

PEDIATRIC HEART TRANSPLANT STUDY

FORM 09: 2010: Coronary Revascularization (PG 1 of 1)

To be filled out post-transplant

ID#	P								
P	Institutional Code	Sequential Patient Number	Patient Initials	Tran #					

1a. Date of Procedure:
(MO | DAY | YR)

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

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

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

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 any identifiable patient information removed. **Be sure to include PHTS Pt. # and initials.**)

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, 2010