

Vascular Quality Initiative - Infra-Inguinal Bypass

Last Name First Name Middle Initial
 Date of Birth Medical Record Number Social Security Number

General Information

Patient Data

Zip/Postal Code Gender Male Female
 Ethnicity Not Hispanic or Latino Hispanic or Latino Race White Black or African American
 Height inches or cm Asian More than 1 race
 Weight lbs or kg American Indian or Alaskan Native
 Native Hawaiian or other Pacific Islander
 Unknown/other

Admission Data

Visit code (not required)
 Admit Date Discharge Date
 Surgeon Surgery Date
 Discharge Status Home Rehab Unit
 Nursing Home Dead
 Other Hospital Skilled Nursing Facility
 Was the Procedure Billed to Medicare Part B? No Yes
 If dead, date of death
 Transferred from? No Hospital Rehab Unit

Demographics

Smoking Never Prior (>1 yr) Current (within 1 yr) Hypertension No Yes (>=140/90 or history)
 Diabetes None Diet Oral Meds Insulin Beta Blockers No Op Day only
 Pre-op 1-30 days Chronic > 30 days
 Intolerant
 CAD None hx MI but no sx CABG/PTCA None <5yr >=5yrs ago
 Symptoms Stable Angina Unstable Angina or MI < 6 mos
 CHF None Mild Asymp, hx CHF Severe COPD No Not Treated On Meds
 On Home Oxygen
 Dialysis No On Dialysis Functioning Transplant Creatinine mg/dl OR umol/L
 Stress Test Not Done Normal (+)ischemia (+)MI (+)both Pre-adm Living Home Nursing Home

ASA 1=Normal/healthy 2=w/Mild Systemic dx *Pre-op Hemoglobin* g/dl OR g/L
 Class 3=w/Severe Systemic dx
 4=w/Severe Systemic dx That's Constant Threat to Life
 5=Moribund/not Expected to Survive w/o Op

HbA1c %

Previous Arterial

Bypass No Yes *CEA* No Yes
Aneurysm Repair No Yes *PTA/Stent* No Yes
Major Amp No Yes

Pre-Op Medications

ASA No Yes Intolerant *Plavix* No Yes Intolerant
 Statin No Yes Intolerant

History

	<i>Right:</i>		<i>Left:</i>
<i>Indication</i>	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Claudication	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Claudication	<input type="checkbox"/> Claudication
	<input type="checkbox"/> Rest Pain <input type="checkbox"/> Tissue Loss	<input type="checkbox"/> Rest Pain <input type="checkbox"/> Tissue Loss	<input type="checkbox"/> Tissue Loss
	<input type="checkbox"/> Acute Ischemia <input type="checkbox"/> Not Treated	<input type="checkbox"/> Acute Ischemia <input type="checkbox"/> Not Treated	<input type="checkbox"/> Not Treated
<i>Pathology</i>	<input type="checkbox"/> Not Treated <input type="checkbox"/> Occlusive	<input type="checkbox"/> Not Treated <input type="checkbox"/> Occlusive	<input type="checkbox"/> Occlusive
	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Aneurysm	
<i>Ambulation</i>	<input type="checkbox"/> Amb <input type="checkbox"/> Amb w/Assistance		
	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden		
<i>Previous:</i>	<i>Right:</i>	<i>Left:</i>	
<i>Inflow Bypass</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Inflow PTA/Stent</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Leg Bypass</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Leg PTA/Stent</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Major Amputation</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Minor Amputation</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>Pre-Op:</i>	<i>Right:</i>	<i>Left:</i>	
<i>Pre-Op ABI</i>	<input type="text"/>	<input type="text"/>	
<i>Pre-Op TBI</i>	<input type="text"/>	<input type="text"/>	

Pre-Op Imaging:

Duplex No Yes *MRA* No Yes *CTA* No Yes
DSA/Arteriogram No Yes *Vein Mapping* No Yes

Procedure

Urgency Elective Urgent *Anesthesia* Spinal Epidural
 Emergent General
Side Right Left *Skin Prep* Chlorhexadine Alcohol
 Iodine Chlor + Iodine
 Chlor + Alcohol Iodine + Alcohol
 All 3

Graft Origin Ext Iliac Com Fem *Graft Recipient* SFA Profunda
 Profunda SFA AK Pop BK Pop
 AK Pop BK Pop T-P Trunk AT
 Tibial PT Peroneal
 DP Ankle PT Ankle
 Tarsal/Plantar Com Fem

Graft Vein Type None Reversed GSV # *Vein Segments* None
 In Situ GSV Non-reversed Transposed GSV 1
 Lesser Saph Cephalic 2
 Basilic Composite Vein 3 or more

Prosthetic None Dacron *EBL* ml
 PTFE Non-autologous biologic
 Composite w/ vein

Groin Incision None Vertical *Total Procedure Time* minutes
 Horizontal

If Graft Vein, Vein Harvest Incision Continuous Skip *If Graft Vein, Vein Graft Location* Sub-cutaneous
 Endoscope Sub-fascial

Adjuncts:

Vein Cuff No Yes *Sequential Graft* No Yes

Heart Rate:

On Arrival in OR bpm *Highest intra-op* bpm

Concomitant Proximal Ipsilateral:

PVI No Yes *Endarterectomy* No Yes
Bypass No Yes

Completion Study:

Doppler No Yes *Duplex* No Yes
Arteriogram No Yes

Post-Op Data

Wound Infection No Yes *Graft Infection* No Yes
Transfusion # Units PRBC
(During total hospitalization) Myocardial Infarction No
 Troponin Only
 EKG or Clinical
Dysrhythmia (new) No Yes *CHF* No Yes
Respiratory No Pneumonia *Change of Renal Function* None
 Ventilator Creat. Increase >
0.5mg/dl(44.2umol/L)
 Temp. Dialysis
 Perm. Dialysis
Stroke None Minor Major *Ipsilateral Amputation* No Minor Amp
 BK Amp AK Amp

Discharge Primary Prim-Assisted Patency Doppler Only Palpable Graft Pulse
Patency Secondary Occluded Judged By Palpable Distal Pulse ABI Inc. >0.15
Return to OR No Yes Duplex

If Return to OR is Yes:

for Bleeding No Yes for Thrombosis No Yes
for Infection No Yes for Revision No Yes

Discharge Medications:

ASA No Yes Intolerant Statin No Yes Intolerant
Beta-Blocker No Yes Intolerant Coumadin No Yes Intolerant
Plavix No Yes Intolerant

Discharge:

Right:

Left:

Post-Op ABI

Post-Op TBI

Discharge Amb Amb w/Assistance
Ambulation Wheelchair Bedridden

Peri-Op Antibiotic Ordered:

Start <1hr Pre-op No Yes Stop <24hr Post-op No Yes
 No, for medical reason No, for medical reason
1st-2nd Gen Cephalosporin No Yes
 No, for medical reason

Vascular Quality Initiative - Infra-Inguinal Bypass Follow-Up

Last Name First Name Middle Initial

Date of Birth Medical Record Number Social Security Number

Visit code (not required) Zip/Postal Code
 Surgeon Procedure:
 Surgery Date Side:

General Information

Date of Contact	<input type="text"/>	Contact By	<input type="checkbox"/> Face to Face	Current Smoking	<input type="checkbox"/> No
			<input type="checkbox"/> Phone		<input type="checkbox"/> Yes
			<input type="checkbox"/> No Follow-up Possible		
Current Living Status	<input type="checkbox"/> Home	Date of Death	<input type="text"/>	Cause	<input type="checkbox"/> Operation Related
	<input type="checkbox"/> Nursing Home				<input type="checkbox"/> Non-Related
	<input type="checkbox"/> Dead				<input type="checkbox"/> Unsure
Current Medications					
ASA	<input type="checkbox"/> No	Plavix	<input type="checkbox"/> No	Coumadin	<input type="checkbox"/> No
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	Beta Blocker	<input type="checkbox"/> No
	<input type="checkbox"/> Intolerant		<input type="checkbox"/> Intolerant		<input type="checkbox"/> Yes
					<input type="checkbox"/> Yes
					<input type="checkbox"/> Intolerant
					<input type="checkbox"/> Intolerant

Infra-Inguinal Bypass

Current Ambulation	<input type="checkbox"/> Amb	Ipsilateral Symptoms	<input type="checkbox"/> Asymptomatic
	<input type="checkbox"/> Amb w/Assistance		<input type="checkbox"/> Claudication
	<input type="checkbox"/> Wheelchair		<input type="checkbox"/> Rest Pain
	<input type="checkbox"/> Bedridden		<input type="checkbox"/> Tissue Loss
Current Patency	<input type="checkbox"/> Primary	Patency Judged By	<input type="checkbox"/> Doppler Only
	<input type="checkbox"/> Prim-Assisted		<input type="checkbox"/> Palpable Graft Pulse
	<input type="checkbox"/> Secondary		<input type="checkbox"/> Palpable Distal Pulse
	<input type="checkbox"/> Occluded		<input type="checkbox"/> ABI Increase > 0.15
If Occluded, Date	<input type="text"/>		<input type="checkbox"/> Duplex
Ipsilateral ABI	<input type="text"/>	Ipsilateral TBI	<input type="text"/>
		Infection	<input type="checkbox"/> None
Bypass Revision	<input type="checkbox"/> No		<input type="checkbox"/> Superficial Cellulitis
	<input type="checkbox"/> Yes, surgery	If Bypass revision, date:	<input type="checkbox"/> Deep Abscess
	<input type="checkbox"/> Yes, catheter-based	<input type="text"/>	<input type="checkbox"/> Infection involving artery or graft
	<input type="checkbox"/> Both		
Thrombectomy/lysis - Revision	<input type="checkbox"/> No	If Thromb. revision, date:	
	<input type="checkbox"/> Yes, surgery	<input type="text"/>	
	<input type="checkbox"/> Yes, catheter-based		
	<input type="checkbox"/> Both		
Major Amputation	<input type="checkbox"/> No	If Amputation, date:	
	<input type="checkbox"/> Minor Amp	<input type="text"/>	
	<input type="checkbox"/> BK Amp		
	<input type="checkbox"/> AK Amp		