PINNACLE Registry™
Practice INNovation And CLinical Excellence

NCDR® PINNACLE Registry™ Data Collection Form v1.0 (999999)

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** 999999 **Location ID:** 001

Physician Name(Last, First MI): Your Name, MD **Physician NPI:** 1111111111

A. Patient Demographics

Patient Name(Last, First MI): **SSN:** ☐ **Patient new to the Practice**

Date of Birth: mm / dd / yyyy **Sex:** O Male O Female **Patient Zip:**

Race: (Check all that apply)
☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

☐ **Hispanic or Latino Ethnicity**

Insurance Payers: (Check all that apply) **Payer ID:** ___ ___ ___ ___ ___
☐ Private Health Insurance ☐ Medicare (fee for service) ☐ Medicare (managed care) ☐ Medicaid ☐ Military Health Care
☐ State Specific Plan (non-Medicaid) ☐ Indian Health Service ☐ Non-US Insurance ☐ None

B. Diagnoses/Conditions/Co-Morbidities

Note: Indicate if the patient has a history of any of the following.

☐ **Coronary Artery Disease** ☐ **Atrial Fibrillation/Flutter** ☐ **Dyslipidemia** ☐ **Diabetes Mellitus**
☐ **Hypertension** ☐ **Systemic Embolism** ☐ **Peripheral Arterial Disease** ☐ **Prior Stroke/TIA**
☐ **Unstable Angina** ☐ **Heart Failure** → (If Yes), ☐ **New diagnosis** (within 12 months)
☐ **Stable Angina** → (If Yes), ☐ **New diagnosis** (within 12 months)

C. Cardiac Events

Note: Indicate if the patient has a history of any of the following.

☐ **Myocardial Infarction** (any history of) → (If Yes), ☐ **Myocardial Infarction** (within 12 months)
☐ **Coronary Artery Bypass Graft** (within 12 months) ☐ **PCI - Bare Metal Stent Implant** (within 12 months)
☐ **Cardiac Valve Surgery** (within 12 months) ☐ **PCI - Drug Eluting Stent Implant** (within 12 months)
☐ **Heart Transplantation** (within 12 months) ☐ **PCI - Other (non-stent) Intervention** (within 12 months)

D. Encounter Information

Note: Complete only if assessed during today's encounter. If not assessed, leave blank.

Height: _____ O in O cm **Blood Pressure:** _____ / _____ mmHg **Heart Rate:** _____ bpm

Weight: _____ O lbs O kg ☐ **Patient unable to be weighed**

Tobacco Use: O Never O Current O Quit within past 12 months O Quit more than 12 months ago
→ If Current or Quit within 12 months, ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
→ If Current or Quit within 12 months, **Smoking Cessation Counseling:** O No O Yes

☐ **Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco**

Advance Care Plan OR Discussion of Advance Care Plan Documented: O No O Yes

Angina Symptoms and Activity Assessment(s)

CAD

CCS Class: O No angina O I O II O III O IV
☐ **Seattle Angina Questionnaire Completed**
☐ **Other Tool/Method Used to Assess Angina Symptoms and Activity Completed**

Heart Failure Activity Assessment(s)

HF

NYHA Class: O I O II O III O IV
☐ **Kansas City Cardiomyopathy Questionnaire Completed**
☐ **Minnesota Living with HF Questionnaire Completed**
☐ **Chronic Heart Failure Questionnaire from Guyatt Completed**
☐ **Other Tool/Method Used to Assess Heart Failure Activity Completed**

Heart Failure Symptoms Assessment(s)

HF

Dyspnea Present: O No O Yes **Orthopnea Present:** O No O Yes

Heart Failure Physical Assessment(s)

HF

Rales Present: O No O Yes **Peripheral Edema Present:** O No O Yes **S_3 Gallop Present:** O No O Yes
Ascites Present: O No O Yes **Hepatomegaly Present:** O No O Yes **S_4 Gallop Present:** O No O Yes
Jugular Venous Distention Present: O No O Yes

Plan of Care

HTN

Hypertension plan of care documented: O No O Yes **Note:** Required for patients that have been diagnosed with Hypertension.

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CAD

Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months:

Note: Cardiac event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, CABG, PCI or new Stable Angina diagnosis.

O Yes–Referral/Plan Documented
O No Qualifying Event/Diagnosis
O Patient Already Participating in Rehab
O No Referral/Plan – Medical Reason
O No Referral/Plan – Patient Reason
O No Referral/Plan – System Reason

HF

☐ **HF Education Completed/Documented**

→ If Yes, **HF Education** (Check all that apply)**:**

☐ All of the following
☐ Weight Monitoring
☐ Diet (Sodium Restriction)
☐ Symptom Management
☐ Physical Activity
☐ Smoking Cessation
☐ Medication Instruction
☐ Minimizing or Avoiding use of NSAIDs
☐ Prognosis/end-of-life Issues
☐ Referral for visiting nurse or specific educational or management programs

ATRIAL FIBRILLATION/FLUTTER ASSESSMENT AND TREATMENT

AFib

AFib/Flutter Duration: O First episode detected O Chronic – paroxysmal O Chronic – persistent/permanent

AFib/Flutter Type: O Non-Valvular O Valvular

→ If Non-Valvular, **Etiology** (Check all that apply)**:** ☐ Transient/reversible cause (e.g., pneumonia, hyperthyroidism)
☐ Cardiac surgery within past 3 months
☐ Pregnancy

All Thromboembolic Risk Factors Assessed:
O Yes (All risk factors assessed)
O No – Medical Reason
O No – Patient Reason
O No – System Reason

Note: Thromboembolic risk factors include all of the following: 1.) Prior Stroke/TIA, 2.) Age ≥75, 3.) Hypertension, 4.) Diabetes Mellitus, 5.) HF or LVSD.

E. LABORATORY RESULTS

Note: Enter **most recent** lab results and/or indicate the labs ordered during this encounter.

CAD/HF

LVEF Assessed Date: mm / dd / yyyy (most recent)

LVEF: _____ **%** **- OR -**

Note: If a LVEF range is documented, take the average, round up and refer to the **LVEF Status** ranges (right) to code.

LV Qualitative Assessment:
O Normal: ≥ 50
O Mildly reduced: 40 – 49
O Moderately reduced: 26 – 39
O Severely reduced: ≤ 25

CAD

Lipid Panel Obtained Date: mm / dd / yyyy ☐ **Fasting**

Total Cholesterol: _____ mg/dL

High Density Lipoprotein (HDL): _____ mg/dL

Low Density Lipoprotein (LDL): _____ mg/dL

Triglycerides: _____ mg/dL

☐ **Lipid Panel Ordered**

☐ **Serum Glucose Ordered** (If not known Diabetic)

Glucose Date: mm / dd / yyyy **Glucose:** _____ mg/dL

Glucose timing: O Fasting O 2hr-post prandial O Random O Unknown

HbA1c Date: mm / dd / yyyy **HbA1c**: _____ %

HF

☐ **Initial Labs ordered for newly diagnosed Heart Failure** (within past 12 months) **or patient new to the practice**

Note: Initial labs for HF include Serum Electrolytes (including Ca+ and Mg+), CBC, U/A, TSH, Liver Function tests, BUN, Creatinine and Glucose.

F. MEDICATIONS

Note: If no documentation exists as to if a medication was prescribed/continued, then leave blank.

Medication Considerations					Indicate prescribed/continued medications or reason not prescribed.			
CAD	HF	AFib	HTN	Medication	Yes (Prescribed)	No (Medical Reason)	No (Patient Reason)	No (System Reason)
√	√		√	ACE Inhibitor	O	O	O	O
√				ADP ANTAGONISTS: Clopidogrel	O	O	O	O
				ADP ANTAGONISTS: Ticlopidine	O	O	O	O
				ADP ANTAGONISTS: Prasugrel	O	O	O	O
√				Aggrenox	O	O	O	O
√	√		√	ARB	O	O	O	O
√	√	√	√	Aspirin	O	O	O	O
√	√		√	Beta Blocker	O	O	O	O
			√	Calcium Channel Blockers	O	O	O	O
	√		√	Diuretics	O	O	O	O
√				Lipid Lowering Non-Statin	O	O	O	O
√				Lipid Lowering Statin	O	O	O	O
		√		Warfarin	O	O	O	O