

Patient ID:				Bold Question = Required
DEMOGRAPHICS				<i>Demographics Tab</i>
Sex	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown			
Date of Birth:	____/____/____	Age:	_____	
Zip Code:	_____ - _____	Homeless:	<input type="checkbox"/>	
Payment Source	<input type="checkbox"/> Medicare Title 18 <input type="checkbox"/> Medicaid Title 19 <input type="checkbox"/> Medicare – Private/ HMO/ PPO/ Other <input type="checkbox"/> Medicaid – Private/ HMO/ PPO/ Other <input type="checkbox"/> Private/ HMO/ PPO/ Other <input type="checkbox"/> Other <input type="checkbox"/> Self Pay/ No Insurance <input type="checkbox"/> Other/ Not Documented/ UTD <input type="checkbox"/> VA/ CHAMPVA/ Tricare			
RACE AND ETHNICITY				
Race (Select all that apply):	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian [if Asian selected] <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander [if native Hawaiian or pacific islander selected] <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> UTD			
Hispanic Ethnicity:	<input type="radio"/> Yes <input type="radio"/> No/UTD			
If Yes,	<input type="radio"/> Another Hispanic, Latino or Spanish Origin <input type="radio"/> Mexican, Mexican American, Chicano/a <input type="radio"/> Cuban <input type="radio"/> Puerto Rican			
ADMIN				<i>Admin Tab</i>
Arrival Date/Time:	____/____/____:____	<input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown	Admission Date:	____/____/____
Discharge Date/Time:	____/____/____:____	<input type="checkbox"/> MM/DD/YYYY only		
What was the patient's discharge disposition on the day of discharge?	<input type="checkbox"/> 1 – Home <input type="checkbox"/> 2 – Hospice – Home <input type="checkbox"/> 3 – Hospice – Health Care Facility <input type="checkbox"/> 4 – Acute Care Facility <input type="checkbox"/> 5 – Other Health Care Facility <input type="checkbox"/> 6 – Expired <input type="checkbox"/> 7 – Left Against medical Advice / AMA <input type="checkbox"/> 8 – Not Documented or Unable to Determine (UTD)			
If Other Health Care Facility	<input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Intermediate Care facility (ICF) <input type="radio"/> Other <input type="radio"/> Long Term Care Hospital (LTCH)			
ARRIVAL AND ADMISSION INFORMATION				<i>Admission Tab</i>
Means of Transport to your Facility:	<input type="radio"/> Air <input type="radio"/> Ambulance <input type="radio"/> Transfer from another hospital <input type="radio"/> Walk-In <input type="radio"/> ND or Unknown			
MEDICAL HISTORY				

Past Medical History:	<input type="checkbox"/> No Medical History <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebrovascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Currently on Dialysis <input type="checkbox"/> DVT <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> eCigarette (vaping) <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Immune disorders <input type="checkbox"/> HIV <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Peripheral Artery Disease	<input type="checkbox"/> Prior CABG <input type="checkbox"/> Prior MI <input type="checkbox"/> Prior PCI <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Pulmonary disease <input type="checkbox"/> COPD <input type="checkbox"/> Interstitial lung Disease (ILD) <input type="checkbox"/> Asthma <input type="checkbox"/> Other <input type="checkbox"/> Smoking
DIAGNOSIS & EVALUATION			
COVID-19 Diagnosis	<input type="radio"/> Yes, prior to admission <input type="radio"/> Yes, after discharge <input type="radio"/> Yes, during hospitalization <input type="radio"/> Unknown/ND		
Method of diagnosis:	<input type="radio"/> Clinical diagnosis using hospital specific criteria <input type="radio"/> RT-PCR Test		
Date of dx	_____ / _____ / _____ <input type="checkbox"/> Unknown		
Date of COVID-19 symptom onset?	_____ / _____ / _____ <input type="checkbox"/> Unknown		
Documented Symptoms	<input type="checkbox"/> Confusion or Altered Mental Status <input type="checkbox"/> Myalgia <input type="checkbox"/> Cough <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Fatigue <input type="checkbox"/> Nausea, Vomiting, or Diarrhea <input type="checkbox"/> Fever/ Chills <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Headache <input type="checkbox"/> Sore Throat <input type="checkbox"/> Loss of Sense of Smell/ Taste <input type="checkbox"/> Other: _____ <input type="checkbox"/> Headache <input type="checkbox"/> Not Documented		
Presence of interstitial infiltrates on initial Chest X-ray or CT	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND		
During admission, was this patient enrolled in a clinical trial related to COVID-19?	<input type="radio"/> Yes <input type="radio"/> No/ND		
MEDICATION PRIOR TO ADMISSION			
Medications prescribed or taking at time of admission:			
Anti-hypertensive	<input type="radio"/> Yes <input type="radio"/> No/ND		
Anti-hypertensive Tx (Select all that apply)	<input type="checkbox"/> Ace Inhibitors <input type="checkbox"/> CA++ Channel Blockers <input type="checkbox"/> ARB <input type="checkbox"/> Diuretics <input type="checkbox"/> ARNI <input type="checkbox"/> MRA <input type="checkbox"/> Beta Blockers <input type="checkbox"/> Other anti-hypertensive med		
ACEI administered during hospitalization	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND		
ARB administered during hospitalization	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> ND		
Lipid Lowering Therapy	<input type="radio"/> Yes <input type="radio"/> No/ND		
Lipid lowering therapy (Select all that apply)	<input type="checkbox"/> Ezetimibe <input type="checkbox"/> Statin <input type="checkbox"/> PCSK 9 Inhibitor <input type="checkbox"/> Other lipid lowering med		
Antiplatelet	<input type="radio"/> Yes <input type="radio"/> No/ND		
Antiplatelet Tx (Select all that apply)	<input type="checkbox"/> Aspirin <input type="checkbox"/> Other Antiplatelet <input type="checkbox"/> P2Y12 Inhibitors		
Anticoagulant	<input type="radio"/> Yes <input type="radio"/> No/ND		

Anticoagulant Tx (Select all that apply)	<input type="checkbox"/> Direct Thrombin Inhibitor <input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Warfarin <input type="checkbox"/> Other Anticoagulant
Anti-hyperglycemic	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> GLP-1 Receptor Agonist <input type="checkbox"/> Insulin <input type="checkbox"/> Metformin <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> Other Injectable/ Subcutaneous Agent <input type="checkbox"/> Other Oral Agents
Corticosteroid	<input type="radio"/> Inhaled <input type="radio"/> Oral <input type="radio"/> None/ND
Immunosuppressive medications (other than steroids)	<input type="radio"/> Yes <input type="radio"/> No/ND
Chemo or biological treatment for cancer	<input type="radio"/> Yes <input type="radio"/> No/ND
Hydroxychloroquine	<input type="radio"/> Yes <input type="radio"/> No/ND

HOSPITALIZATION *Hospitalization Tab*

During this admission: If multiple events, record Date/Time of first episode.

Documentation of Presenting EKG Rhythm QTC Value _____ ms EKG abnormalities	<input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Atrial Fibrillation <input type="radio"/> Atrial Flutter <input type="radio"/> Sinus <input type="radio"/> Other <input type="radio"/> Not Documented <input type="checkbox"/> None <input type="checkbox"/> Right Bundle Branch Block <input type="checkbox"/> ST-Segment Elevation <input type="checkbox"/> Left Bundle Branch Block <input type="checkbox"/> ST-Segment Depression <input type="checkbox"/> Not Documented
Sustained ventricular arrhythmias Date/Time of sustained ventricular arrhythmia	<input type="radio"/> Yes <input type="radio"/> No/ND ____/____/____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
Atrial Fibrillation Date/Time of A-Fib	<input type="radio"/> Yes <input type="radio"/> No/ND ____/____/____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
Heart block requiring a temporary or permanent pacemaker Date/Time of HB intervention	<input type="radio"/> Yes <input type="radio"/> No/ND ____/____/____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
Acute Myocardial Infarction (AMI): STEMI reperfusion NSTEMI type Date/time of AMI	<input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="radio"/> No/ND <input type="radio"/> Fibrinolytic Therapy <input type="radio"/> Primary PCI <input type="radio"/> No reperfusion therapy <input type="radio"/> Type 1 MI <input type="radio"/> Type 2 (demand-related) MI <input type="radio"/> ND ____/____/____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
Percutaneous Coronary Intervention (PCI) Date/Time of PCI	<input type="radio"/> Yes <input type="radio"/> No/ND ____/____/____ : ____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
LVEF assessment: Date of LVEF assessment EF – Quantitative (%)	<input type="radio"/> Yes <input type="radio"/> No/ND ____/____/____ <input type="radio"/> Unknown _____% <input type="radio"/> Not Documented
Is there documentation of	<input type="radio"/> Yes <input type="radio"/> No/ND

an LVEF assessment within the last year? Last Known EF _____ % <input type="radio"/> Not Documented
Coronary Angiogram Angiogram type <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> CTA <input type="radio"/> Invasive (cath) <input type="radio"/> ND Number of vessels with ≥ 50% stenosis <input type="radio"/> 0 <input type="radio"/> 2 <input type="radio"/> Left main CAD <input type="radio"/> 1 <input type="radio"/> ≥3 <input type="radio"/> Not Documented Date/Time of cardiac angiogram _____/_____/_____:____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
In-hospital Shock Shock type <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Cardiogenic <input type="radio"/> Mixed <input type="radio"/> Distributive (e.g. Sepsis) <input type="radio"/> Other/Unknown Shock Management (select all that apply) <input type="checkbox"/> IABP <input type="checkbox"/> V-A ECMO <input type="checkbox"/> Impella or other PVAD <input type="checkbox"/> V-V ECMO <input type="checkbox"/> Inotropes/Vasopressors Date/Time of mechanical circulatory support _____/_____/_____:____ <input type="radio"/> MM/DD/YYYY only <input type="radio"/> Unknown
New-onset heart failure Specify HF: <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Systolic (HFrEF) <input type="radio"/> Diastolic (HFpEF) Date of HF _____/_____/_____ <input type="radio"/> Unknown
Myocarditis Diagnostic test <input type="radio"/> Yes <input type="radio"/> No/ND <input type="checkbox"/> Cardiac biopsy <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Clinical diagnosis Date of Myocarditis _____/_____/_____ <input type="radio"/> Unknown
Deep Vein Thrombosis (DVT) Date of DVT diagnosis _____/_____/_____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Unknown
Pulmonary Embolus (PE) Date of PE diagnosis _____/_____/_____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Unknown
Intracardiac Thrombus Date of Intracardiac thrombus diagnosis _____/_____/_____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Unknown
Clinical bleeding requiring transfusion Date of transfusion _____/_____/_____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Unknown
New Hemodialysis or CRRT Date of New hemodialysis _____/_____/_____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Unknown
Ischemic stroke / intracranial hemorrhage Initial NIH Stroke Scale _____ <input type="radio"/> Yes <input type="radio"/> No/ND <input type="radio"/> Not Documented Imaging <input type="radio"/> CT <input type="radio"/> MRI <input type="radio"/> Not Documented Imaging shows acute stroke? <input type="radio"/> Yes <input type="radio"/> No/ND Stroke treatment <input type="radio"/> Thrombolysis <input type="radio"/> Thrombectomy <input type="radio"/> None/ND

Stroke or intracranial hemorrhage type:	<input type="checkbox"/> Cerebral Venous Sinus Thrombosis <input type="checkbox"/> Subarachnoid Hemorrhage <input type="checkbox"/> Intracerebral Hemorrhage <input type="checkbox"/> Subdural/ Epidural Hemorrhage <input type="checkbox"/> Ischemic Stroke <input type="checkbox"/> Transient Ischemic Attack (TIA) <input type="checkbox"/> Stroke Not Otherwise Specified <input type="checkbox"/> Not Documented						
Date of stroke diagnosis	____/____/____		○ Unknown				
Seizure	○ Yes ○ No/ND						
Date of seizure	____/____/____		○ Unknown				
Cardiac Arrest (Code Blue, CPR)	○ Yes ○ No/ND						
First documented pulseless rhythm	<input type="checkbox"/> Asystole <input type="checkbox"/> Pulseless Electrical Activity (PEA) <input type="checkbox"/> Pulseless Ventricular Tachycardia (VT)		<input type="checkbox"/> Ventricular Fibrillation (VF) <input type="checkbox"/> Unknown/ND				
Date/Time of cardiac arrest	____/____/____ : ____		○ MM/DD/YYYY only ○ Unknown				
Cause of death documented	○ Yes ○ No/ND						
Cause of death:	<input type="checkbox"/> AMI <input type="checkbox"/> Respiratory <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Stroke <input type="checkbox"/> HF <input type="checkbox"/> Other						
Date of death	____/____/____		○ Unknown				
PULMONARY / CRITICAL CARE							
Was this patient managed in an ICU	○ Yes ○ No/ND						
Date Transferred to ICU	____/____/____		○ Unknown				
During this hospitalization was the patient intubated or placed on mechanical ventilation?	○ Yes ○ No/ND						
Date mechanical ventilation initiated	____/____/____		○ Unknown				
Date mechanical ventilation terminated	____/____/____		○ Unknown				
Was V-V ECMO performed	○ Yes ○ No/ND						
Date V-V ECMO initiated	____/____/____		○ Unknown				
Date V-V ECMO terminated	____/____/____		○ Unknown				
VITALS (Admission)							
Height	____	○ In ○ cm	<input type="checkbox"/> ND	Weight (Admission)	____	○ lbs ○ kgs	<input type="checkbox"/> ND
Temperature:	<input type="checkbox"/> C <input type="checkbox"/> F	Heart Rate:	____ bpm <input type="checkbox"/> HR ND	Blood Pressure:	____/____ <input type="checkbox"/> BP ND	Respiratory Rate:	____ bpm <input type="checkbox"/> RR ND
<input type="checkbox"/> Temp ND						SAO2:	____ % <input type="checkbox"/> SAO2 ND ○ Room air ○ Supplemental O2 ○ Unknown
ADMISSION LABS					Admission Labs Tab		
Labs (Closest to Admission):	Hemoglobin:	____	○ g/dL ○ g/L	○ Unavailable			
	WBC	____	○ K/uL ○ mCL	○ Unavailable			
	Platelet:	____	○ K/uL	○ Unavailable			
	Absolute lymphocyte count:	____	○ X10 ⁹	○ Unavailable			
	Serum Creatinine (SCR)	____	○ mg/dL ○ μmol/L	○ Unavailable			

AST	_____	<input type="radio"/> u/L	<input type="radio"/> Unavailable
ALT	_____	<input type="radio"/> u/L	<input type="radio"/> Unavailable
Total Bilirubin	_____	<input type="radio"/> mg/dL	<input type="radio"/> Unavailable
Bicarbonate	_____	<input type="radio"/> mEq/l <input type="radio"/> mmol/L	<input type="radio"/> Unavailable
Troponin	_____	<input type="radio"/> ng/mL <input type="radio"/> ug/L	<input type="radio"/> Unavailable
NT-proBNP	_____	<input type="radio"/> pg/mL <input type="radio"/> ng/L	<input type="radio"/> Unavailable
BNP	_____	<input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L	<input type="radio"/> Unavailable
Ferritin	_____	<input type="radio"/> ng/mL	<input type="radio"/> Unavailable
CRP	_____	<input type="radio"/> mg/L <input type="radio"/> ng/L	<input type="radio"/> Unavailable
IL6	_____	<input type="radio"/> pg/mL <input type="radio"/> ng/mL	<input type="radio"/> Unavailable
D-dimer	_____	<input type="radio"/> ng/mL <input type="radio"/> μ/mL	<input type="radio"/> Unavailable
Procalcitonin	_____	<input type="radio"/> μg/L <input type="radio"/> ng/mL	<input type="radio"/> Unavailable
Hemoglobin A1C	_____	<input type="radio"/> %	<input type="radio"/> Unavailable

SERIAL LABS

Serial Labs Tab

Enter the date and the first reported lab value for the corresponding labs in the medical record, if available. Click “Add Instance” to enter lab values for subsequent days of the hospitalization. Serial Labs should be collected for each day of hospitalization.

Select if serial labs were NOT performed on this patient:	<input type="checkbox"/>
Date:	____ / ____ / ____
Troponin	_____ <input type="radio"/> ng/mL <input type="radio"/> ug/L
NT-proBNP	_____ <input type="radio"/> pg/mL <input type="radio"/> ng/L
BNP	_____ <input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L
Ferritin	_____ <input type="radio"/> ng/mL
CRP	_____ <input type="radio"/> mg/L <input type="radio"/> ng/L
Absolute Lymphocyte count	_____ <input type="radio"/> X10 ⁹
Procalcitonin	_____ <input type="radio"/> μg/L <input type="radio"/> ng/mL
IL6	_____ <input type="radio"/> pg/mL <input type="radio"/> ng/mL
Serum Creatinine (SCr)	_____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L
D-dimer	_____ <input type="radio"/> ng/mL <input type="radio"/> μ/mL

MEDICATIONS

Medications Tab

During this hospitalization, was the patient treated with any of the following medications? (Enter Date of first administration)

Glucocorticoids	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Date: Glucocorticoids	____ / ____ / ____ <input type="checkbox"/> Unknown
Anticoagulation for DVT prophylaxis/treatment	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC
Anticoagulant type (DVT)	<input type="radio"/> Full Dose DOAC <input type="radio"/> SCD <input type="radio"/> Full Dose Enoxaparin <input type="radio"/> Sub-Q Unfractionated Heparin <input type="radio"/> Low Dose DOAC <input type="radio"/> Not Documented <input type="radio"/> Low Dose Enoxaparin

	Date: Anticoagulation	___/___/___	<input type="checkbox"/> Unknown
Immunoglobulins		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Immunoglobulins	___/___/___	<input type="checkbox"/> Unknown
Convalescent serum		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Convalescent serum	___/___/___	<input type="checkbox"/> Unknown
Ritonavir/lopinavir		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Ritonavir/lopinavir	___/___/___	<input type="checkbox"/> Unknown
Hydroxychloroquine		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Hydroxychloroquine	___/___/___	<input type="checkbox"/> Unknown
Azithromycin		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Azithromycin	___/___/___	<input type="checkbox"/> Unknown
Remdesivir		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Remdesivir	___/___/___	<input type="checkbox"/> Unknown
Tocilizumab		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NC	
	Date: Tocilizumab	___/___/___	<input type="checkbox"/> Unknown
Other 1 (not listed):		_____	
	Date: Other 1	___/___/___	<input type="checkbox"/> Unknown
Other 2 (not listed):		_____	
	Date: Other 2	___/___/___	<input type="checkbox"/> Unknown
Other 3 (not listed):		_____	
	Date: Other 3	___/___/___	<input type="checkbox"/> Unknown