

APPENDIX F: CASE REPORT FORM

NATIONAL CARDIOVASCULAR DISEASE DATABASE (NCVD) NOTIFICATION FORM

For NCVD Use only:

ID: / Centre:

Instruction: Complete this form to notify all ACS admissions at your centre to National Cardiovascular Disease Registry. Where check boxes are provided, check (✓) one or more boxes. Where radio buttons are provided, check (✓) one box only.

A. Reporting centre: _____

B. Date of Admission (dd/mm/yy):

SECTION 1 : DEMOGRAPHICS

1. Patient Name :			2. Local RN No (if applicable):		
3. Identification Card Number :	MyKad / MyKid:	<input type="text"/> - <input type="text"/> - <input type="text"/>	Old IC:	<input type="text"/>	
	Other ID document No:	<input type="text"/>	Specify type (eg. passport, armed force ID):	<input type="text"/>	
4. Gender:	<input type="radio"/> Male <input type="radio"/> Female				
5a. Date of Birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	5b. Age on admission:	<input type="text"/>	Auto Calculated	
6. Ethnic Group:	<input type="radio"/> Malay	<input type="radio"/> Orang Asli	<input type="radio"/> Murut	<input type="radio"/> Iban	
	<input type="radio"/> Chinese	<input type="radio"/> Kadazan	<input type="radio"/> Bajau	<input type="radio"/> Other M'sian, specify :
	<input type="radio"/> Indian	<input type="radio"/> Melanau	<input type="radio"/> Bidayuh	<input type="radio"/> Foreigner, specify country of origin:
7. Contact Number	(1): <input type="text"/>	(2): <input type="text"/>			

SECTION 2 : STATUS BEFORE EVENT

1. Smoking Status:	<input type="radio"/> Never <input type="radio"/> Former (quit >30 days) <input type="radio"/> Current (any tobacco use within last 30 days)				
2. Status of Aspirin Use:	<input type="radio"/> None <input type="radio"/> Used less than 7 days previously <input type="radio"/> Used more than or equal to 7 days previously				
3. Premorbid or past medical history :					
a) Dyslipidaemia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	h) New onset angina (Less than 2 weeks)		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
b) Hypertension	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	i) Heart failure		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
c) Diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	j) Chronic lung disease		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
d) Family history of premature cardiovascular disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	k) Renal disease		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
e) Myocardial infarction history	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	l) Cerebrovascular disease		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
f) Documented CAD > 50% stenosis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	m) Peripheral vascular disease		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
g) Chronic Angina (onset more than 2 weeks ago)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	n) None of the above		<input type="checkbox"/>	

SECTION 3 : ONSET

1a. Date of onset of ACS symptoms:	<input type="text"/> / <input type="text"/> / <input type="text"/>	1b. Time of onset of ACS symptoms:	<input type="text"/> : <input type="text"/> (24hr) <input type="checkbox"/> Not available
2a. Date Patient presented :	<input type="text"/> / <input type="text"/> / <input type="text"/>	2b. Time Patient presented :	<input type="text"/> : <input type="text"/> (24hr) <input type="checkbox"/> Not available
3. Was patient transferred from another centre?	<input type="radio"/> Yes <input type="radio"/> No		

SECTION 4 : CLINICAL PRESENTATION & EXAMINATION

1. Number of distinct episodes of angina in past 24 hours:	<input type="checkbox"/> Not available				
2. Heart rate at presentation:	<input type="text"/> (beats / min)				
3. Blood pressure at presentation:	a. Systolic:	<input type="text"/> (mmHg)	b. Diastolic:	<input type="text"/> (mmHg)	
4. Anthropometric :	a. Height:	<input type="text"/> (cm)	<input type="checkbox"/> Not available	BMI:	<input type="text"/> Auto Calculated
	b. Weight:	<input type="text"/> (kg)	<input type="checkbox"/> Not available		
	c. Waist Circumference:	<input type="text"/> (cm)	<input type="checkbox"/> Not available	WHR:	<input type="text"/> Auto Calculated
	d. Hip Circumference:	<input type="text"/> (cm)	<input type="checkbox"/> Not available		
5. Kilip classification code :	<input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> Not stated / inadequately described				

SECTION 5 : ELECTROCARDIOGRAPHY (ECG)

1. ECG abnormalities type (Check one or more boxes)	<input type="checkbox"/> ST-segment elevation \geq 1mm (0.1 mV) in \geq 2 contiguous limb leads	<input type="checkbox"/> Bundle branch block (BBB)
	<input type="checkbox"/> ST-segment elevation \geq 2mm (0.2 mV) in \geq 2 contiguous frontal leads or chest leads	<input type="checkbox"/> Non-specific
	<input type="checkbox"/> ST-segment depression \geq 0.5mm (0.05 mV) in \geq 2 contiguous leads	<input type="checkbox"/> None
	<input type="checkbox"/> T-wave inversion \geq 1mm (0.1 mV)	<input type="checkbox"/> Not stated / inadequately described
2. ECG abnormalities location : (Check one or more boxes)	<input type="checkbox"/> Inferior leads: II, III, aVF	<input type="checkbox"/> Right ventricle: ST elevation in lead V4R
	<input type="checkbox"/> Anterior leads: V1 to V4	<input type="checkbox"/> None
	<input type="checkbox"/> Lateral leads: I, aVL, V5 to V6	<input type="checkbox"/> Not stated / inadequately described
	<input type="checkbox"/> True posterior: V1 V2	

a. Patient Name :		b. Local RN No (if applicable):	
c. Identification Card Number :			

SECTION 6 : BASELINE INVESTIGATIONS (Values obtained within 48 hours from admission)

	Absolute values	Unit	Reference upper limits	Check (✓) if not done
1. Peak CK-MB		Unit/L		<input type="radio"/> Not done
2. Peak CK		Unit/L		<input type="radio"/> Not done
3. Peak Troponin:	a. T n T:	<input type="radio"/> +ve <input type="radio"/> -ve OR <input type="text"/>	ng/mL or mcg/L	<input type="radio"/> Not done
	b. T n I:	<input type="radio"/> +ve <input type="radio"/> -ve OR <input type="text"/>	ng/mL or mcg/L	<input type="radio"/> Not done
4. Lipid profile (Fasting):	a. Total cholesterol:		mmol/L	<input type="radio"/> Not done
	b. HDL-C:		mmol/L	<input type="radio"/> Not done
	c. LDL-C:		mmol/L	<input type="radio"/> Not done
	d. Triglycerides:		mmol/L	<input type="radio"/> Not done
5. Fasting Blood Glucose:		mmol/L		<input type="radio"/> Not done
6. Left Ventricular Ejection Fraction:		%		<input type="radio"/> Not done

SECTION 7 : CLINICAL DIAGNOSIS AT ADMISSION

1. Acute coronary syndrome stratum:	<input type="radio"/> STEMI	<input type="radio"/> NSTEMI	<input type="radio"/> UA
2a. TIMI risk score UAP / NSTEMI:	<input type="text"/>	Auto Calculated	2b. TIMI risk score STEMI: <input type="text"/>
			Auto Calculated

SECTION 8 : FIBRINOLYTIC THERAPY (Following Section is applicable for STEMI only)

1. Fibrinolytic therapy status :	<input type="radio"/> Given at this centre → (Please proceed to 2, 3, 4 below) <input type="radio"/> Given at another centre prior to transfer here <input type="radio"/> Not given-proceeded directly to primary angioplasty <input type="radio"/> Not given-Missed thrombolysis <input type="radio"/> Not given-patient refusal <input type="radio"/> Not given- Contraindicated		
Fill in (2), (3), (4) only if you check 'Given at this centre' in (1) above	2. Fibrinolytic drug used:	<input type="radio"/> Streptokinase <input type="radio"/> Others (t-PA, r-PA, TNK t-PA)	
	3. Intravenous fibrinolytic therapy :	a. Date: <input type="text"/>	b. Time: <input type="text"/> (24hr)
	4. Door to needle time:	<input type="text"/> (mins) Auto Calculated - (time pt presented to time of intravenous fb ty)	

SECTION 9 : INVASIVE THERAPEUTIC PROCEDURES

1. Did patient undergo cardiac catheterization on this admission at your centre?	<input type="radio"/> No <input type="radio"/> No - Transferred to another centre <input type="radio"/> Yes
2. Did patient undergo percutaneous coronary intervention on this admission? (If No or Not Applicable, Please skip 5, 6 & 7b below)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable <input type="radio"/> a. For STEMI → <input type="radio"/> Urgent → <input type="radio"/> Primary PCI <input type="radio"/> Rescue PCI <input type="radio"/> Facilitated PCI <input type="radio"/> Elective → Routine hospital practice? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> b. For NSTEMI / UA → <input type="radio"/> Urgent <input type="radio"/> Elective → Routine hospital practice? <input type="radio"/> Yes <input type="radio"/> No
3a. Number of diseased vessels:	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
3b. Left Main Stem involvement:	<input type="radio"/> Yes <input type="radio"/> No
4. Culprit artery:	<input type="radio"/> LAD <input type="radio"/> LCx <input type="radio"/> RCA <input type="radio"/> LM <input type="radio"/> Bypass Graft
5. First balloon inflation: (for STEMI - Urgent PCI only)	a. Date: <input type="text"/> b. Time: <input type="text"/> (24hr)
6. Door to balloon time (mins): (for STEMI - Urgent PCI only)	<input type="text"/> Auto Calculated - (time pt presented to time of first angio balloon inflation)
7a(i). TIMI flow classification pre-PCI:	<input type="radio"/> 0 <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III
7a(ii). Intra-coronary Thrombus present?	<input type="radio"/> Yes <input type="radio"/> No
7b. TIMI flow classification post-PCI:	<input type="radio"/> 0 <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III
8. PCI type:	<input type="radio"/> Angioplasty <input type="radio"/> Stenting → a) <input type="checkbox"/> Direct stenting b) <input type="checkbox"/> Pre-dilatation done c) <input type="checkbox"/> Stent type: 'Drug-eluting' d) <input type="checkbox"/> Stent type: 'Bare-metal'
9. Did patient undergo CABG on this admission?	<input type="radio"/> Yes → a. Date of CABG: <input type="text"/> <input type="radio"/> No

a. Patient Name :		b. Local RN No (if applicable):	
c. Identification Card Number :			

SECTION 10 : PHARMACOLOGICAL THERAPY *(used / given during admission)*

Group	Given pre admission	Given during admission	Given after discharge
1. ASA	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. ADP antagonist	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. GP receptor inhibitor	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
4. Unfrac Heparin	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
5. LMWH	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
6. Beta blocker	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
7. ACE Inhibitor	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8. Angiotensin II receptor blocker	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. Statin	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
10. Other lipid lowering agent	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
11. Diuretics	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
12. Calcium antagonist	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
13. Oral Hypoglycaemic agent	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
14. Insulin	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
15. Anti-arrhythmic agent	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

SECTION 11 : IN-HOSPITAL CLINICAL OUTCOMES

1. Number of overnight stays	a. CCU		days
	b. ICU / CICU:		days
2. Outcome:	<input type="radio"/> Discharged a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Total number of overnight stays: <input type="text"/> Auto Calculated		
	<input type="radio"/> Transferred to another centre a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Name of Centre : <input type="text"/>		
	<input type="radio"/> Died a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Cause of Death : <input type="radio"/> Cardiovascular <input type="radio"/> Non Cardiovascular <input type="radio"/> Other,specify : _____		
3. Final diagnosis at discharge:	<input type="radio"/> Q wave MI <input type="radio"/> non-Q wave MI <input type="radio"/> Unstable angina <input type="radio"/> Stable angina <input type="radio"/> Non-cardiac		
4. Bleeding Complication (TIMI Criteria):	<input type="radio"/> Major <input type="radio"/> Minor <input type="radio"/> None <input type="radio"/> Not stated / Inadequately described		

NATIONAL CARDIOVASCULAR DISEASE DATABASE FOLLOW UP FORM AT 30 DAYS

For NCVD Use only:
 ID: /
 Centre:

Instruction: This form is to be completed at patient follow-up 30 days (+ 2 weeks) after admission. Following may be performed by clinic visit or telephone interview.

Where check boxes are provided, check (✓) one or more boxes. Where radio button are provided, check (✓) one box only.

A. Name of reporting centre:

B. Patient Name :

C. Identification Card Number : MyKad / MyKid: - - Old IC:

Other ID document No: Specify type (eg.passport, armed force ID):

D. Date of Follow up Notification: (dd/mm/yy)

SECTION 1: OUTCOME

1. Outcome:	1. Alive <input type="checkbox"/>	
	2. Died <input type="checkbox"/>	a. Date of death: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy) b. Cause of Death: <input type="radio"/> Cardiovascular <input type="radio"/> Non Cardiovascular <input type="radio"/> Other,specify : _____
	3. Transferred to another centre : <input type="checkbox"/>	a. Date of last follow-up: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy) b. Name of Centre : <input style="width: 100%;" type="text"/>
	4. Lost to Follow up: <input type="checkbox"/>	a. Date of last follow-up: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)
2. Cardiovascular readmission:	1. ACS <input type="checkbox"/>	a. Date : <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy) b. ACS Stratum: <input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="radio"/> UA
	2. Heart failure <input type="checkbox"/>	a. Date : <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)
	3. Revascularization <input type="checkbox"/>	a. Date : <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy) b. Type of Revascularization : <input type="checkbox"/> 1. PCI → <input type="radio"/> Urgent <input type="radio"/> Elective <input type="checkbox"/> 2. CABG → <input type="radio"/> Urgent <input type="radio"/> Elective
	4. Stroke <input type="checkbox"/>	a. Date : <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)

SECTION 2: CLINICAL HISTORY AND EXAMINATION (OPTIONAL)

1. Angina Status: (CCS classification)	<input type="radio"/> None	<input type="radio"/> Class I	<input type="radio"/> Class II	<input type="radio"/> Class III	<input type="radio"/> Class IV
2. Functional capacity: (NYHA classification)	<input type="radio"/> None	<input type="radio"/> NYHA I	<input type="radio"/> NYHA II	<input type="radio"/> NYHA III	<input type="radio"/> NYHA IV
3. BP	a. Systolic:	<input style="width: 50px;" type="text"/>	mmHg	b. Diastolic:	<input style="width: 50px;" type="text"/>
4. Anthropometric:	a. Weight:	<input style="width: 50px;" type="text"/>	kg	b. Waist circumference:	<input style="width: 50px;" type="text"/>
	c. Hip circumference:	<input style="width: 50px;" type="text"/>	cm		

SECTION 3: INVESTIGATIONS (OPTIONAL)

1. Lipid profile:	Values	Unit
a. Total cholesterol:	<input style="width: 100%;" type="text"/>	mmol/L
b. HDL-C:	<input style="width: 100%;" type="text"/>	mmol/L
c. LDL-C:	<input style="width: 100%;" type="text"/>	mmol/L
d. Triglycerides:	<input style="width: 100%;" type="text"/>	mmol/L
2. Left Ventricular Ejection Fraction:	<input style="width: 100%;" type="text"/>	%

SECTION 4: MEDICATIONS (OPTIONAL)

Group	Given	Group	Given
1. ASA	<input type="radio"/> Yes <input type="radio"/> No	9. Statin	<input type="radio"/> Yes <input type="radio"/> No
2. ADP antagonist	<input type="radio"/> Yes <input type="radio"/> No	10. Other lipid lowering agent	<input type="radio"/> Yes <input type="radio"/> No
3. GP receptor inhibitor	<input type="radio"/> Yes <input type="radio"/> No	11. Diuretics	<input type="radio"/> Yes <input type="radio"/> No
4. Warfarin	<input type="radio"/> Yes <input type="radio"/> No	12. Calcium antagonist	<input type="radio"/> Yes <input type="radio"/> No
5. LMWH	<input type="radio"/> Yes <input type="radio"/> No	13. Oral Hypoglycaemic agent	<input type="radio"/> Yes <input type="radio"/> No
6. Beta blocker	<input type="radio"/> Yes <input type="radio"/> No	14. Insulin	<input type="radio"/> Yes <input type="radio"/> No
7. ACE Inhibitor	<input type="radio"/> Yes <input type="radio"/> No	15. Anti-arrhythmic agent	<input type="radio"/> Yes <input type="radio"/> No
8. Angiotensin II receptor blocker	<input type="radio"/> Yes <input type="radio"/> No		

SECTION 5: REHABILITATION AND COUNSELLING (OPTIONAL)

1. Was patient referred to cardiac rehabilitation?	<input type="radio"/> Yes	<input type="radio"/> No
2. Has patient stopped smoking?	<input type="radio"/> Yes	<input type="radio"/> No

NATIONAL CARDIOVASCULAR DISEASE DATABASE FOLLOW UP FORM AT 1 YEAR

For NCVD Use only:

ID: /
Centre:

Instruction: This form is to be completed at patient follow-up 1 year ± 1 month after admission. Following may be performed by clinic visit or telephone interview.

Where check boxes are provided, check (✓) one or more boxes. Where radio button are provided, check (✓) one box only.

A. Name of reporting centre:

B. Patient Name : Hj/Hjh/Dato'/Dr.

C. Identification Card Number : MyKad / MyKid: - - Old IC:
Other ID document No: Specify type (eg.passport, armed force ID):

D. Date of Follow up Notification: (dd/mm/yy)

SECTION 1: OUTCOME

1. Outcome:

1. Alive <input type="checkbox"/>	
2. Died <input type="checkbox"/>	→ a. Date of death: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Cause of Death: <input type="radio"/> Cardiovascular <input type="radio"/> Non Cardiovascular <input type="radio"/> Other,specify : _____
3. Transferred to another centre : <input type="checkbox"/>	→ a. Date of last follow-up: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Name of Centre : <input type="text"/>
4. Lost to Follow up: <input type="checkbox"/>	→ a. Date of last follow-up: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy)

2. Cardiovascular readmission:

1. ACS <input type="checkbox"/>	→ a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. ACS Stratum: <input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="radio"/> UA
2. Heart failure <input type="checkbox"/>	→ a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy)
3. Revascularization <input type="checkbox"/>	→ a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy) b. Type of Revascularization : <input type="checkbox"/> 1. PCI → <input type="radio"/> Urgent <input type="radio"/> Elective <input type="checkbox"/> 2. CABG → <input type="radio"/> Urgent <input type="radio"/> Elective
4. Stroke <input type="checkbox"/>	→ a. Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy)

SECTION 2: CLINICAL HISTORY AND EXAMINATION

1. Angina Status: (CCS classification) None Class I Class II Class III Class IV

2. Functional capacity: (NYHA classification) None NYHA I NYHA II NYHA III NYHA IV

3. BP a. Systolic: mmHg b. Diastolic: mmHg

4. Anthropometric: a. Weight: kg b. Waist circumference: cm
c. Hip circumference: cm

SECTION 3: INVESTIGATIONS

	Values	Unit
1. Lipid profile:		
a. Total cholesterol:	<input type="text"/>	mmol/L
b. HDL-C:	<input type="text"/>	mmol/L
c. LDL-C:	<input type="text"/>	mmol/L
d. Triglycerides:	<input type="text"/>	mmol/L
2. Left Ventricular Ejection Fraction:	<input type="text"/>	%

SECTION 4: MEDICATIONS

Group	Given	Group	Given
1. ASA	<input type="radio"/> Yes <input type="radio"/> No	9. Statin	<input type="radio"/> Yes <input type="radio"/> No
2. ADP antagonist	<input type="radio"/> Yes <input type="radio"/> No	10. Other lipid lowering agent	<input type="radio"/> Yes <input type="radio"/> No
3. GP receptor inhibitor	<input type="radio"/> Yes <input type="radio"/> No	11. Diuretics	<input type="radio"/> Yes <input type="radio"/> No
4. Warfarin	<input type="radio"/> Yes <input type="radio"/> No	12. Calcium antagonist	<input type="radio"/> Yes <input type="radio"/> No
5. LMWH	<input type="radio"/> Yes <input type="radio"/> No	13. Oral Hypoglycaemic agent	<input type="radio"/> Yes <input type="radio"/> No
6. Beta blocker	<input type="radio"/> Yes <input type="radio"/> No	14. Insulin	<input type="radio"/> Yes <input type="radio"/> No
7. ACE Inhibitor	<input type="radio"/> Yes <input type="radio"/> No	15. Anti-arrhythmic agent	<input type="radio"/> Yes <input type="radio"/> No
8. Angiotensin II receptor blocker	<input type="radio"/> Yes <input type="radio"/> No		

SECTION 5: REHABILITATION AND COUNSELLING

1. Was patient referred to cardiac rehabilitation? Yes No

2. Has patient stopped smoking? Yes No