HEART FAILURE			
Protocol Identifier	**Subject Identifier**		**Visit Description**
			Treatment Period Visit XYZ

PAST MEDICAL HISTORY

Has the subject had a prior episode of heart failure? [Y] ☐Yes [N] ☐No

Does the subject have a prior history of exposure to cardiotoxins, such as anthracyclines? [Y] ☐Yes [N] ☐No

URGENT HEART FAILURE VISIT

Did heart failure lead to an unplanned visit to an emergency department or health care clinic? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

If Yes, admission date and time: **Day** **Month** **Year**

Discharge date and time **Day** **Month** **Year** **Hrs:Mins (00:00-23:59)**

HOSPITALISATION

Did the subject's clinical status at the time of presenting with the event reported as heart failure lead to admission to the hospital? [Y] ☐Yes [N] ☐No

If Yes, complete the following:

If Yes, admission date and time: **Day** **Month** **Year** **Hrs:Mins**

(00:00-23:59)

Discharge date and time: **Day** **Month** **Year** **Hrs:Mins (00:00-23:59)**

Did subject have evidence of an arrhythmia at time of presentation? [Y] ☐Yes [N] ☐No

If Yes, fill out Arrhythmia eCRF.

Did subject have evidence of acute coronary syndrome? [Y] ☐Yes [N] ☐No

If Yes, fill out Myocardial Infarction / Unstable Angina eCRF

HEART FAILURE			
Protocol Identifier	**Subject Identifier** ☐☐☐☐☐☐		**Visit Description** **Treatment Period** **Visit XYZ**

VITAL SIGNS AT PRESENTATION (will add appropriate unit fields prior to Dec. mtg)

Systolic Blood Pressure

Diastolic Blood Pressure

Heart Rate

Respiratory Rate

Temperature

NYHA SCORE at Presentation (✓only one)	
Class	**Functional Status**
☐**I**	No symptoms and no limitation in ordinary physical activity.
☐**II**	Mild symptoms and slight limitation during ordinary activity.
☐**III**	Marked limitation in activity due to symptoms, even during less-than ordinary activity. Comfortable only at rest.
☐**IV**	Severe limitations. Experiences symptoms even while at rest.
Criteria committee, New York Heart Association, Diseases of the heart and blood vessels. Nomenclature and criteria for diagnosis, 9th ed. Boston: Little, Brown, 1994	

LABORATORY RESULT DATA
Enter 'NR' if the laboratory results are not available to report or if a lab error occurred.

Laboratory Name_____ Address_____ _____	Lab ID

Date Day Month Year	**Time** Hr: Min 00:00-23:59	**Test**	**Result**	**Normal Ranges**		
				Low	**High**	**Unit**
e.g. 01 JAN 2012	**13:25**	**Serum Creatinine**	**83**	**62**	**115**	**umol/l**

HEART FAILURE			
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		Brain nutriuretic peptide				
		N-terminal pro-Brain natriuretic peptide				
		Atrial natriuretic peptide				
		Troponin				
List all labs available. Add lines for serial values of the same lab as needed.						

HEART FAILURE (continued)

CURRENT CLINICAL SIGNS AND SYMPTOMS OF HEART FAILURE

Symptoms (✓**all that apply**)

Dyspnea

- ☐ Dyspnea with exertion
- ☐ Dyspnea at rest
- ☐ Orthopnea
- ☐ Paroxysmal Nocturnal Dyspnea

☐ Decreased exercise tolerance

☐ Fatigue

☐ Other symptoms of worsened end-organ perfusion or volume overload (must be specified and described by the protocol): list: _____

Signs (✓all that apply)

☐ Peripheral edema

HEART FAILURE			
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- ☐ Increasing abdominal distention or ascites (in the absence of primary hepatic disease)
- ☐ Pulmonary rales / crackles / crepitations
- ☐ Increased jugular venous pressure
- ☐ Hepatojugular reflex
- ☐ S3 cardiac gallop
- ☐ Clinically significant or rapid weight gain thought to be related to fluid retention
- ☐ Tachypnea with respiratory rate > 20 breaths / minute

HEART FAILURE (continued)

ECHOCARDIOGRAPHY

Was an Echocardiogram performed? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

Date and time of Echocardiogram: **Day** **Month** **Year** **Hrs:Mins** **(00:00-23:59)**

Ejection Fraction Assessment (systolic function)? [Y] ☐Yes [N] ☐N

If Yes, record percentage **%**

Evidence of diastolic dysfunction? [Y] ☐Yes [N] ☐N

Evidence of significant valvular disease? [Y] ☐Yes [N] ☐N

Evidence of cardiac dilatation? [Y] ☐Yes [N] ☐N
If Yes, indicate which chamber(s) [A] ☐Atrial [V] ☐Ventricular
Evidence of regional wall motion abnormality? [Y] ☐Yes [N] ☐N

Was a prior Echocardiogram performed? [Y] ☐Yes [N] ☐N
If Yes, complete the following:

Date and time of prior Echocardiogram: **Day** **Month** **Year** **Hrs:Mins** **(00:00-23:59)**

Prior Ejection Fraction Assessment (systolic function)? [Y] ☐Yes [N] ☐N

If Yes, record percentage **%**

Prior evidence of diastolic dysfunction? [Y] ☐Yes [N] ☐N

Evidence of significant valvular disease? [Y] ☐Yes [N] ☐N

Evidence of cardiac dilatation? [Y] ☐Yes [N] ☐N
If Yes, indicate which chamber(s) [A] ☐Atrial [V] ☐Ventricular
Evidence of regional wall motion abnormality? [Y] ☐Yes [N] ☐N

RIGHT HEART CATHERIZATION

Was a right heart catheterization performed? [Y] ☐Yes [N] ☐N

Did RHC demonstrate Pulmonary Capillary Wedge Pressure ≥ 18 mmHg [Y] ☐Yes [N] ☐N

Did RHC demonstrate Cardiac output < 2.2 l/min/m^2? [Y] ☐Yes [N] ☐N

CHEST XRAY

Was a Chest Xray performed? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

Date and time of Chest Xray: ☐☐ **Day** ☐☐☐ **Month** ☐☐ **Year** ☐☐ ☐☐ **Hrs:Mins**

(00:00-23:59)

Evidence of Pulmonary Edema [Y] ☐Yes [N] ☐N

Pleural Effusion [Y] ☐Yes [N] ☐N

Evidence of Cardiomegaly [Y] ☐Yes [N] ☐N

HEART FAILURE (continued)

MUGA

Was a Multiple Gated Acquisition Scan (MUGA) performed? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

Date and time of MUGA: ☐☐ **Day** ☐☐☐ **Month** ☐☐ **Year** ☐☐ ☐☐

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Hrs:Mins

(00:00-23:59)

Ejection Fraction Assessment? | | | **%** |

_ box for "not done"

Evidence of wall motion abnormalities? [Y] ☐Yes [N] ☐N

Was a prior Multiple Gated Acquisition Scan (MUGA) performed? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

	Day	**Month**	**Year**	**Hrs:Mins**
Date and time of prior MUGA:				

(00:00-23:59)

Prior Ejection Fraction Assessment? [Y] ☐Yes [N] ☐N

If Yes, record percentage | | | **%** |

Evidence of wall motion abnormalities? [Y] ☐Yes [N] ☐N

ACUTE THERAPY FOR HEART FAILURE EPISODE

Were any acute changes to the subject's treatment for heart failure required to treat their acute episode of heart failure during their clinic or emergency room visit or hospitalization? [Y] ☐Yes [N] ☐N

If Yes, complete the following:

Escalation of chronic cardiovascular medication (not including diuretics) [Y] ☐Yes [N] ☐N

Increase in oral diuretics [Y] ☐Yes [N] ☐N

Uptitration of IV therapy if already on therapy [Y] ☐Yes [N] ☐N

New class of medication added (e.g., beta blocker, ACE inhibitor /Angiotensin Receptor Blocker, Aldosterone receptor blocker, morphine sulfate) [Y] ☐Yes [N] ☐N therapy: _____

Intravenous diuretics [Y] ☐Yes [N] ☐N

Inotropes (e.g., dobutamine, milrinone) [Y] ☐Yes [N] ☐N therapy: _____

Intravenous vasodilators (e.g., nitroglycerin, nitroprusside, nesiritide) [Y] ☐Yes [N] ☐N therapy: _____

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Mechanical assisted device [Y] ☐Yes [N] ☐N

If Yes, complete the following:

Intra-aortic balloon placement [Y] ☐Yes [N] ☐N

Ventricular assist device insertion [Y] ☐Yes [N] ☐N

[Y] ☐Yes [N] ☐N

Mechanical fluid removal

If Yes, complete the following:

Ultrafiltration [Y] ☐Yes [N] ☐N

Hemofiltration [Y] ☐Yes [N] ☐N

Dialysis [Y] ☐Yes [N] ☐N

Others [Y] ☐Yes [N] ☐N

DISCHARGE

Were the symptoms of heart failure resolved at the time of discharge? Y] ☐Yes [N] ☐N

If yes, indicate degree [P] ☐ Partially

[Y] ☐Completely

BNP / NT-pro BNP at discharge: result: _____

Send Discharge Summary

HEART FAILURE (continued)

FINAL PRIMARY DIAGNOSIS
(✓only one)

☐ Arrhythmia

☐ Acute coronary syndrome

☐ Ischemic cardiomyopathy

☐ Dilated cardiomyopathy

☐ Hypertrophic cardiomyopathy

☐ Restrictive cardiomyopathy

☐ Arrhythmogenic right ventricular cardiomyopathy

☐ Unclassified cardiomyopathies

HEART FAILURE			
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☐ Myocarditis

☐ Other, specify_____

"Additional Supplemental information (to what has already been highlighted in yellow in the form): Source documents for data requested in the eCRF (e.g., labs, CXR) as well as admission History and Physical, ECG tracings at baseline and at time of event(s) and Discharge Summary".