

Pediatric Heart Transplant Study

FORM 0905: Coronary Revascularization (Page 1 of 1)

ID# P

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P	Institution Code	Sequential Patient Number	Patient Initials
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1a. Date of Procedure:

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Month Day Year

1b. Intravascular Ultrasound Performed: Yes No
 Use separate form for separate procedure, even if on same date.
 If yes, check vessel(s) studied:
 L Main LAD LCX RCA
 Stanford Score: _____ Stanford Score, Not Done

2. PTCA/Stent/Atherectomy: (complete one section for each lesion treated, indicate all procedures performed):

2a. *Procedure Codes: _____ If other, specify: _____	**Vessel: <input type="checkbox"/> LAD <input type="checkbox"/> RCA <input type="checkbox"/> PDA <input type="checkbox"/> D-1 <input type="checkbox"/> LCx <input type="checkbox"/> PLSA <input type="checkbox"/> D-2 <input type="checkbox"/> M1 <input type="checkbox"/> PLB1 <input type="checkbox"/> D-3 <input type="checkbox"/> M2 <input type="checkbox"/> PLB2 <input type="checkbox"/> M3 <input type="checkbox"/> PLB3	Location: <input type="checkbox"/> Prox <input type="checkbox"/> Mid <input type="checkbox"/> Distal	Lesion Characteristic: <input type="checkbox"/> Eccentric <input type="checkbox"/> Concentric <input type="checkbox"/> Tubular	Pre Procedure Stenosis: _____%	Post Procedure Stenosis: _____%
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Comments on Procedure:

2b. *Procedure Codes: _____ If other, specify: _____	**Vessel: <input type="checkbox"/> LAD <input type="checkbox"/> RCA <input type="checkbox"/> PDA <input type="checkbox"/> D-1 <input type="checkbox"/> LCx <input type="checkbox"/> PLSA <input type="checkbox"/> D-2 <input type="checkbox"/> M1 <input type="checkbox"/> PLB1 <input type="checkbox"/> D-3 <input type="checkbox"/> M2 <input type="checkbox"/> PLB2 <input type="checkbox"/> M3 <input type="checkbox"/> PLB3	Location: <input type="checkbox"/> Prox <input type="checkbox"/> Mid <input type="checkbox"/> Distal	Lesion Characteristic: <input type="checkbox"/> Eccentric <input type="checkbox"/> Concentric <input type="checkbox"/> Tubular	Pre Procedure Stenosis: _____%	Post Procedure Stenosis: _____%
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Comments on Procedure:

3. Coronary Artery Bypass Grafting: Yes No (Please attach operative note with patient name, Medical Record Number and dates obliterated.)

*** Percutaneous Procedures Codes** (write letter code in space for each lesion):
PTCA = Angioplasty **S** = Stent [write brand(s) and size(s) in comments]
DA = Directional Atherectomy **RA** = Rotational Atherectomy
AA = Angiojet Atherectomy

****Vessel:**
LM= Left Main (write under comments) **LAD**= Left Anterior Descending **D1-D3** = Diagonals 1-3
LCx = Left Circumflex **RI** = Ramus Intermedius **M1-M3** =Marginals 1-3
RCA = Right Coronary Artery **PDA** = Posterior Descending Aorta
PLB1 – PLB3 = Branches 1-3 of the PLSA **PLSA** = Posterior Lateral Segment Artery

Person Completing this form: _____ Date Original Form Mailed (do not send copy): _____

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS AFTER JANUARY 1, 2005