



APPENDIX E: 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:		5b. Age on admission:	
d d m m y y		<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:	d d m m y y	1b. Time of onset of ACS symptoms:	h h m m (24hr) <input type="checkbox"/> Not available
2a. Date Patient presented :	d d m m y y	2b. Time Patient presented :	h h m m (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:	(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. Killip 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)

Fill in (2), (3), (4) only if you check 'Given at this centre' in (1) above	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	
	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:	b. Time:
	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)	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: 150px;" 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"/> mmHg			
4. Anthropometric:	a. Weight: <input style="width: 50px;" type="text"/> kg	b. Waist circumference: <input style="width: 50px;" type="text"/> cm			
	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 (ACS REGISTRY) NOTIFICATION FORM

For NCVD Use only:

Centre:

ID:

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

A. Reporting Centre: _____

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

SECTION 1: DEMOGRAPHICS

1. Patient Name: <i>(as per MyKad / Other ID)</i>			2. Hospital RN:	
3. Identification Card Number:	MyKad: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Old IC No.: <input style="width: 100px;" type="text"/>		
	Other ID Document No.: <input style="width: 150px;" type="text"/>	Specify type: <i>(eg. Passport, armed force ID)</i> <input style="width: 150px;" type="text"/>		
4. Gender:	<input type="radio"/> Male <input type="radio"/> Female		5. Nationality:	<input type="radio"/> Malaysian <input type="radio"/> Non Malaysian
6a. Date of birth: <i>(dd/mm/yy)</i>	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<i>(write DOB as 01/01/yy if age is known)</i>		6b. Age on admission: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <i>(auto calculate)</i>
7. Ethnic Group:	<input type="radio"/> Malay <input type="radio"/> Punjabi <input type="radio"/> Melanau <input type="radio"/> Bidayuh <input type="radio"/> Foreigner, specify country of origin: <input type="radio"/> Chinese <input type="radio"/> Orang Asli <input type="radio"/> Murut <input type="radio"/> Iban <input type="radio"/> Indian <input type="radio"/> Kadazan Dusun <input type="radio"/> Bajau <input type="radio"/> Other Malaysian, specify:			
8. Contact Number:	(1): <input style="width: 100px;" type="text"/>	(2): <input style="width: 100px;" 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) <input type="radio"/> Not Available			
2. Status of Aspirin use:	<input type="radio"/> Never <input type="radio"/> Used less than 7 days previously <input type="radio"/> Used more than or equal to 7 days previously			
3. Medical history:				
a) Dyslipidaemia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	g) Chronic Angina (≥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	h) New onset angina (<2 weeks)	<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	i) History of heart failure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
		<input type="checkbox"/> OHA <input type="checkbox"/> Insulin <input type="checkbox"/> Non pharmacology therapy/diet therapy		
d) Family history of premature cardiovascular disease <i>(1st degree relative with either MI or stroke; <55 y/o if Male & <65 y/o if Female)</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	k) Chronic renal disease <i>[>200 μmol(micromol) serum creatinine]</i>	<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 <i>(presence of >50% stenosis on CTA, angiogram or ischaemia on functional Cardiac Imaging such as nuclear, MRI, echo). Positive treadmill test or high Calcium score alone are not sufficient.)</i>	<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	
		n) None of the above	<input type="checkbox"/>	

SECTION 3 : ONSET

1a. Date of onset of ACS symptoms:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	1b. Time of onset of ACS symptoms: <i>(24 hr format)</i>	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (hh:mm) <input type="checkbox"/> Not Available
2a. Date patient presented:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	2b. Time patient presented: <i>(24 hr format)</i>	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (hh:mm) <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 24h:	<input type="checkbox"/> Not Available	2. Heart rate at presentation:	<input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> beats / min
3. Blood pressure at presentation:	a. Systolic: <input style="width: 40px;" type="text"/> mmHg	b. Diastolic: <input style="width: 40px;" type="text"/> mmHg	
4. Anthropometric: <i>(if not measured, please tick as 'Not Available')</i>	a. Height: <input style="width: 40px;" type="text"/> (cm) <input type="checkbox"/> Not Available	BMI:	<input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <i>(auto calculate)</i>
	b. Weight: <input style="width: 40px;" type="text"/> (cm) <input type="checkbox"/> Not Available		
	c. Waist Circumference: <input style="width: 40px;" type="text"/> (cm) <input type="checkbox"/> Not Available	WHR:	<input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <i>(auto calculate)</i>
	d. Hip Circumference: <input style="width: 40px;" type="text"/> (cm) <input type="checkbox"/> Not Available		
5. Killip classification:	<input type="radio"/> Killip I <i>(no clinical signs of heart failure)</i> <input type="radio"/> Killip II <i>(rales or crackles in the lungs, an S₃, and elevated jugular venous pressure)</i> <input type="radio"/> Killip III <i>(frank acute pulmonary oedema)</i> <input type="radio"/> Killip IV <i>(cardiogenic shock or hypotension [measured as systolic blood pressure <90 mmHg], and evidence of peripheral vasoconstriction [oliguria, cyanosis or sweating])</i> <input type="radio"/> Not Applicable/ Not Available		

a. Patient Name:		b. Reporting Centre:	
c. Identification Card No.:		d. Hospital RN:	

SECTION 5: BASELINE INVESTIGATION (values obtained within 48 hours from admission)

	Absolute Value	Unit	Reference Upper Limit	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. Triglyceride:		mmol/L	<input type="radio"/> Not done
5. Fasting blood glucose:		mmol/L		<input type="radio"/> Not done
6. HbA1c		mmol/L		<input type="radio"/> Not done
7. Left Ventricular Ejection Fraction:		%		<input type="radio"/> Not done

SECTION 6: ELECTROCARDIOGRAPHY (ECG)

1. ECG abnormalities type: <i>(Check one or more boxes)</i>	<input type="checkbox"/> ST-segment elevation $\geq 1\text{mm}$ (0.1mV) in ≥ 2 contiguous limb leads	<input type="checkbox"/> Bundle branch block (BBB)
	<input type="checkbox"/> ST-segment elevation $\geq 2\text{mm}$ (0.2mV) in ≥ 2 contiguous frontal leads or chest leads	<input type="checkbox"/> Non-specific
	<input type="checkbox"/> ST-segment depression $\geq 0.5\text{mm}$ (0.05mV) in ≥ 2 contiguous leads	<input type="checkbox"/> None
	<input type="checkbox"/> T-wave inversion $\geq 1\text{mm}$ (0.1mV)	<input type="checkbox"/> Not stated/ inadequately described
2. ECG abnormalities location: <i>(Check one or more boxes)</i>	<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	

SECTION 7: CLINICAL DIAGNOSIS AT ADMISSION

1. <u>Acute Coronary Syndrome stratum:</u>	<input type="radio"/> STEMI	<input type="radio"/> NSTEMI	<input type="radio"/> Unstable Angina (UA)
2a. TIMI Risk Score for NSTEMI/ UA:	<input type="text"/>	<i>(auto calculate)</i>	2b. TIMI Risk Score for STEMI:
			<input type="text"/>
			<i>(auto calculate)</i>

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

1. <u>Fibrinolytic therapy status:</u>	<input type="radio"/> Given at this centre → <i>(Please proceed to number 2 and 3 below)</i>			
	<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) and (3) only if you check 'Given at this centre' in no. (1) above	2. Fibrinolytic drug used:	<input type="radio"/> Streptokinase		
		<input type="radio"/> Others (t-PA, r-PA, TNK t-PA)		
	3. <u>Intravenous fibrinolytic therapy:</u>	a. Date: <i>(dd/mm/yy)</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	b. Time: <i>(in 24 hr format)</i>
	4. Door to Needle time:	<input type="text"/>	<input type="text"/> : <input type="text"/> <i>(hh:mm)</i>	<i>(minutes) Auto calculated—(time patient presented to time of fibrinolytic therapy given)</i>

SECTION 9: INVASIVE THERAPEUTIC PROCEDURES

1. Did patient undergo cardiac catheterization on this admission at your centre?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No-transferred to another centre
2. Did patient undergo Percutaneous Coronary intervention (PCI) on this admission?	<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	
3. First balloon inflation (for STEMI-Urgent PCI only):	a. Date: <i>(dd/mm/yy)</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	b. Time: <i>(in 24 hr format)</i>
		<input type="text"/> : <input type="text"/> <i>(hh:mm)</i>	
4. Door to balloon time (for STEMI-Urgent PCI only):	<input type="text"/>	<i>(minutes) Auto calculated—(time patient presented to time of first angio balloon inflation)</i>	
5. Did patient undergo CABG on this admission?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not applicable

a. Patient Name:		b. Reporting Centre:	
c. Identification Card No.:		d. Hospital RN:	

SECTION 10: PHARMACOLOGICAL THERAPY

Group	Given during admission		Given at discharge	
1. ASA	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
2. Ticlopidine	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
3. Clopidogrel	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
4. Prasugrel	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
5. Ticagrelor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
6. Other antiplatelet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
7. GP receptor inhibitor	<input type="radio"/> Yes	<input type="radio"/> No		
8. Unfrac heparin	<input type="radio"/> Yes	<input type="radio"/> No		
9. LMWH	<input type="radio"/> Yes	<input type="radio"/> No		
10. Fondaparinux	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
11. Oral anticoagulant (eg. Warfarin)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
12. Beta blocker	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
13. ACE inhibitor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
14. Angiotensin II receptor blocker	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
15. Statin	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
16. Other lipid lowering agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
17. Diuretics	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
18. Calcium antagonist	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
19. Oral hypoglycaemic agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
20. Insulin	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
21. Anti-arrhythmic agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No

SECTION 11 : IN HOSPITAL OUTCOME

1. Number of overnight stays:	a. CCU (days):		
	b. ICU/CICU (days):		
2. Outcome:	<input type="radio"/> Discharged →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
	<input type="radio"/> Transferred to another centre →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
		b) Name of centre:	<input type="text"/>
	<input type="radio"/> Died →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
		b) <u>Cause of death:</u>	<input type="radio"/> Cardiac <input type="radio"/> Non Cardiac
3. Total number of overnight stays:		(auto calculate)	
4. <u>Final diagnosis at discharge:</u>	<input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="radio"/> UA <input type="radio"/> Non Cardiac / Non ACS		
5. <u>Bleeding Complication:</u> (TIMI criteria)	<input type="radio"/> Major (Any intracranial bleed or other bleeding ≥ 5g/dL Hb drop) <input type="radio"/> Minor (Non-CNS bleeding with 3-5g/dL Hb drop) <input type="radio"/> Minimal (Non-CNS bleeding, non-overt bleeding, < 3g/dL Hb drop) <input type="radio"/> None <input type="radio"/> Not stated / Inadequately described		

NATIONAL CARDIOVASCULAR DISEASE DATABASE (ACS REGISTRY) FOLLOW UP FORM

For NCVD use only:

Centre:

ID:

Instruction: This form is to be completed at patient follow-up at specified duration (30 days / 12 months) after admission. Following may be performed by telephone interview or clinic visit.

Where check boxes are provided, please check (✓) one or more boxes. Where radio buttons are provided, check (✓) **only one** option.

A. Reporting Centre:			
B. Patient Name:			
C. Identification Card Number:	MyKad: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Old IC:	<input style="width: 100%;" type="text"/>
	Other ID document No.: <input style="width: 100%;" type="text"/>	Specify type: <i>(eg. Passport, armed force ID)</i>	<input style="width: 100%;" type="text"/>
D. Date of 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)	E. Type of Follow Up:	<input type="radio"/> 30 days <input type="radio"/> 12 months

SECTION 1: OUTCOME

1. Outcome	<input type="radio"/> Alive				
	<input type="radio"/> Died	→ 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)	b. Cause of death: <input type="radio"/> Cardiac <input type="radio"/> Non Cardiac		
	<input type="radio"/> Transferred to another centre	→ 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"/> <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"/>		
	<input type="radio"/> Lost to Follow Up	→ 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)			
2. Cardiovascular Readmission:	<input type="checkbox"/> ACS	→ 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"/> <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		
	<input type="checkbox"/> Heart Failure	→ 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)			
	<input type="checkbox"/> Revascularization	→ a. Type:	<input type="checkbox"/> PCI 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)	→ <input type="radio"/> Urgent <input type="radio"/> Elective	
			<input type="checkbox"/> CABG 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"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (dd/mm/yy)	→ <input type="radio"/> Urgent <input type="radio"/> Elective	
<input type="checkbox"/> Stroke	→ 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"/> <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"/> CCS I	<input type="radio"/> CCS II	<input type="radio"/> CCS III	<input type="radio"/> CCS 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. Blood Pressure:	a. Systolic:	<input style="width: 40px;" type="text"/>	mmHg	b. Diastolic:	<input style="width: 40px;" type="text"/> mmHg
4. Anthropometric:	a. Weight:	<input style="width: 40px;" type="text"/>	kg	b. Waist circumference:	<input style="width: 40px;" type="text"/> cm
	c. Hip circumference:	<input style="width: 40px;" type="text"/>	cm		

SECTION 3: INVESTIGATIONS (OPTIMAL)

1. Lipid Profile:	a. Total Cholesterol:	<input style="width: 60px;" type="text"/>	mmol/L	b. HDL-C:	<input style="width: 60px;" type="text"/>	mmol/L
	c. LDL-C:	<input style="width: 60px;" type="text"/>	mmol/L	d. Triglycerides:	<input style="width: 60px;" type="text"/>	mmol/L
2. Left Ventricular Ejection Fraction:	<input style="width: 60px;" type="text"/>	%	3. HbA1c	<input style="width: 60px;" type="text"/>	mmol/L	

SECTION 4: MEDICATION (OPTIONAL)

Group	Given	Group	Given
1. ASA	<input type="radio"/> Yes <input type="radio"/> No	12. Beta Blocker	<input type="radio"/> Yes <input type="radio"/> No
2. Ticlopidine	<input type="radio"/> Yes <input type="radio"/> No	13. ACE inhibitor	<input type="radio"/> Yes <input type="radio"/> No
3. Clopidogrel	<input type="radio"/> Yes <input type="radio"/> No	14. Angiotensin II receptor blocker	<input type="radio"/> Yes <input type="radio"/> No
4. Prasugrel	<input type="radio"/> Yes <input type="radio"/> No	15. Statin	<input type="radio"/> Yes <input type="radio"/> No
5. Ticagrelor	<input type="radio"/> Yes <input type="radio"/> No	16. Other lipid lowering agent	<input type="radio"/> Yes <input type="radio"/> No
6. Other antiplatelet	<input type="radio"/> Yes <input type="radio"/> No	17. Diuretics	<input type="radio"/> Yes <input type="radio"/> No
7. GP receptor inhibitor	<input type="radio"/> Yes <input type="radio"/> No	18. Calcium antagonists	<input type="radio"/> Yes <input type="radio"/> No
8. Heparin	<input type="radio"/> Yes <input type="radio"/> No	19. Oral Hypoglycaemic Agent	<input type="radio"/> Yes <input type="radio"/> No
9. LMWH	<input type="radio"/> Yes <input type="radio"/> No	20. Insulin	<input type="radio"/> Yes <input type="radio"/> No
10. Fondaparinux	<input type="radio"/> Yes <input type="radio"/> No	21. Anti-arrhythmic agent	<input type="radio"/> Yes <input type="radio"/> No
11. Oral anticoagulant agent (eg. Warfarin)	<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	<input type="radio"/> Not Applicable
2. Has patient stopped smoking?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Applicable