

A. DEMOGRAPHICS

Last Name²⁰⁰⁰:	First Name²⁰¹⁰:	Middle Name²⁰²⁰:	Birth Date²⁰⁵⁰:
SSN²⁰³⁰: <input type="checkbox"/> SSN N/A ²⁰³¹	Patient ID²⁰⁴⁰:	Other ID²⁰⁴⁵:	Sex²⁰⁶⁰: <input type="radio"/> Male <input type="radio"/> Female
Race: (check all that apply) <input type="checkbox"/> White ²⁰⁷⁰ <input type="checkbox"/> Black/African American ²⁰⁷¹ <input type="checkbox"/> Asian ²⁰⁷² <input type="checkbox"/> American Indian/Alaskan Native ²⁰⁷³ <input type="checkbox"/> Native Hawaiian/Pacific Islander ²⁰⁷⁴	Hispanic or Latino Ethnicity²⁰⁷⁶: <input type="radio"/> No <input type="radio"/> Yes		
Patient Zip Code³⁰⁰⁰: <input type="checkbox"/> Zip Code N/A ³⁰⁰¹			

B. ADMISSION

Means of Transport to First Facility³¹⁰⁰: Self/Family Ambulance Mobile ICU Air
 → **If Ambulance or Mobile ICU or Air, Pre-Arrival 1st Med. Contact Date/Time^{3105, 3106}:** _____ Time Estimated³¹⁰⁷

Transferred from Outside Facility³¹¹⁰: No Yes → **If Yes, Means of Transfer³¹¹⁵:** Ambulance Mobile ICU Air
 → **If Yes, Arrival at Outside Facility Date/Time^{3120, 3121}:** _____ Time Estimated³¹²²
 → **If Yes, Transfer from Outside Facility Date/Time^{3125, 3126}:** _____ Time Estimated³¹²⁷
 → **If Yes, Name of Transferring Facility/AHA Number^{3150, 3151}:** _____

Your Facility	Arrival Date/Time^{3200, 3201}:	Admission Date³²¹⁰:	HIC #³³²⁰:
	Insurance Payers: <input type="checkbox"/> Private Health Insurance ³³⁰⁰ <input type="checkbox"/> Medicare ³³⁰¹ <input type="checkbox"/> Medicaid ³³⁰² <input type="checkbox"/> Military Health Care ³³⁰³ (check all that apply) <input type="checkbox"/> State-Specific Plan (non-Medicaid) ³³⁰⁴ <input type="checkbox"/> Indian Health Service ³³⁰⁵ <input type="checkbox"/> Non-US Insurance ³³⁰⁶ <input type="checkbox"/> None ³³⁰⁷		

C. CARDIAC STATUS ON FIRST MEDICAL CONTACT

Symptom Onset Date/Time^{4000, 4001}: _____ Time Estimated⁴⁰⁰² Time Not Available⁴⁰⁰³

First ECG Obtained⁴⁰¹⁰: Pre-Hospital (e.g. ambulance) After 1st hosp. arrival **First ECG Date/Time^{4020, 4021}:** _____

STEMI or STEMI Equivalent⁴⁰³⁰: No Yes → **If Yes, ECG Findings⁴⁰⁴⁰:** ST elevation LBBB (new or presumed new) Isolated posterior MI
 → **If Yes, STEMI or STEMI Equivalent First Noted⁴⁰⁴¹:** First ECG Subsequent ECG
 → **If Subsequent ECG, Subsequent ECG with STEMI or STEMI Equivalent Date/Time^{4042, 4043}:** _____
 → **If No, Other ECG Findings⁴⁰⁴⁴:** New or presumed new ST depression New or presumed new T-Wave inversion
(demonstrated within first 24 hours of medical contact) Transient ST elevation lasting < 20 minutes None

Heart Failure⁴¹⁰⁰: No Yes **Cardiogenic Shock⁴¹¹⁰:** No Yes **Heart Rate⁴¹²⁰:** _____ (bpm) **Systolic BP⁴¹³⁰:** _____ (mmHg)

D. HISTORY AND RISK FACTORS

Weight⁵⁰¹⁰: _____ (kg)	Hypertension⁵⁰³⁰: <input type="radio"/> No <input type="radio"/> Yes
Current/Recent Smoker (< 1 year)⁵⁰²⁰: <input type="radio"/> No <input type="radio"/> Yes	Diabetes Mellitus⁵⁰⁷⁰: <input type="radio"/> No <input type="radio"/> Yes
Currently on Dialysis⁵⁰⁵⁰: <input type="radio"/> No <input type="radio"/> Yes	Peripheral Arterial Disease⁵¹⁴⁰: <input type="radio"/> No <input type="radio"/> Yes
	Cerebrovascular Disease⁵¹³⁰: <input type="radio"/> No <input type="radio"/> Yes
	→ If Yes, Prior Stroke⁵¹³¹: <input type="radio"/> No <input type="radio"/> Yes

J. DISCHARGE

Discharge Date¹¹⁰⁰⁰: _____

Comfort Measures Only¹¹⁰¹⁰: No Yes

Enrolled in Clinical Trial During Hospitalization¹¹⁰²⁰: No Yes

Discharge Status¹¹¹⁰⁰: Alive Deceased

→ **If Alive, Smoking Counseling¹¹¹⁰¹:** No Yes

→ **If Alive, Exercise Counseling¹¹¹⁰³:** No Yes Ineligible

→ **If Alive, Cardiac Rehabilitation Referral¹¹¹⁰⁴:** No Yes Ineligible

→ **If Alive, Discharge Location¹¹¹⁰⁵:** Home Extended care/transitional care unit Other hospital

→ **If Other Hospital, Transfer Time¹¹¹⁰⁶:** _____

→ **If Other Hospital, Transfer for PCI¹¹¹⁰⁷:** No Yes

E. MEDICATIONS

Oral Medications

Medication	Medications Administered in First 24 Hours (Up to 24 hours after first medical contact*)	Medications Prescribed At Hospital Discharge (do not code for patients who die or are AMA or are transferred to another hospital)
Aspirin ⁶⁰¹⁰⁻⁶⁰²⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Start Date/Time: _____ * Note: code "Yes" for Aspirin if admin. 24 hrs before or after first medical contact	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Clopidogrel ⁶⁰⁶⁰⁻⁶⁰⁷⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Start Date/Time: _____ → If Yes, Dose: _____ mg	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Ticlopidine ⁶¹¹⁰⁻⁶¹²⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Start Date/Time: _____	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Prasugrel ⁶¹⁶⁰⁻⁶¹⁷⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Start Date/Time: _____	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Warfarin ⁶²²⁰		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Beta Blocker ⁶²⁶⁰⁻⁶²⁷⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
ACE Inhibitor ⁶³²⁰		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Angiotensin Receptor Blocker ⁶³⁷⁰		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Aldosterone Blocking Agent ⁶⁴²⁰		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded
Statin ⁶⁴⁷⁰		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded

Intravenous and Subcutaneous Medications

GP IIb/IIIa Inhibitor ⁶⁸⁰⁰ (any time during this hospitalization)	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Medication Type ⁶⁸⁰¹ : <input type="radio"/> Eptifibatide <input type="radio"/> Tirofiban <input type="radio"/> Abciximab → If Yes, Start Date/Time ^{6802, 6803} : _____
Anticoagulant ⁶⁸⁵⁰	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Contraindicated <input type="radio"/> Blinded → If Yes, Medication Type(s) : <input type="checkbox"/> IV Unfractionated Heparin ⁶⁸⁵¹ <input type="checkbox"/> Enoxaparin (LMWH) ⁶⁸⁶⁰ <input type="checkbox"/> Dalteparin (LMWH) ⁶⁸⁷⁰ <input type="checkbox"/> Bivalirudin ⁶⁸⁷⁵ <input type="checkbox"/> Fondaparinux ⁶⁸⁸⁰ <input type="checkbox"/> Argatroban ⁶⁸⁸⁵ <input type="checkbox"/> Lepirudin ⁶⁸⁹⁰

F. PROCEDURES AND TESTS

Diagnostic Coronary Angiography ⁷⁰²⁰ :	<input type="radio"/> No <input type="radio"/> Yes	LVEF ⁷⁰¹⁰ : %	<input type="checkbox"/> LVEF Not Assessed ⁷⁰¹¹
PCI ⁷¹⁰⁰ :	<input type="radio"/> No <input type="radio"/> Yes → If Yes, Cath Lab Arrival Date/Time ^{7101, 7102} : _____ → If Yes, First Device Activation Date/Time ^{7103, 7104} : _____ → If Yes, Stent(s) Placed ⁷¹⁰⁵ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Stent Type(s) : <input type="checkbox"/> Bare metal stent ⁷¹⁰⁶ <input type="checkbox"/> Drug eluting stent ⁷¹⁰⁷ <input type="checkbox"/> Other ⁷¹⁰⁸ → If Yes, PCI Indication ⁷¹⁰⁹ : <input type="radio"/> Immediate, primary PCI for STEMI <input type="radio"/> Rescue PCI (after failed full-dose lytics for STEMI) <input type="radio"/> PCI for NSTEMI <input type="radio"/> Stable, successful reperfusion for STEMI, or completed infarction post-STEMI <input type="radio"/> Other → If Immediate, Primary PCI for STEMI, Non-System Reason for Delay in PCI ⁷¹¹⁰ : <input type="radio"/> Difficult vascular access <input type="radio"/> Cardiac arrest and/or need for intubation before PCI <input type="radio"/> Patient delays in providing consent for the procedure <input type="radio"/> Difficulty crossing the culprit lesion during the PCI procedure <input type="radio"/> Other <input type="radio"/> None		
CABG ⁷²⁰⁰ :	<input type="radio"/> No <input type="radio"/> Yes		

G. REPERFUSION STRATEGY (IMMEDIATE REPERFUSION)

Was Patient a **Reperfusion Candidate**⁸⁰⁰⁰: No Yes
 → If Yes, **Thrombolytics**⁸⁰²⁰: No Yes
 → If Yes, **Dose Start Date/Time**^{8023, 8024}: _____
 → If Yes, **Non-System Reason for Delay**⁸⁰²⁵: No Yes

H. IN-HOSPITAL CLINICAL EVENTS

Reinfarction ⁹⁰⁰⁰ : <input type="radio"/> No <input type="radio"/> Yes	Suspected Bleeding Event ⁹⁰⁴⁰ : <input type="radio"/> No <input type="radio"/> Yes
Cardiogenic Shock ⁹⁰¹⁰ : <input type="radio"/> No <input type="radio"/> Yes	RBC/Whole Blood Transfusion ⁹⁰⁵⁰ : <input type="radio"/> No <input type="radio"/> Yes
Heart Failure ⁹⁰²⁰ : <input type="radio"/> No <input type="radio"/> Yes	CVA/Stroke ⁹⁰³⁰ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Hemorrhagic ⁹⁰³² : <input type="radio"/> No <input type="radio"/> Yes

I. LABORATORY RESULTS

Positive Cardiac Markers Within First 24 Hours¹⁰⁰⁰⁰: No Yes

TROPONIN		CREATININE	
Initial	Collected ¹⁰⁰¹⁰ : <input type="radio"/> No <input type="radio"/> Yes – I <input type="radio"/> Yes – T → If Yes, Value ¹⁰⁰¹³ : _____ (ng/mL) → URL ¹⁰⁰¹⁴ : _____	Initial	Collected ¹⁰¹⁰⁰ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Value ¹⁰¹⁰³ : _____ (mg/dL)
HEMOGLOBIN		LIPIDS (mg/dL)	
Initial	Collected ¹⁰¹⁵⁰ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Value ¹⁰¹⁵³ : _____ (g/dL)	Panel Performed ¹⁰³⁵⁰ : <input type="radio"/> No <input type="radio"/> Yes	→ If Yes, LDL ¹⁰³⁵⁵ : _____

K. OPTIONAL ELEMENTS (FOR AMI CORE MEASURE REPORTING ONLY)

Point of Origin¹²⁰⁰⁰:
 Non-health care facility
 Clinic
 Transfer from a hospital (different facility)
 Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF)
 Transfer from another health care facility
 Emergency room
 Court/law enforcement
 Information not available
 D: Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the Payor
 E: Transfer from ambulatory surgery center
 F: Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program

Transfer from Another ED¹²⁰¹⁰: No Yes

CMS Comfort Measures Timing¹²⁰²⁰: Day 0 or 1 Day 2 or after Timing unclear Not documented/UTD

Principal Diagnosis Code¹²⁰⁹⁰: _____ **Principal Procedure Code**¹²¹⁰⁰: _____ **Date**¹²¹⁰¹: _____

Other Diagnosis Code(s)¹²¹¹⁰⁻¹²: _____

Other Procedure Code(s)¹²¹²⁰⁻²¹: _____ **Date(s)**¹²¹²²⁻²³: _____

Physician 1¹²¹³⁰: _____ **Physician 2**¹²¹³¹: _____

CMS Discharge Status¹²¹⁴⁰:
 D/C – Home or self care
 D/C – Short term general hospital
 D/C – To a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
 D/C – Intermediate care facility
 D/C – Institution not defined elsewhere in this code list
 D/C – Home under care of organized home health service organization in anticipation of covered skilled care
 Left against medical advice or discontinued care
 Expired
 Expired in a medical facility (e.g. hospital, SNF, ICF, or freestanding hospice)
 D/C – Federal health care facility
 Hospice – Home
 Hospice – Medical facility
 D/C – Hospital-based Medicare-approved swing bed
 D/C – Inpatient rehabilitation facility (IRF) including rehabilitation-distinct part units of a hospital
 D/C – Medicare-certified long term care hospital (LTCH)
 D/C – Nursing facility certified under Medicaid but not certified under Medicare
 D/C – To a psychiatric hospital or a psychiatric-distinct part unit of a hospital
 D/C – Critical access hospital (CAH)