PMT FORM SELECTION

Legend:
BOLD = Required
^ = MLL Data Element

Admin (Tab)

^Patient ID: _____		Physician/Provider NPI: _____	
DOB: ___/___/_____	**Gender:** O Male O Female OUnknown	Patient Zip Code:	
^Arrival Date/Time:	___/___/_____ ___: ____	**Admission Date:**	___/___/_____ ___: ____

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	O Yes O No/UTD	If yes, ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican	☐ Cuban ☐ Another Hispanic, Latino or Spanish Origin
Cardiac Diagnosis:	O Confirmed AMI – STEMI O Confirmed AMI – non-STEMI	O Confirmed AMI – STEMI/non-STEMI unspecified O Coronary Artery Disease	O Unstable Angina O Other

Pre-Hospital/Arrival

Pre-Hospital

^Means of transport to first facility:	O Air O Ambulance O Walk-in	EMS Agency name/number**:**	_____
		Run/Sequence number:	_____

Pre-Hospital Time Tracker

^EMS First Medical Contact:	___/___/_____ ___: ____	^Non-EMS First Medical Contact:	___/___/_____ ___: ____
EMS Dispatch:	___/___/_____ ___: ____	EMS arrive on scene:	___/___/_____ ___: ____
EMS depart scene:	___/___/_____ ___: ____	Destination Pre-arrival alert or notification:	___/___/_____ ___: ____
		Method of 1st notification:	O ECG Transmission O Phone call O Radio

Transfers

^Transferred from other ED? O Yes O No	Transferring Facility: _____

Transfer Time Tracker

^Arrival at outside hospital:	___/___/_____ ___: ____	Transport requested:	___/___/_____ ___: ____
Transport Arrived Date/Time:	___/___/_____ ___: ____	Transfer out:	___/___/_____ ___: ____
Mode of transport from outside facility	O Air O Ambulance	Inter-facility transport EMS Agency name/number:	_____

ECG

1st ECG Date/Time: ___/___/_____ ___:	1st ECG obtained:	O Prior to hospital arrival O After first hospital arrival
^STEMI or STEMI Equivalent? O Yes O No		
^If yes, STEMI or STEMI equivalent first noted: O First ECG O Subsequent ECG	If subsequent ECG, Date/Time of positive ECG: ___/___/_____ ___:	

Arrival

Symptom onset Date/Time: ___/___/_____ ___: ____		
Patient first evaluated:	O ED O Cath Lab O Other	If ED, Transfer out Date/Time: ___/___/_____ ___: ____

Hospitalization

Reperfusion

Reperfusion Candidate? O Yes O No

If no, primary reason:	O No ST Elevation/LBBB O MI diagnosis unclear O Other	O Chest pain resolved O MI symptoms >2hrs	O ST elevation resolved O No chest pain

^Thrombolytics? O Yes O No	^If yes, Dose Start Date/Time:	___/___/_____ ___: ____	^Documented non-system reason or delay? O Yes O No If yes, reason (check all that apply) ☐ Cardiac Arrest ☐ Intubation ☐ Patient refusal

^Primary PCI? O Yes O No

PCI Time Tracker

Cath Lab Activation: ___/___/_____ ___: ____	Patient Arrival to Cath Lab: ___/___/_____ ___: ____
Attending Arrival to Cath Lab: ___/___/_____ ___: ____	Team Arrival to Cath Lab: ___/___/_____ ___: ____
^First PCI Date/Time: ___/___/_____ ___: ____	

^PCI Indication	O Primary PCI for STEMI O PCI for STEMI (stable after successful full-dose lytic)	O PCI for STEMI (unstable, >12 hr from sx onset) O Rescue PCI for STEMI (after failed full-dose lytic)	O PCI for STEMI (stable, >12 hr from sx onset) O PCI for NSTEMI O Other
^Non-system reason for delay?	O Difficult vascular access O Cardiac arrest and/or need for intubation	O Patient delays in providing consent O Difficulty crossing the culprit lesion	O Other O None

Reperfusion Contraindications	^Reasons for not performing PCI	O Non-compressible vascular puncture(s) O Active bleeding on arrival or within 24 hours O Quality of life decision O Anatomy not suitable to primary PCI	O Spontaneous reperfusion (documented by cath only) O Patient/family refusal O DNR at time of treatment decision O Prior allergic reaction to IV contrast	O Other O Not performed O No reason documented O Thrombolytic Administered
	^Reasons for not administering lytics	O Known bleeding diathesis O Ischemic stroke w/in 3 months except acute ischemic stroke w/in 3hrs O Recent bleeding within 4 weeks O Any prior intracranial hemorrhage O Suspected aortic dissection	O Recent surgery/trauma O Significant close head or facial trauma within previous 3 months O Active peptic ulcer O Pregnancy O Intracranial neoplasm, AV malformation, or aneurysm O Prior allergic reaction to thrombolytics	O Severe uncontrolled hypertension O DNR at time of treatment decision O Traumatic CPR that precludes thrombolytics O Expected DTB < 90 minutes O No reason documented O Other

Hospitalization

Aspirin within 24 hours of arrival?	O Yes	O No
^Antithrombotic taken in 24hrs prior to arrival?	O Yes	O No
^History of Smoking?	O Yes	O No

^LVF Assessment _____%	Obtained:	O This Admission O W/in the last year O > 1 year ago

Discharge

Discharge Date/Time: ___/___/_____ ___: ____

^Discharge Status:		1 - Home
		2 - Hospice-Home
		3 - Hospice-Healthcare Facility
		4 - Acute Care Facility
		5 – Other Health Care Facility
		6 - Expired
		7 – Left Against Medical Advice/AMA
		8 – Not Documented or Unable to Determine (UTD)
^Smoking Cessation Counseling? **O** Yes **O** No		
^ACEI at discharge	Prescribed	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^ARB at discharge	Prescribed	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^Beta Blocker at discharge	Prescribed	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No
^Statin at discharge	Prescribed	**O** Yes **O** No
	Contraindicated	**O** Yes **O** No