

Vascular Quality Initiative - Supra-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 ($\geq 140/90$ or history)
 Diabetes None Diet Oral Meds Insulin Beta Blockers No Op Day only
 Pre-op 1-30 days Chronic > 30 days
 Intolerant
 CAD Symptoms None hx MI but no sx CABG/PTCA None <5yr ≥ 5 yrs ago
 Stable Angina Unstable Angina or MI < 6 mos
 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

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"/> 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</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 *Anesthesia* Spinal *Skin Prep* Chlorhexadine Alcohol
 Urgent Epidural Iodine Chlor + Iodine
 Emergent General Chlor + Alcohol Iodine + Alcohol
 All 3

EBL ml *Groin Incision* None *Total Procedure Time* minutes
 Vertical
 Horizontal

Vascular Quality Initiative - Supra-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 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

Supra-Inguinal Bypass

Current Ambulation Amb Amb w/Assistance Wheelchair Bedridden

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

Current Patency
 Right: Primary Secondary Occluded
 Left: Primary Secondary Occluded

If occluded, Occluded Date

Patency Judged By Doppler Only Palpable Distal Pulse Duplex
 Palpable Graft Pulse ABI Increase > 0.15

ABI
 Right:
 Left:

Infection None Superficial Cellulitis Deep Abscess Infection Involving Artery or Graft

Bypass Revision No Yes, surgery Yes, catheter-based Both
 If Bypass Revision, date:

Thrombectomy/
lysis - Revision

- No
- Yes, surgery
- Yes, catheter-based
- Both

If Thromb. Revision, date:

Major Amputation

Right

- No
- Minor Amp
- BK Amp
- AK Amp

Left

- No
- Minor Amp
- BK Amp
- AK Amp

If Amp, date: