ○ Other (Specify) _____ ○ Unknown/Not Documented
Team Member(s) Performing ECMO Cannulation:	❑ Anesthesiologist ❑ Intensive care physician ❑ ER Physician ❑ Perfusionist	❑ Surgeon (cardiac/cardiothoracic) ❑ Other (Specify) _____ ❑ Unknown/Not Documented

ECMO circuit and components ***ECMO Tab***

Pump	Pump name:	_____
	Manufacturer:	_____
Common device used (e.g., Cardiohelp)	○ Yes ○ No ○ Unknown / Not Documented	
Console/Drive unit	Console Name/Type:	_____
	Console Manufacturer:	_____
Oxygenator	Type/Name:	_____

	Manufacturer:	_____
Safety features incorporated in the ECMO circuit for this event	❑ Bridge ❑ Bubble detectors ❑ O2 saturation monitor ❑ Pressure alarms	❑ Transonic flow meter ❑ Venous bladder and pump controller ❑ Other (Specify): _____
Was any component exchanged or replaced?	○ Yes ○ No ○ Unknown/ Not Documented	
Component Exchanged	○ Console ○ Heat Exchanger	○ Oxygenator ○ Other (Specify): _____
Reason(s) for exchange		
Date/time of exchange		
Additional exchange(s)	**If applicable, multiple instances of Component Exchanged/Replaced repeat group can be added to the form**	
Component Exchanged #2	○ Console ○ Heat Exchanger	○ Oxygenator ○ Other (Specify): _____
Exchange #2 reason		
Date/Time of exchange #2		

Neurologic injury or events detected during ECMO or after ECMO (Less than 6 weeks after separation from ECMO or by Hospital Discharge, which ever one comes first). (check all that apply):	
❑ No Neurological injury or events detected during ECMO or after ECMO	
❑ Anoxic Brain Injury	Date/Time detected: ___/___/_____ ___:___
❑ Brain death	Date/Time detected: ___/___/_____ ___:___
❑ Cerebral Microbleeds	Date/Time detected: ___/___/_____ ___:___
❑ New clinical seizure(s)	Date/Time detected: ___/___/_____ ___:___
❑ Spinal cord ischemia	Date/Time detected: ___/___/_____ ___:___

Other Complications/Events *[Relevant options already captured will be auto-populated]*			
Device-Related Events	❑ None ❑ Air embolism ❑ Circuit clots	❑ Oxygenator failure ❑ Pump failure	❑ Tubing rupture ❑ Other (Specify): _____
Other ECMO complications/events	❑ None ❑ Differential hypoxia (Harlequin syndrome)	❑ Left ventricular distention ❑ Pulmonary hemorrhage	❑ Pulmonary edema ❑ Other (Specify): _____

OUTCOMES /END OF EVENT		***ECMO TAB***
Date/Time ECMO ended	___/___/_____ ___:___	○ Unknown/Not Documented
SAVE (Survival After Veno-Arterial ECMO) Score	_____	○ Not Documented
Reason(s) ECMO ended	☐ Converted to other support ☐ ECMO complication ☐ Limited resources ☐ Patient (or family) refused treatment ☐ Patient recovered/improved	☐ Significant deterioration ☐ Transition to surgical LVAD ☐ Transplant (Heart/Lung) ☐ Patient died ☐ Other (specify): _____ ☐ Unknown

DISCHARGE INFORMATION		***Discharge Tab***
Discharge disposition	○ Home ○ Hospice – Home ○ Hospice – Health Care Facility	○ Expired ○ Left Against Medical Advise/AMA

	○ Acute Care Facility ○ Other Health Care Facility ○ Not documented or Unable to Determine (UTD)
Date/Time of Discharge from hospital:	___/___/_____ ___:____ (MM/DD/YYYY HH:MM) ❑ Not Documented
Most favorable neurological status at discharge	○ Conscious without severe disability ○ Conscious with severe disability ○ Comatose ○ Unable to assess due to sedation ○ Unknown/Not Documented
If patient died, Date/Time of death	___/___/_____ __:__ ○ Not Documented
Primary cause of death	○ Cardiovascular ○ Non-Cardiovascular ○ Unknown
If Cardiovascular:	○ Acute Coronary Syndrome ○ Cardiogenic Shock/HF ○ Stroke ○ Sudden Cardiac Death ○ Unknown ○ Other Cardiovascular
If Non-Cardiovascular	○ Anoxic brain injury ○ Other non-cardiovascular
If Other Health Care Facility:	○ Skilled Nursing Facility (SNF) ○ Inpatient Rehabilitation Facility (IRF) ○ Long Term Care Hospital (LTCH) ○ Intermediate Care Facility (ICF) ○ Other

SOCIAL DETERMINANTS OF HEALTH	***Discharge Tab***
During this admission, was a standardized health related social needs form or assessment completed?	○ Yes ○ No/Not Documented
If yes, identify the areas of unmet social need. (select all that apply):	❑ None ❑ Education ❑ Employment ❑ Financial Strain ❑ Food ❑ Living Situation/Housing ❑ Mental Health ❑ Substance Abuse ❑ Transportation Barriers

END OF FORM