

**Vascular Quality Initiative - Peripheral Vascular Intervention**

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

Was the Procedure Billed to Medicare Part B?  No  Yes

Nursing Home  Dead

Other Hospital  Skilled Nursing Facility

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  
Symptoms  Stable Angina  Unstable Angina or MI < 6 mos

CABG/PTCA  None  <5yr  >=5yrs ago

CHF  None  Asymp, hx CHF  
 Mild  Severe

COPD  No  Not Treated  On Meds  
 On Home Oxygen

Dialysis  No  Functioning Transplant  
 On Dialysis

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

**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 *Coumadin*  No  Yes  Intolerant

**History**

	<b>Right:</b>		<b>Left:</b>	
<i>Indication</i>	<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Claudication	<input type="checkbox"/> Asymptomatic	<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"/> Acute Ischemia	<input type="checkbox"/> Not Treated	<input type="checkbox"/> Acute Ischemia	<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"/> Aneurysm		<input type="checkbox"/> Aneurysm	
<i>Ambulation Pre-Tx</i>	<input type="checkbox"/> Amb	<input type="checkbox"/> Amb w/Assistance		
	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Bedridden		
<b>Previous:</b>	<b>Right:</b>	<b>Left:</b>	<b>Pre-Rx:</b>	<b>Right:</b> <input type="text"/>
<i>Inflow Bypass</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>Pre-Rx ABI</i>	<input type="text"/>
<i>Inflow PTA/Stent</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>Pre-Rx TBI</i>	<input type="text"/>
<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		

**Procedure**

<i>Urgency</i> <input type="checkbox"/> Elective	<i>Femoral</i> <input type="checkbox"/> No	<i>Other</i> <input type="checkbox"/> None	<i>Access</i> <input type="checkbox"/> No
<input type="checkbox"/> Urgent	<i>Access</i> <input type="checkbox"/> Right	<i>Access</i> <input type="checkbox"/> Arm	<i>Guidance</i> <input type="checkbox"/> Fluoro
<input type="checkbox"/> Emergent	<input type="checkbox"/> Left	<input type="checkbox"/> Graft	<input type="checkbox"/> U/S
	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Popliteal	<input type="checkbox"/> Cut-Down
		<input type="checkbox"/> Other	
<i>Fluoro Time</i> <input type="text"/> min	<i>Contrast Volume</i> <input type="text"/> ml	<i>Largest Sheath Size</i> <input type="text"/> Fr	<i>Closure Device</i> <input type="checkbox"/> No
			<input type="checkbox"/> Perclose
			<input type="checkbox"/> Starclose
<i>Concomitant CFA Endarterect</i> <input type="checkbox"/> No	<input type="checkbox"/> Right		<input type="checkbox"/> Mynx
	<input type="checkbox"/> Left		<input type="checkbox"/> Angioseal
	<input type="checkbox"/> Bilateral		<input type="checkbox"/> Other

**Medications Used During Procedure:**

*Heparin*  No  Yes *Bivalirudin*  No  Yes  
*Protamine*  No  Yes *IV Bicarb*  No  Yes  
*C02*  No  Yes *N-Acetylcysteine*  No  Yes

Note:also include pre-op and post-op use of N-Acetylcysteine

**Procedure Details**

Number of Arteries Treated     1     2  
     3     4  
     5     6

Artery Treated	1st	2nd	3rd	4th	5th	6th
Aorta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Common Iliac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Iliac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Com Fem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profunda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SFA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popliteal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TPT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Side	1st	2nd	3rd	4th	5th	6th
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aorta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TASC	1st	2nd	3rd	4th	5th	6th
A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Lesion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Technical Result	1st	2nd	3rd	4th	5th	6th
Successful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stenosis $\geq 30\%$ or 10 mm Gradient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1st	2nd	3rd	4th	5th	6th
Number Lesions Treated						
Total Occlusion Length (cm)						
Total Treated Length (cm)						

<i>1st Treatment Type</i>	1st	2nd	3rd	4th	5th	6th
<i>PTA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent, Self-Expand</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent, Balloon-Expand</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent Graft</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cryoplasty</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cutting Balloon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Laser Atherect</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mechanical Atherect, Orbital</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mechanical Atherect, Excisional</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>2nd Treatment Type</i>	1st	2nd	3rd	4th	5th	6th
<i>None</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>PTA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent, Self-Expand</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent, Balloon-Expand</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stent Graft</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cryoplasty</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cutting Balloon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Laser Atherect</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mechanical Atherect, Orbital</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mechanical Atherect, Excisional</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Adjuncts</i>	1st	2nd	3rd	4th	5th	6th
<i>None</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Thrombolysis, Pharmacological</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Thrombolysis, Mechanical</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Re-entry, Device</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Embolic Protection Device</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Femoral Endarterectomy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Balloon /Stent Max Diameter (mm)</i>	1st	2nd	3rd	4th	5th	6th

Patent Outflow Arteries at Completion (0-3):

		Right		Left	
<i>Proximal (SFA, Prof, Pop)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 0	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 3		<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<input type="checkbox"/> Not Imaged			<input type="checkbox"/> Not Imaged	
		Right		Left	
<i>Distal (AT, PT, Peroneal)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 0	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 3		<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<input type="checkbox"/> Not Imaged			<input type="checkbox"/> Not Imaged	
<i>Arterial Dissection</i>	<input type="checkbox"/> No	<input type="checkbox"/> Iliac		<i>Arterial Perforation</i>	<input type="checkbox"/> No <input type="checkbox"/> Iliac
	<input type="checkbox"/> Fem-pop	<input type="checkbox"/> Tibial			<input type="checkbox"/> Fem-pop <input type="checkbox"/> Tibial
<i>Distal Embolization</i>	<input type="checkbox"/> No	<input type="checkbox"/> Minor		<i>Treatment Required</i>	<input type="checkbox"/> Interventional
	<input type="checkbox"/> Perc. Interv.	<input type="checkbox"/> Operation			<input type="checkbox"/> Surgical
					<input type="checkbox"/> Both

**Post-op**

**Complications:**

<i>Puncture Site</i>	<input type="checkbox"/> No		<i>Access Site</i>	<input type="checkbox"/> No (patent)
<i>Hematoma</i>	<input type="checkbox"/> Minor		<i>Stenosis/Occlusion</i>	<input type="checkbox"/> Medical Rx
	<input type="checkbox"/> Moderate (transfusion)			<input type="checkbox"/> Interventional Rx
	<input type="checkbox"/> Moderate (thrombin injection)			<input type="checkbox"/> Surgical Rx
	<input type="checkbox"/> Major (operation)			
<i>Cx Req Admission</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes			

**Discharge Medications:**

<i>ASA</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Intolerant	<i>Plavix</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Intolerant
<i>Coumadin</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Intolerant	<i>Statin</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Intolerant
<i>Beta-Blocker</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Intolerant				

## Vascular Quality Initiative - Peripheral Vascular Intervention 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  Contact By  Face to Face  Phone  No Follow-up Possible  
 Current Smoking  No  Yes  
 Current Living Status  Home  Nursing Home  Dead  
 Date of Death  Cause  Operation Related  Non-Related  Unsure

### Current Medications

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

### Peripheral Vascular Intervention

Current Ambulation  Amb  Wheelchair  Amb w/Assistance  Bedridden

Indication  
 Right:  Asymptomatic  Rest Pain  Claudication  Tissue Loss  
 Left:  Asymptomatic  Rest Pain  Claudication  Tissue Loss

ABI  
 Right:   
 Left:

TBI  
 Right:   
 Left:

Major Amputation  
 Right:  No  BK Amp  Minor Amp  AK Amp  
 Left:  No  BK Amp  Minor Amp  AK Amp

Number of Arteries Treated     1     2  
     3     4  
     5     6

<i>Artery Treated</i>	1st	2nd	3rd	4th	5th	6th
<i>Aorta</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Common Iliac</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>External Iliac</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Com Fem</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Profunda</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>SFA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Popliteal</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>AT</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>TPT</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>PT</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>PR</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Side</i>	1st	2nd	3rd	4th	5th	6th
<i>Right</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Left</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Aorta</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Technical Result</i>	1st	2nd	3rd	4th	5th	6th
<i>Successful</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stenosis &gt;=30% or     10 mm Gradient</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Technical Failure</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Current Patency</i>	1st	2nd	3rd	4th	5th	6th
<i>Primary</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Prim-Assisted</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Secondary</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Occluded</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Patency Judge</i>	1st	2nd	3rd	4th	5th	6th
<i>Palpable Distal Pulse</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>ABI Increase &gt; 0.15</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>MRA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Duplex</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>CTA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Angio</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Site Re-Intervention</i>	1st	2nd	3rd	4th	5th	6th
<i>None</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Percutaneous</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Surgery</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>If Re-Intervention, Date:</i>	1st	2nd	3rd	4th	5th	6th
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>