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INCLUSION CRITERIA
1) STEMI patients need to meet one of the following:
   - **Patients with STEMI identified prehospital by:**
     - Software ECG interpretation of STEMI **AND/OR**
     - Paramedic ECG interpretation of STEMI
   - **Patients transported by 911 with an ED interpretation of STEMI:**
     - Identified by physician over-read of a prehospital ECG **OR**
     - Identified on the first ED ECG within 1 hour of arrival and no prehospital ECG=STEMI **OR**
     - Identified on a subsequent ED ECG within 1 hour of arrival
   - **ED inter-facility transfer (IFT) to the SRC via 911 or other private ALS transport for suspected STEMI to be evaluated for emergent PCI** (includes Nurse Specialty Care Interfacility Transports)

2) Cardiac arrest patients need to meet one of the following:
   - Adult patients transported by 9-1-1 with non-traumatic out-of-hospital cardiac arrest (OHCA), with or without return of spontaneous circulation (ROSC) **OR**
   - Patient with STEMI complicated by cardiac arrest, with or without ROSC, at any point in the acute phase (prehospital, ED or cath lab)
**Definition**
Patients with a STEMI identified on the prehospital or ED ECG

**Field Values**
- Yes
- No

**Additional Information**
- Includes one of the following:
  - Patients with STEMI identified prehospital by:
    - Software ECG interpretation of STEMI **AND/OR**
    - Paramedic ECG interpretation of STEMI
  - Patients transported by 911 with an ED interpretation of STEMI:
    - Identified by physician over-read of a prehospital ECG **OR**
    - Identified on the first ED ECG within 1 hour of arrival and no prehospital ECG=STEMI **OR**
    - Identified on a subsequent ED ECG within 1 hour of arrival
  - ED inter-facility transfer (IFT) to the SRC via 911 or other ALS transport for suspected STEMI to be evaluated for emergent PCI (includes Nurse Specialty Care Interfacility Transports)

**Uses**
- Identify patients for inclusion
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- SRC Log
- ED Records
CARDIAC ARREST?

Definition
Patients who suffer a non-traumatic cardiac arrest

Field Values
- Yes
- No

Additional Information
- Includes one of the following:
  - Adult patients transported by 9-1-1 with non-traumatic OHCA, with or without ROSC
  - STEMI patients complicated by a cardiac arrest, with or without ROSC, at any point in the acute phase (prehospital, ED, cath lab)

Uses
- Identify patients for inclusion
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Records
GENERAL INFO
**SEQUENCE NUMBER**

**Definition**
Unique alphanumeric EMS record number found pre-printed at the top right corner of EMS report form hard copies, or electronically assigned to electronic patient care records (ePCRs) from approved providers.

**Additional Information**
- Data entry cannot begin without this number.
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider.
- If sequence number is missing or incorrectly documented, every effort must be taken to obtain it – by reviewing the patient’s medical record, or by contacting either the Prehospital Care Coordinator of the applicable base hospital, or the provider who transported the patient.

**Uses**
- Unique patient identifier.

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Fire Station Logs
- SRC Log
**PROVIDER**

**Definition**
Two-letter code for the EMS provider primarily responsible for the patient’s prehospital care

**Field Values**

<table>
<thead>
<tr>
<th>PUBLIC PROVIDERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Arcadia Fire</td>
</tr>
<tr>
<td>AH</td>
<td>Alhambra Fire</td>
</tr>
<tr>
<td>AV</td>
<td>Avalon Fire</td>
</tr>
<tr>
<td>BA</td>
<td>Burbank Airport Fire</td>
</tr>
<tr>
<td>BF</td>
<td>Burbank Fire</td>
</tr>
<tr>
<td>BH</td>
<td>Beverly Hills Fire</td>
</tr>
<tr>
<td>CB</td>
<td>LA County Beaches</td>
</tr>
<tr>
<td>CC</td>
<td>Culver City Fire</td>
</tr>
<tr>
<td>CF</td>
<td>LA County Fire</td>
</tr>
<tr>
<td>CG</td>
<td>US Coast Guard</td>
</tr>
<tr>
<td>CI</td>
<td>LA City Fire</td>
</tr>
<tr>
<td>CM</td>
<td>Compton Fire</td>
</tr>
<tr>
<td>CS</td>
<td>LA County Sheriff</td>
</tr>
<tr>
<td>DF</td>
<td>Downey Fire</td>
</tr>
<tr>
<td>ES</td>
<td>El Segundo Fire</td>
</tr>
<tr>
<td>FS</td>
<td>U.S. Forest Service</td>
</tr>
<tr>
<td>GL</td>
<td>Glendale Fire</td>
</tr>
<tr>
<td>LB</td>
<td>Long Beach Fire</td>
</tr>
<tr>
<td>LH</td>
<td>La Habra Heights Fire</td>
</tr>
<tr>
<td>LV</td>
<td>La Verne Fire</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRIVATE PROVIDERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>American Professional Ambulance Corp.</td>
</tr>
<tr>
<td>AB</td>
<td>AmbulLife Ambulance, Inc.</td>
</tr>
<tr>
<td>AN</td>
<td>Antelope Ambulance Service</td>
</tr>
<tr>
<td>AR</td>
<td>American Medical Response</td>
</tr>
<tr>
<td>AT</td>
<td>All Town Ambulance</td>
</tr>
<tr>
<td>AU</td>
<td>AmbuServe Ambulance</td>
</tr>
<tr>
<td>AW</td>
<td>AMWest Ambulance</td>
</tr>
<tr>
<td>AZ</td>
<td>Ambulnz Health, Inc.</td>
</tr>
<tr>
<td>CA</td>
<td>CARE Ambulance</td>
</tr>
<tr>
<td>CL</td>
<td>CAL-MED Ambulance</td>
</tr>
<tr>
<td>EA</td>
<td>Emergency Ambulance Service, Inc.</td>
</tr>
<tr>
<td>EX</td>
<td>Explorer 1 Ambulance &amp; Medical Services</td>
</tr>
<tr>
<td>FC</td>
<td>First Care Ambulance</td>
</tr>
<tr>
<td>FM</td>
<td>Firstmed Ambulance Services, Inc.</td>
</tr>
<tr>
<td>GU</td>
<td>Guardian Ambulance Service</td>
</tr>
<tr>
<td>LE</td>
<td>Lifeline Ambulance</td>
</tr>
<tr>
<td>LT</td>
<td>Liberty Ambulance</td>
</tr>
<tr>
<td>LY</td>
<td>Lynch EMS Ambulance</td>
</tr>
</tbody>
</table>

**Uses**
• System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
Definition
Number assigned to the Advanced Life Support (ALS) provider unit that transported the patient

Field Values
- Up to three-digit numeric field
- ND: Not Documented

Uses
- System evaluation and monitoring

Data Hierarchy
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records
DISPATCH DATE

**Definition**
Date the provider was notified by dispatch of the incident

**Field Values**
- Collected as MMDDYYYY
- **ND**: Not Documented

**Uses**
- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
**DISPATCH TIME**

**Definition**
Time of day the provider was notified by dispatch of the incident

**Field Values**
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

**Uses**
- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
PATIENT AGE

Definition
Numeric value for the age (actual or best approximation) of the patient

Field Values
- Up to three-digit numeric value
- **ND**: Not Documented

Uses
- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Billing Sheet / Medical Records Coding Summary Sheet
- SRC Log
PATIENT GENDER

Definition
Checkout indicating the gender of the patient

Field Values
• **F**: Female
• **M**: Male
• **N**: Nonbinary
• **ND**: Not Documented

Additional Information
• Nonbinary refers to patients whose gender identity isn’t exclusively male or female
• Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
• Patients unable to state their preference should be coded according to paramedic observation/judgment

Uses
• Assists with patient identification
• Epidemiological statistics
• System evaluation and monitoring

Data Source Hierarchy
• Facesheet
• ED Records
• History and Physical
• EMS Report Form
• Base Hospital Form
• Base Hospital Log
• Billing Sheet / Medical Records Coding Summary Sheet
• SRC Log
RACE/ETHNICITY

Definition
Checkbox indicating the race and/or ethnicity of the patient

Field Values
- **A**: Asian/Non-Pacific Islander: person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- **B**: Black/African American: person having origins in any of the Black racial groups of Africa (includes Haitians)
- **H**: Latino/Hispanic: person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
- **N**: Native American/Alaska Native: person having origins in any of the original peoples of North, Central, and South America and who maintains tribal affiliation or community attachment
- **P**: Pacific Islander/Native Hawaiian: person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- **W**: White: person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White)
- **O**: Other
- **ND**: Not Documented: race is unknown or not documented

Additional Information
- Patient race/ethnicity should be coded as stated by patient or family member

Uses
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet
## PROVIDER IMPRESSION

### Definition
Four-letter code(s) representing the paramedic’s primary impression of the patient’s presentation

### Field Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABOP</td>
<td>Abdominal Pain/Problems</td>
<td>ELCT</td>
<td>Electrocut</td>
<td>PALP</td>
<td>Palpitations</td>
</tr>
<tr>
<td>AGDE</td>
<td>Agitated Delirium</td>
<td>ENTP</td>
<td>ENT/Dental Emergencies</td>
<td>PREG</td>
<td>Pregnancy Complications</td>
</tr>
<tr>
<td>CHOK</td>
<td>Airway Obstruction/Choking</td>
<td>NOBL</td>
<td>Epistaxis - Nosebleed</td>
<td>LABR</td>
<td>Pregnancy/Labor</td>
</tr>
<tr>
<td>ETOH</td>
<td>Alcohol Intoxication</td>
<td>EXNT</td>
<td>Extremity Pain/Swelling – Non-Traumatic</td>
<td>RARF</td>
<td>Respiratory Arrest/Failure</td>
</tr>
<tr>
<td>ALRX</td>
<td>Allergic Reaction</td>
<td>EYEP</td>
<td>Eye Problem – Unspecified</td>
<td>SOBB</td>
<td>Resp. Distress/Bronchospasm</td>
</tr>
<tr>
<td>ALOC</td>
<td>ALOC – Not Hypoglycemia or Seizure</td>
<td>FEVR</td>
<td>Fever</td>
<td>RDOT</td>
<td>Resp. Distress/Other</td>
</tr>
<tr>
<td>ANPH</td>
<td>Anaphylaxis</td>
<td>GUDO</td>
<td>Genitourinary Disorder – Unspecified</td>
<td>CHFF</td>
<td>Resp. Distress/Pulmonary Edema/CHF</td>
</tr>
<tr>
<td>PSYC</td>
<td>Behavioral/Psychiatric Crisis</td>
<td>DCON</td>
<td>HazMat Skin Exposure</td>
<td>SEAC</td>
<td>Seizure – Active</td>
</tr>
<tr>
<td>BPNT</td>
<td>Body Pain – Non-Traumatic</td>
<td>HPNT</td>
<td>Head Pain – Non-Traumatic</td>
<td>SEPI</td>
<td>Seizure – Postictal</td>
</tr>
<tr>
<td>BURN</td>
<td>Burn</td>
<td>HYPR</td>
<td>Hyperglycemia</td>
<td>SEPS</td>
<td>Sepsis</td>
</tr>
<tr>
<td>COMO</td>
<td>Carbon Monoxide</td>
<td>HYTN</td>
<td>Hypertension</td>
<td>SHOK</td>
<td>Shock</td>
</tr>
<tr>
<td>CANT</td>
<td>Cardiac Arrest – Non-Traumatic</td>
<td>HEAT</td>
<td>Hyperthermia</td>
<td>SMOK</td>
<td>Smoke Inhalation</td>
</tr>
<tr>
<td>DYSR</td>
<td>Cardiac Dysrhythmia</td>
<td>HYPO</td>
<td>Hypoglycemia</td>
<td>STNG</td>
<td>Stings/Venomous Bites</td>
</tr>
<tr>
<td>CPNC</td>
<td>Chest Pain – Non-Cardiac</td>
<td>HOTN</td>
<td>Hypotension</td>
<td>STRK</td>
<td>Stroke/CVA/TIA</td>
</tr>
<tr>
<td>CPMI</td>
<td>Chest Pain – STEMI</td>
<td>COLD</td>
<td>Hypothermia/Cold Injury</td>
<td>DRWN</td>
<td>Submersion/Drowning</td>
</tr>
<tr>
<td>CPSC</td>
<td>Chest Pain – Suspected Cardiac</td>
<td>INHL</td>
<td>Inhalation Injury</td>
<td>SYNC</td>
<td>Syncope/Near Syncope</td>
</tr>
<tr>
<td>BRTH</td>
<td>Childbirth (Mother)</td>
<td>LOGI</td>
<td>Lower GI Bleeding</td>
<td>TRMA</td>
<td>Traumatic Injury</td>
</tr>
<tr>
<td>COFL</td>
<td>Cold/Flu Symptoms</td>
<td>FAIL</td>
<td>Medical Device Malfunction – Fail</td>
<td>UPGI</td>
<td>Upper GI Bleeding</td>
</tr>
<tr>
<td>DRHA</td>
<td>Diarrhea</td>
<td>NAVM</td>
<td>Nausea/Vomiting</td>
<td>VABL</td>
<td>Vaginal Bleeding</td>
</tr>
<tr>
<td>DIZZ</td>
<td>Dizziness/Vertigo</td>
<td>NOMC</td>
<td>No Medical Complaint</td>
<td>WEAK</td>
<td>Weakness – General</td>
</tr>
<tr>
<td>DYRX</td>
<td>Dystonic Reaction</td>
<td>ODPO</td>
<td>Overdose/Poisoning/Ingestion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information
- Enter up to two provider impressions, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Do not enter more than one copy of the same provider impression code

### Uses
- System evaluation and monitoring
- Epidemiological statistics

### Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
# CHIEF COMPLAINT

## Definition
Two-letter code(s) representing the patient’s most significant medical complaints

## Field Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>Agitated Delirium</td>
</tr>
<tr>
<td>AP</td>
<td>Abdominal/Pelvic Pain</td>
</tr>
<tr>
<td>AR</td>
<td>Allergic Reaction</td>
</tr>
<tr>
<td>AL</td>
<td>Altered Level of Consciousness</td>
</tr>
<tr>
<td>AE</td>
<td>Apneic Episode</td>
</tr>
<tr>
<td>EH</td>
<td>Behavioral (abnormal behavior of apparent mental or emotional origin)</td>
</tr>
<tr>
<td>OS</td>
<td>Bleeding: Other Site (NOT associated with trauma, e.g., dialysis shunt)</td>
</tr>
<tr>
<td>CA</td>
<td>Cardiac Arrest (NOT associated with trauma)</td>
</tr>
<tr>
<td>CP</td>
<td>Chest Pain (NOT associated with trauma)</td>
</tr>
<tr>
<td>CH</td>
<td>Choking/Airway Obstruction</td>
</tr>
<tr>
<td>CC</td>
<td>Cough/Congestion</td>
</tr>
<tr>
<td>DC</td>
<td>Device Complaint (associated with existing medical device, e.g., g-tube, AICD, ventilator, etc.)</td>
</tr>
<tr>
<td>DI</td>
<td>Dizzy (sensation of spinning or feeling off-balance)</td>
</tr>
<tr>
<td>DY</td>
<td>Dysrhythmia</td>
</tr>
<tr>
<td>FE</td>
<td>Fever</td>
</tr>
<tr>
<td>FB</td>
<td>Foreign Body (anywhere in body)</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal Bleeding</td>
</tr>
<tr>
<td>HP</td>
<td>Head Pain (NOT associated with trauma)</td>
</tr>
<tr>
<td>HY</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>IM</td>
<td>Inpatient Medical Interfacility Transfer (IFT) of an admitted, ill (NOT injured) patient, from one facility to an inpatient bed at another facility, excluding ER To ER transfers</td>
</tr>
<tr>
<td>LN</td>
<td>Local Neuro signs (e.g., weakness, numbness, paralysis, slurred speech, facial droop, aphasia)</td>
</tr>
<tr>
<td>NV</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>ND</td>
<td>Near-Drowning/Drowning (submersion causing water inhalation, unconsciousness, or death)</td>
</tr>
<tr>
<td>NB</td>
<td>Neck/Back Pain (NOT associated with trauma)</td>
</tr>
<tr>
<td>NC</td>
<td>No Medical Complaint, or signs or symptoms of illness (NOT associated with trauma)</td>
</tr>
<tr>
<td>NO</td>
<td>Nosebleed (NOT associated with trauma)</td>
</tr>
<tr>
<td>OB</td>
<td>Obstetrics (any complaint possibly related to a known pregnancy, e.g., bleeding, pain, hypertension)</td>
</tr>
<tr>
<td>OP</td>
<td>Other Pain (pain at site not listed, NOT associated with trauma – e.g., toothache, earache, etc.)</td>
</tr>
<tr>
<td>OD</td>
<td>Overdose (dose greater than recommended or generally given)</td>
</tr>
<tr>
<td>PO</td>
<td>Poisoning (ingestion of or contact with a toxic substance)</td>
</tr>
<tr>
<td>PS</td>
<td>Palpitations</td>
</tr>
<tr>
<td>RA</td>
<td>Respiratory Arrest (cessation of breathing NOT associated with trauma)</td>
</tr>
<tr>
<td>SE</td>
<td>Seizure (NOT associated with trauma)</td>
</tr>
<tr>
<td>SB</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>SY</td>
<td>Syncope</td>
</tr>
<tr>
<td>VA</td>
<td>Vaginal Bleeding</td>
</tr>
<tr>
<td>WE</td>
<td>Weakness</td>
</tr>
<tr>
<td>OT</td>
<td>Other (signs or symptoms not listed above, NOT associated with trauma)</td>
</tr>
<tr>
<td>N/D</td>
<td>Not Documented</td>
</tr>
</tbody>
</table>
Additional Information
- Enter up to three complaints, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Electrical shock, lightning strike, and hanging are mechanisms of injury rather than chief complaints – use “Other” and document the injury description in the comment section of the General Info tab
- Do not enter more than one copy of the same chief complaint code

Uses
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records
- History and Physical
SRC ED ARRIVAL DATE

Definition
Date the patient arrived at the SRC ED

Field Values
• Collected as MMDDYYYY

Additional Information
• If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door date

Uses
• Establishes care intervals and incident timelines
• Assists with determination of appropriate treatment and transport
• System evaluation and monitoring

Data Source Hierarchy
• SRC Log
• ED Records
• EMS Report Form
• Other Hospital Records
SRC ED ARRIVAL TIME

Definition
Time of day the patient arrived at the SRC ED

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door time

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- SRC Log
- ED Records
- EMS Report Form
- Other Hospital Records
HOSP. DISCHARGE DATE

Definition
Date the patient was discharged from the acute care unit at your facility

Field Values
- MMDDYYYY
- ND: Not Documented

Additional Information
- Applicable when the patient:
  - Expires
  - Is discharged
  - Leaves against medical advice (AMA)
  - Leaves without being seen (LWBS) or elopes
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit (at your facility or another facility)
  - Is transferred to an acute inpatient unit at another facility

Uses
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet
OUTCOME

Definition
Checkbox indicating whether the patient lived or died during their hospital stay at your facility

Field Values
- L: Lived
- ED: Died in ED
- CL: Died in Cath Lab
- OT: Died in Other
- ND: Not Documented

Additional Information
- If patient died in the Emergency Department (ED), ED Pronounced Time must have a value

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Hospital Discharge Summary
- ED Records
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet
ED PRONOUNCED TIME

Definition
Time of day patient was pronounced dead at your facility’s Emergency Department, if applicable

Field Values
• HHMM
• ND: Not Documented

Uses
• Establishes care intervals and incident timelines
• Assists with determination of appropriate treatment and transport
• System evaluation and monitoring

Data Source Hierarchy
• ED Records
• Hospital Discharge Summary
• Billing Sheet / Medical Records Coding Summary Sheet
DNR STATUS

Definition
Field indicating the patient’s Do Not Resuscitate (DNR) status

Field Values
- **E:** Existing (DNR order in place upon arrival)
- **NE:** New (DNR order written during hospital stay)
- **NO:** None (patient does not have a DNR order)

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- ED Records
- Other Hospital Records
- Progress Notes
- Hospital Discharge Summary
COMORBIDITIES

Definition
Field indicating whether co-morbid conditions or factors were also present (check all that apply)

Field Values
- BM: Body Mass Index greater than 40
- BP: Hypertension
- CG: Prior CABG
- CH: Congestive Heart Failure
- CO: Chronic Obstructive Pulmonary Disease
- CS: Cardiogenic Shock on presentation
- CV: Cerebrovascular Disease
- DM: Diabetes
- ES: End-stage Renal Disease
- HX: Family History of Coronary Artery Disease (CAD)
- HL: Hyperlipidemia
- MI: Prior Myocardial Infarction
- NO: None
- PC: Prior Percutaneous Coronary Intervention (PCI)
- PV: Peripheral Vascular Disease
- SM: Smoker - current/recent Tobacco (within 1 year)
- SP: Sepsis
- ND: Not Documented

Additional Information
- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Body Mass Index is calculated as weight in kg divided by height in meters-squared
- Cerebrovascular disease is defined as history of TIA or stroke
- End-stage renal disease is defined as patient receiving peritoneal or hemodialysis
- Family history of coronary artery disease is defined as a parent or sibling with history of myocardial infarction, PCI and/or CABG
- Cardiogenic shock is defined as:
  - Sustained (>30 min) episode of systolic blood pressure <90mm Hg and/or
  - Cardiac index <2.2L/min/m² determined to be secondary to cardiac dysfunction and/or
  - Requires parenteral inotropic or vasopressor agents OR
  - Requires mechanical support (from an IABP, extracorporeal circulation, ventricular assist devices, etc.) to maintain blood pressure and cardiac index above specified levels
Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Hospital Discharge Summary
- Billing Sheet / Medical Records Coding Summary Sheet
HOSP. DISPOSITION

Definition
Checkbox indicating the patient’s destination upon discharge from the acute care unit at your facility

Field Values
• **Home**: Home/Previous place of residence
• **SNF**: Extended Care/Skilled Nursing Facility (SNF)
• **Subacute**: Sub-Acute/Transitional Care/Rehabilitation Care Facility
• **Acute**: Other Acute Care Facility
• **Morgue**: Morgue/Mortuary
• **AMA**: Left Against Medical Advice (AMA)/Eloped/Left Without Being Seen (LWBS)
• **Other**: Other
• **ND**: Not Documented

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Hospital Discharge Summary
• Progress Notes
• Billing Sheet / Medical Records Coding Summary Sheet
**Definition**
Field provided to document relevant information regarding the patient’s care, not already captured by a defined data field

**Field Values**
- Free-text

**Uses**
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- ED Notes
- Progress Notes
- Other Hospital Records
SRC
EARLIEST REPORTED SYMPTOM ONSET DATE

Definition
Date when the patient first noted to have symptoms lasting longer than ten minutes

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Additional Information
- If symptoms are intermittent, symptom onset can be determined by when the symptoms became constant in quality or intensity
- Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other symptoms suggestive of a myocardial infarction

Uses
- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
EARLIEST REPORTED SYMPTOM ONSET TIME

Definition
Time of day when the patient first noted to have symptoms lasting longer than ten minutes

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information
- If symptom onset time is not specified, it may be recorded as:
  - 0700 for morning
  - 1200 for lunchtime
  - 1500 for afternoon
  - 1800 for dinnertime
  - 2200 for evening
  - 0300 if awakened from sleep

Uses
- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
TRANSFER?

Definition
Checkbox indicating whether the patient was transferred to the SRC from another acute care facility

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- SRC Log
- ED Records
# TRANSFERRING FACILITY

**Definition**
Three-letter code of the facility from which the patient was transferred, if applicable

**Field Values**

<table>
<thead>
<tr>
<th>LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
</tr>
<tr>
<td>ACH Alhambra Hospital Medical Center</td>
</tr>
<tr>
<td>AHM Catalina Island Medical Center</td>
</tr>
<tr>
<td>AMH Methodist Hospital of Southern California</td>
</tr>
<tr>
<td>AVH Antelope Valley Hospital</td>
</tr>
<tr>
<td>BEV Beverly Hospital</td>
</tr>
<tr>
<td>BMC Southern California Hospital at Culver City</td>
</tr>
<tr>
<td>CAL Dignity Health - California Hospital Medical Center</td>
</tr>
<tr>
<td>CHH Children's Hospital Los Angeles</td>
</tr>
<tr>
<td>CHP Community Hospital of Huntington Park</td>
</tr>
<tr>
<td>CNT Centinela Hospital Medical Center</td>
</tr>
<tr>
<td>CPM Coast Plaza Doctors Hospital</td>
</tr>
<tr>
<td>CSM Cedars-Sinai Medical Center</td>
</tr>
<tr>
<td>DCH PIH Health Hospital - Downey</td>
</tr>
<tr>
<td>DFM Marina Del Rey Hospital</td>
</tr>
<tr>
<td>DHL Lakewood Regional Medical Center</td>
</tr>
<tr>
<td>ELA East Los Angeles Doctors Hospital</td>
</tr>
<tr>
<td>ENH Encino Hospital Medical Center</td>
</tr>
<tr>
<td>FPH Foothill Presbyterian Hospital</td>
</tr>
<tr>
<td>GAR Garfield Medical Center</td>
</tr>
<tr>
<td>GEM Greater El Monte Community Hospital</td>
</tr>
<tr>
<td>GMH Dignity Health - Glendale Memorial Hospital and Health Center</td>
</tr>
<tr>
<td>GSH Good Samaritan Hospital</td>
</tr>
<tr>
<td>GWT Adventist Health - Glendale</td>
</tr>
<tr>
<td>HCH Providence Holy Cross Medical Center</td>
</tr>
<tr>
<td>HEV Glendora Community Hospital</td>
</tr>
<tr>
<td>HGH LAC Harbor-UCLA Medical Center</td>
</tr>
<tr>
<td>HMM Henry Mayo Newhall Hospital</td>
</tr>
<tr>
<td>HWH West Hills Hospital &amp; Medical Center</td>
</tr>
<tr>
<td>ICH Emanate Health Inter-Community Hospital</td>
</tr>
<tr>
<td>KFA Kaiser Foundation Hospital - Baldwin Park</td>
</tr>
<tr>
<td>KFB Kaiser Foundation Hospital - Downey</td>
</tr>
<tr>
<td>KFH Kaiser Foundation Hospital - South Bay</td>
</tr>
<tr>
<td>KFL Kaiser Foundation Hospital - Sunset (LA)</td>
</tr>
<tr>
<td>KFO Kaiser Foundation Hospital - Woodland Hills</td>
</tr>
<tr>
<td>KFP Kaiser Foundation Hospital - Panorama City</td>
</tr>
<tr>
<td>KFW Kaiser Foundation Hospital - West Los Angeles</td>
</tr>
</tbody>
</table>
### ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name</th>
<th>Code</th>
<th>Hospital Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANH</td>
<td>Anaheim Regional Medical Center</td>
<td>LAG</td>
<td>Los Alamitos Medical Center</td>
</tr>
<tr>
<td>CHO</td>
<td>Children’s Hospital of Orange County</td>
<td>LPI</td>
<td>La Palma Intercommunity Hospital</td>
</tr>
<tr>
<td>FHP</td>
<td>Fountain Valley Regional Hospital &amp; Medical Center</td>
<td>PLH</td>
<td>Placentia Linda Hospital</td>
</tr>
<tr>
<td>KHA</td>
<td>Kaiser Foundation Hospital - Anaheim</td>
<td>SJD</td>
<td>St. Jude Medical Center</td>
</tr>
<tr>
<td>KFI</td>
<td>Kaiser Foundation Hospital - Irvine</td>
<td>UCI</td>
<td>University of California - Irvine Medical Center</td>
</tr>
</tbody>
</table>

### SAN BERNADINO COUNTY 9-1-1 RECEIVING HOSPITALS

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>Arrowhead Regional Medical Center</td>
</tr>
<tr>
<td>CHI</td>
<td>Chino Valley Medical Center</td>
</tr>
<tr>
<td>DHM</td>
<td>Montclair Hospital Medical Center</td>
</tr>
<tr>
<td>KFF</td>
<td>Kaiser Foundation Hospital - Fontana</td>
</tr>
<tr>
<td>KFN</td>
<td>Kaiser Foundation Hospital - Ontario</td>
</tr>
<tr>
<td>LRU</td>
<td>Los Robles Hospital &amp; Med Ctr (Ventura)</td>
</tr>
<tr>
<td>SAC</td>
<td>San Antonio Community Hospital</td>
</tr>
<tr>
<td>SJO</td>
<td>St. John Regional Medical Center (Ventura)</td>
</tr>
</tbody>
</table>

### OTHER COUNTY 9-1-1 RECEIVING HOSPITALS

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRR</td>
<td>Los Robles Hospital &amp; Med Ctr (Ventura)</td>
</tr>
<tr>
<td>SIM</td>
<td>Adventist Health - Simi Valley (Ventura)</td>
</tr>
<tr>
<td>RCC</td>
<td>Ridgecrest Regional Hospital (Kern)</td>
</tr>
</tbody>
</table>

### Uses
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

### Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- SRC Log
- SRC ED Records
- SRC Progress Notes
SRF ED ARRIVAL DATE

Definition
Date the patient arrived at the STEMI Referral Facility (SRF) ED

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- SRF Facesheet
- SRF Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
SRF ED ARRIVAL TIME

Definition
Time of day the patient arrived at the SRF ED

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- SRF Facesheet
- SRF Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
**1st SRF STEMI ECG DATE**

**Definition**
Date the first ECG performed at the SRF was interpreted as STEMI

**Field Values**
- Collected as MMDDYYYY
- **ND**: Not Documented

**Uses**
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**
- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Report Form
- Base Hospital Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
1st SRF STEMI ECG TIME

Definition
Time of day the first ECG performed at the SRF was interpreted as STEMI

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy
- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Report Form
- Base Hospital Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
Definition
Date the patient left the SRF ED en route to the SRC ED

Field Values
- Collected as MMDDYYYY
- **ND:** Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- SRF Facesheet
- SRF Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
SRF ED DEPARTURE TIME

Definition
Time of day the patient left the SRF en route to the SRC ED

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information
- If departure time is not documented by the SRF, it is acceptable to use the departure time ('Left' time) documented by the medic on the EMS Report Form/ePCR

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- SRF Facesheet
- SRF ED Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records
PREHOSPITAL ECG PERFORMED?

Definition
Checkbox indicating whether an ECG was performed prior to the patient’s arrival at the SRC ED

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- SRC Log
- ED Records
- Progress Notes
**1st PREHOSPITAL ECG DATE**

**Definition**
Date of the first ECG performed prior to the patient’s arrival at the SRC ED

**Field Values**
- Collected as MMDDYYYY
- **ND**: Not Documented

**Additional Information**
- Enter the date of the first ECG performed, regardless of impression

**Uses**
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes
1st PREHOSPITAL ECG TIME

Definition
Time of day of the first ECG performed prior to the patient’s arrival at the SRC ED

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information
- Enter the time of the first ECG performed, regardless of impression

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes
1st PREHOSPITAL ECG PERFORMED BY

Definition
Checkbox indicating who performed the first ECG prior to the patient’s arrival at the SRC ED

Field Values
- **EMS**: EMS Personnel
- **Clinic**: Physician’s office, clinic, urgent care, other facility where medical care provided, etc.
- **ND**: Not Documented

Additional Information
- Enter the information from the first ECG performed, regardless of impression

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- ED Records
- Progress Notes
PRE-HOSPITAL ECG=STEMI?

Definition
Checkbox indicating whether any of the ECGs performed prehospital had an interpretation of STEMI

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- ED Records
- Progress Notes
Definition
Date of the first ECG performed prior to the patient’s arrival at the SRC ED that was interpreted as STEMI

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes
Definition
Time of day of the first ECG performed prior to the patient’s arrival at the SRC ED
that was interpreted as STEMI, if applicable

Field Values
• Collected as HHMM
• Use 24-hour clock
• ND: Not Documented

Uses
• Establishes care intervals and incident timelines
• Assists with determination of appropriate treatment
• Provides documentation of care
• System evaluation and monitoring

Data Source Hierarchy
• EMS Report Form
• Base Hospital Form
• Physician’s Office/Clinic/Urgent Care Records
• SRC Log
• ECG Tracing
• ED Records
• Progress Notes
SOFTWARE INTERPRETED STEMI?

Definition
Checkbox indicating whether STEMI was interpreted by prehospital equipment software

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information
- Indicate yes if the software interpretation is ***MEETS ST ELEVATION MI CRITERIA*** (Physio-Control) or ***STEMI*** (Zoll) or other manufacturer equivalent

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ECG Tracing
- ED Records
EMS INTERPRETED STEMI?

Definition
Checkbox indicating whether STEMI was identified by EMS interpretation of the ECG

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Additional Information
- Indicate yes if there is an EMS interpretation of STEMI with 1-2 mm of ST Elevation in two (2) contiguous leads

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ECG Tracing
- ED Records
WAS THE PREHOSPITAL ECG RECEIVED PRIOR TO PATIENT ARRIVAL?

Definition
Checkbox indicating whether a transmitted copy of the prehospital ECG was received by the SRC ED prior to the patient’s arrival

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Receiving Equipment (Cloud/Xchanger/Email/Fax)
- SRC Log
- ED Records
PREHOSPITAL ECG RECEIVED DATE

Definition
Date the prehospital ECG was received by your facility’s ECG receiving equipment

Field Values
- Collected as MMDDYYYY
- **ND**: Not Documented

Additional Information
- ECG receiving equipment includes the Cloud, Xchanger, email (Gmail, etc.), or fax
- Enter “ND” if the prehospital ECG was not received by your facility’s ECG receiving equipment

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Receiving Equipment
- SRC Log
- ED Records
PREHOSPITAL ECG RECEIVED TIME

Definition
Time of day the prehospital ECG was received by your facility’s ECG receiving equipment

Field Values
• Collected as HHMM
• Use 24-hour clock
• ND: Not Documented

Additional Information
• ECG receiving equipment includes the Cloud, Xchanger, email (Gmail, etc.), or fax
• Enter “ND” if the prehospital ECG was not received by your facility’s ECG receiving equipment

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• ECG Receiving Equipment
• SRC Log
• ED Records
Definition
Checkbox indicating whether an ECG was performed in the SRC ED

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Other Hospital Records
INITIAL SRC ED ECG DATE

Definition
Date the initial ECG was performed at the SRC ED

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Additional Information
- Enter the date of the first ECG performed at the SRC ED, regardless of impression

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
INITIAL SRC ED ECG TIME

Definition
Time of day the initial ECG was performed at the SRC ED

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information
- Enter the time of the first ECG performed at the SRC ED, regardless of impression

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
STEMI IDENT. ON INITIAL SRC ED ECG?

Definition
Checkbox indicating whether the initial ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
STEMI IDENT. ON SUBSEQUENT SRC ED ECG?

Definition
Checkbox indicating whether a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Additional Information
- Only enter a value when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
SUBSEQUENT SRC ED STEMI ECG DATE

Definition
Date that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Additional Information
- Only enter the date of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
SUBSEQUENT SRC ED STEMI ECG TIME

Definition
Time of day that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information
- Only enter the time of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records
**Definition**
Patient’s initial SRC ED systolic blood pressure (SBP)

**Field values**
- Up to three-digit numeric field

**Additional Information**
- Value cannot be greater than 300

**Uses**
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- ED Records
- Progress Notes
- Other Hospital Records
 SRC ED HR

Definition
Patient's initial SRC ED heart rate (HR)

Field values
• Up to three-digit numeric field

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• ED Records
• Progress Notes
• Other Hospital Records
ELEVATED TROPONIN?

Definition
Checkbox indicating whether the troponin level was elevated above lab threshold within the first 24 hours from SRC ED arrival

Field values
- **Y**: Yes
- **N**: No

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records
PEAK TROPONIN VALUE

Definition
The highest troponin value resulted within the first 24 hours from SRC ED arrival

Field Values
- Up to seven-digit numeric value

Additional Information
- Include decimals when indicated

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records
FIBRINOLYTIC INFUSION?

Definition
Checkbox indicating whether the patient received a fibrinolytic infusion at the SRF or SRC ED as an urgent treatment for a STEMI

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Additional Information:
- Do not include the fibrinolytics used during percutaneous intervention (PCI)

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records
**FIBRINOLYTIC INFUSION DATE**

**Definition**
Date patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

**Field Values**
- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records
FIBRINOLYTIC INFUSION TIME

Definition
Time of day the patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

Field Values
- Collected as HHMM
- Use 24-hr clock
- ND: Not Documented

Additional Information
- Enter the time the infusion began

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records
CL ACTIVATED?

Definition
  Checkbox indicating whether the cath lab (CL) team was activated

Field Values
  • Y: Yes
  • N: No
  • ND: Not Documented

Uses
  • Assists with determination of appropriate treatment
  • System evaluation and monitoring

Data Source Hierarchy
  • Cath Lab pager
  • ED Records
  • SRC Log
  • Progress Notes
  • Other Hospital Records
REASON CL NOT ACTIVATED

Definition
Checkbox indicating the primary reason why the CL team was not activated from the field or SRC ED

Field Values
- **Poor Quality**: Poor quality Pre-SRC ECG
- **Non-ischemic**: Non-ischemic cause of ST-elevation
- **Dysrhythmia**: Dysrhythmia
- **Early Repol**: Early Repolarization
- **MD**: Physician Judgment
- **Vasospasm**: Vasospasm
- **DNR**: DNR
- **Refused**: Patient refused
- **Expired**: Patient expired
- **Other**: Other
- **ND**: Not Documented

Additional Information
- Non-ischemic cause of ST-elevation includes but is not limited to: Pericarditis/myocarditis, Brugada syndrome, Takotsubo syndrome, hyperkalemia, bundle branch blocks, paced rhythm, and left ventricular aneurysm
- Dysrhythmia includes any atrial or ventricular dysrhythmia: atrial tachycardias, atrial fibrillation, atrial flutter, junctional tachycardias, ventricular tachycardias
- If “Other” is marked, must document reason in ‘Comment to Other’ field

Uses
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records
**COMMENT TO OTHER**

**Definition**
Field provided to specify why “Other” was selected as the primary reason why the CL team was not activated

**Field Values**
- Free-text

**Additional Information**
- Do not enter information into this field unless ‘Reason CL Not Activated’ has a value of “Other”

**Uses**
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- ED Records
- Progress Notes
- Other Hospital Records
DIAGNOSIS AT DISCHARGE

Definition
Checkbox indicating whether any of the below diagnoses were included in the list of final diagnoses for the patient

Field Values
- **STEMI:** STEMI
- **NSTEMI:** NSTEMI
- **Neither:** Neither

Additional Information
- Patients with a final diagnosis of STEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.0
  - I21.1
  - I21.2
  - I21.3
  - I22.0
  - I22.1
  - I22.8
  - I22.9
- Patients with a final diagnosis of NSTEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.4
  - I22.2

Uses
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records
CL
PT LOCATION WHEN CL ACTIVATED

Definition
Patient’s location when the CL team was activated

Field Values
- **Pre-SRC**: Pre-SRC
- **SRC**: SRC ED
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- SRC Log
- Cath Lab Report
- EMS Report Form
CL ACTIVATION DATE

Definition
Date the CL team was activated

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Records
CL ACTIVATION TIME

Definition
Time of day the CL team was activated

Field Values
- Collected as HHMM
- Use 24-hour clock
- **ND**: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports
DID THE PATIENT GO TO THE CATH LAB?

Definition
Checkbox indicating whether the patient went to the cath lab

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports
REASON PT DID NOT GO TO CL

Definition
Checkbox indicating the primary reason why the patient was not transported to the cath lab directly from the field or ED

Field Values
- **Poor quality**: Poor quality Pre-SRC ECG
- **Non-ischemic**: Non-ischemic cause of ST-elevation
- **Dysrhythmia**: Dysrhythmia
- **Early Repol**: Early Repolarization
- **Age**: Age
- **Allergy**: Allergy to contrast
- **CL Not Avail**: Cath lab not available
- **DNR**: DNR
- **Co-morbid**: Co-morbidities
- **Multi-vessel**: Known multi-vessel disease
- **CABG**: CABG (candidate or recent surgery)
- **Vasospasm**: Vasospasm
- **Refused**: Patient refused
- **Expired**: Patient expired
- **Other**: Other
- **ND**: Not documented

Additional Information
- Non-ischemic cause of ST-elevation includes but is not limited to: Pericarditis/myocarditis, Brugada syndrome, Takotsubo syndrome, hyperkalemia, bundle branch blocks, paced rhythm, left ventricular aneurysm
- Dysrhythmia includes any atrial or ventricular dysrhythmia: atrial tachycardias, atrial fibrillation, atrial flutter, junctional tachycardias, ventricular tachycardias
- If “Other” is marked, must document reason in ‘Comment to Other’ field

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
- Progress Notes
- ED Records
**COMMENT TO OTHER**

**Definition**
Field provided to specify why “Other” was selected as the primary reason why patient did not go to cath lab directly from the field or ED

**Field Values**
- Free-text

**Additional Information**
- Do not enter information into this field unless ‘Reason Pt Did Not Go to CL’ has a value of “Other”

**Uses**
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- Cath Lab Report
- Progress Notes
- ED Records
LOCATION OF PATIENT WHEN ROUTED TO CATH LAB

Definition
Patient’s location when directed to the cath lab

Field Values
- E: SRC ED
- P: Pre-SRC
- I: Inpatient

Additional Information
- Enter “SRC ED” if the patient was transported to the cath lab from the SRC ED
- Enter “Pre-SRC” if the patient was transported directly to the cath lab by EMS and did not stop in the SRC ED
- Enter “Inpatient” if the patient was transported to the cath lab from an inpatient bed within 24 hours of admission

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports
CL ARRIVAL DATE

Definition
Date patient arrived in the cath lab

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
CL ARRIVAL TIME

**Definition**
Time of day patient arrived in the cath lab

**Field Values**
- Collected as HHMM
- Use 24-hour clock
- **ND**: Not Documented

**Uses**
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- Cath Lab Report
CATH STATUS

Definition
Checkbox indicating the urgency of the primary diagnostic catheterization

Field Values
- **E**: Emergent
- **U**: Urgent
- **S**: Salvage

Additional Information
- Emergent: there is a concern for ongoing STEMI
- Urgent: inpatient procedure prior to discharge, includes non-salvage catheterization following ROSC
- Salvage: last resort to save the patient’s life, defined by the presence of at least one of the following:
  - The patient is in cardiogenic shock at the start of the procedure OR
  - The patient has received chest compressions within ten minutes of the start of the procedure OR
  - The patient was on unanticipated extracorporeal support

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
- Progress Notes
ARTERIAL ACCESS SITE

Definition
Checkbox indicating the location used to gain vascular access for catheterization

Field Values
- **F**: Femoral only
- **B**: Brachial only
- **R**: Radial only
- **FB**: Femoral then Brachial
- **FR**: Femoral then Radial
- **BF**: Brachial then Femoral
- **RF**: Radial then Femoral
- **RB**: Radial then Brachial
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
PCI PERFORMED?

**Definition**
Checkbox indicating whether a PCI, or placement of a device for the purpose of mechanical coronary revascularization, was performed

**Field Values**
- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- Cath Lab Report
REASON PCI NOT PERFORMED

Definition
Checkbox indicating the primary reason why PCI was not performed

Field Values
- **CABG/IABP**: Candidate for CABG/IABP
- **No Access**: Unable to Gain Vascular Access
- **Lesion Unable**: Unable to Cross Lesion
- **Multi-vessel**: Multi-Vessel Disease
- **No Lesions**: No Lesions Found/Normal Coronaries
- **Expired**: Patient Expired in Cath Lab
- **Takotsubo**: Takotsubo Syndrome
- **Spasm**: Vessel Spasm
- **Other**: Other
- **ND**: Not Documented

Additional Information
- If “Other” is marked, must document reason in ‘Comment to Other’ field

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
COMMENT TO OTHER

Definition
Field provided to specify why “Other” was selected as the primary reason why PCI was not performed

Field Values
• Free-text

Additional Information
• Do not enter information into this field unless ‘Reason PCI Not Performed’ has a value of “Other”

Uses
• Provides documentation of assessment
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Cath Lab Report
PCI DATE

Definition
Date PCI was performed

Field Values
- Collected as MMDDYYYY
- **ND**: Not Documented

Additional Information
- Use the date that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
**PCI TIME**

**Definition**
Time of day PCI was performed

**Field Values**
- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**
- Use the time that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only

**Uses**
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- Cath Lab Report
NON-SYSTEM DELAYS TO PCI?

Definition
Checkbox indicating whether there were patient-related delays to performing PCI

Field Values
• Y: Yes
• N: No
• ND: Not Documented

Uses
• Establishes care intervals and incident timelines
• Provides documentation of care
• System evaluation and monitoring

Data Source Hierarchy
• Cath Lab Report
DELAYS TO PCI

Definition
  Checkbox indicating patient-related delays to performing PCI

Field Values
  • CA: Cardiac Arrest
  • Intubation: Intubation Required
  • Access: Difficulty Obtaining Vascular Access
  • Lesion: Difficulty Crossing Lesion
  • Consent: Consent Delay
  • Other: Other
  • ND: Not Documented

Additional Information
  • If “Other” is marked, must document reason in ‘Comment to Other’ field
  • Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

Uses
  • Establishes care intervals and incident timelines
  • Provides documentation of care
  • System evaluation and monitoring

Data Source Hierarchy
  • Cath Lab Report
COMMENT TO OTHER

Definition
Field provided to specify why “Other” was selected as the reason why there were patient-related delays to performing PCI

Field Values
• Free-text

Additional Information
• Do not enter information into this field unless ‘Delays to PCI’ has a value of “Other”

Uses
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Cath Lab Report
CULPRIT LESION?

Definition
Checkbox indicating whether the primary lesion responsible for the acute coronary event was located

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Additional Information
- Refers to the primary lesion responsible for the acute coronary event as documented by the interventionalist
- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

Data Source Hierarchy
- Cath Lab Report
- Progress Notes
- Other Hospital Records
CULPRIT LESION LOCATION

Definition
Checkbox indicating the segment where the primary lesion responsible for the acute coronary event was located

Field Values

<table>
<thead>
<tr>
<th>Culprit Lesion Segment Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>pRCA</strong></td>
</tr>
<tr>
<td><strong>mRCA</strong></td>
</tr>
<tr>
<td><strong>dRCA</strong></td>
</tr>
<tr>
<td><strong>rPDA</strong></td>
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<tr>
<td><strong>rPAV</strong></td>
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<tr>
<td><strong>1st RPL</strong></td>
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<tr>
<td><strong>2nd RPL</strong></td>
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<tr>
<td><strong>3rd RPL</strong></td>
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<tr>
<td><strong>pDSP</strong></td>
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<tr>
<td><strong>aMarg</strong></td>
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<tr>
<td><strong>LM</strong></td>
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<tr>
<td><strong>pLAD</strong></td>
</tr>
<tr>
<td><strong>mLAD</strong></td>
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<tr>
<td><strong>dLAD</strong></td>
</tr>
<tr>
<td><strong>1st Diag</strong></td>
</tr>
<tr>
<td><strong>Lat 1st Diag</strong></td>
</tr>
<tr>
<td><strong>2nd Diag</strong></td>
</tr>
<tr>
<td><strong>Lat 2nd Diag</strong></td>
</tr>
<tr>
<td><strong>LAD SP</strong></td>
</tr>
<tr>
<td><strong>pCIRC</strong></td>
</tr>
<tr>
<td><strong>mCIRC</strong></td>
</tr>
<tr>
<td><strong>dCIRC</strong></td>
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<tr>
<td><strong>1st OM</strong></td>
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<td><strong>Lat 1st OM</strong></td>
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<td><strong>2nd OM</strong></td>
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<td><strong>Lat 2nd OM</strong></td>
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<tr>
<td><strong>3rd OM</strong></td>
</tr>
<tr>
<td><strong>Lat 3rd OM</strong></td>
</tr>
<tr>
<td><strong>1st LPL</strong></td>
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<td><strong>2nd LPL</strong></td>
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<tr>
<td><strong>3rd LPL</strong></td>
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<td><strong>LPDA</strong></td>
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<td><strong>Ramus</strong></td>
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<tr>
<td><strong>Lat Ramus</strong></td>
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<tr>
<td><strong>3rd Diag</strong></td>
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<tr>
<td><strong>Lat 3rd Diag</strong></td>
</tr>
<tr>
<td><strong>OTH</strong></td>
</tr>
<tr>
<td><strong>ND</strong></td>
</tr>
</tbody>
</table>

Additional Information
- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
- Progress Notes
- Other Hospital Records
PT INCURRED INTRA- OR POST-PROCEDURAL STROKE?

Definition
Checkbox indicating whether the patient experienced stroke signs or symptoms during or immediately following the PCI procedure that did not resolve within 24 hours.

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Additional Information
- Check “Yes” if symptoms started during the PCI procedure and did not resolve within 24 hours after the procedure.

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Cath Lab Report
- Progress Notes
- Billing Sheet/ Medical Records Coding Summary Sheet
PT REQUIRED INTRA- OR POST-PROCEDURE TRANSFUSION?

Definition
Checkbox indicating whether the patient experienced a vascular complication requiring transfusion of packed red blood cells (PRBCs)

Field Values
• **Y**: Yes
• **N**: No
• **ND**: Not Documented

Uses
• Provides documentation of assessment
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Cath Lab Report
• Progress Notes
• Billing Sheet/ Medical Records Coding Summary Sheet
CABG PERFORMED?

Definition
Checkbox indicating whether the patient had Coronary Artery Bypass Grafting (CABG) performed during the same hospitalization

Field Values
- Y: Yes
- N: No

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records
CABG STATUS

Definition
Checkbox indicating the urgency of the CABG

Field Values
• **U**: Urgent
• **E**: Emergent
• **S**: Salvage
• **EL**: Elective
• **ND**: Not Documented

Additional Information
• Urgent: procedure required during same hospitalization to minimize deterioration
• Emergent: patient has ischemic or mechanical dysfunction that is not responsive to any form of therapy except surgery
• Salvage: last resort to save the patient’s life, defined by the presence of CPR en route to the operating room, or prior to induction of anesthesia
• Elective: patient’s cardiac function has been stable prior to the operation, procedure can be deferred without risk of compromising cardiac outcome

Uses
• Provides documentation of assessment
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Operative Report
• Progress Notes
CABG DATE

Definition
Date the CABG was performed

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records
CABG TIME

Definition
Time of day the CABG was performed

Field Values
• Collected as HHMM
• Use 24-hour clock
• ND: Not Documented

Uses
• Establishes care intervals and incident timelines
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• Operative Report
• Cath Lab Report
• Progress Notes
• Other Hospital Records
CARDIAC ARREST
ROSC?

**Definition**
Checkbox indicating whether ROSC occurred, which is defined as restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure, and/or a sudden rise in capnography to a normal to high reading.

**Field Values**
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

**Additional Info**
- Indicate yes if the patient had ROSC at any time during resuscitation, even if transiently

**Uses**
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- ED Records
- Progress Notes
SUSTAINED ROSC?

Definition
Checkbox indicating whether sustained ROSC occurred, which is defined as persistent signs of circulation, with no chest compressions required, for at least twenty (20) consecutive minutes

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- ED Records
- Progress Notes
INIT. CARDIAC ARREST DATE

Definition
Date of the initial cardiac arrest

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. CARDIAC ARREST TIME

Definition
Time of day of the initial cardiac arrest

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. CARDIAC ARREST LOCATION

Definition
Checkbox indicating where the patient was when the initial cardiac arrest occurred

Field Values
- **Home**: Home/Residence
- **SNF**: Nursing Home/Assisted Living
- **Public**: Public Building/Areas
- **Clinic**: Physician Office/Clinic/Urgent Care
- **Industrial**: Industrial Site
- **ED**: Hospital Emergency Department
- **Other**: Other
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. CARDIAC ARREST WITNESSED?

Definition
Checkbox indicating whether the initial cardiac arrest was witnessed

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. CARDIAC ARREST WITNESSED BY

Definition
Checkbox indicating who observed the initial cardiac arrest

Field Values
- C: Citizen
- E: EMS
- H: Healthcare Professional
- ND: Not Documented

Additional Information
- "Healthcare professionals" are defined as medically trained, on-duty individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- "Citizens" are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

Uses
- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
Definition
Checkbox indicating the initial cardiac rhythm observed during the initial cardiac arrest

Field Values
- **AA**: AED-Analyzed Only
- **AD**: AED-Defibrillated
- **AG**: Agonal
- **ASY**: Asystole
- **IV**: Idioventricular
- **PEA**: Pulseless Electrical Activity
- **VT**: Pulseless Ventricular Tachycardia
- **VF**: Ventricular Fibrillation
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
**Definition**
Checkbox indicating who initiated CPR during the initial cardiac arrest

**Field Values**
- **C**: Citizen
- **E**: EMS
- **H**: Healthcare Professional
- **ND**: Not Documented

**Additional Information**
- “Healthcare professionals” are defined as medically trained, on-duty individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- “Citizens” are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

**Uses**
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
**PRE-SRC DEFIB?**

**Definition**
Checkbox indicating whether defibrillation occurred prior to arrival at the SRC

**Field Values**
- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
**Definition**
Checkbox indicating who defibrillated the patient prior to arrival at the SRC

**Field Values**
- **AC**: AED Citizen
- **AE**: AED EMS
- **ED**: EMS Defibrillation
- **HP**: Healthcare Professional
- **ND**: Not Documented

**Additional Information**
- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- “Citizens” are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

**Uses**
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. ROSC DATE

Definition
Date initial ROSC occurred

Field Values
- Collected as MMDDYYYY
- **ND**: Not Documented

Additional Information
- This is the date that ROSC was first obtained for any length of time

Uses
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
**INIT. ROSC TIME**

**Definition**
Time of day initial ROSC occurred

**Field Values**
- Collected as HHMM
- Use 24-hour clock
- **ND**: Not Documented

**Additional Information**
- This is the time of day that ROSC was first obtained for any length of time

**Uses**
- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
INIT. ROSC LOCATION

Definition
Checkbox indicating where the patient was when initial ROSC occurred

Field Values
- **PRE:** Pre-SRC
- **SRC:** SRC ED
- **ND:** Not Documented

Uses
- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
1ST CARDIAC RHYTHM UPON ROSC

Definition
First documented cardiac rhythm observed upon ROSC

Field Values
- **AFI**: Atrial Fibrillation
- **AFL**: Atrial Flutter
- **AVR**: Accelerated Ventricular
- **1HB**: 1\(^{st}\) Degree Heart Block
- **2HB**: 2\(^{nd}\) Degree Heart Block
- **3HB**: 3\(^{rd}\) Degree Heart Block
- **JR**: Junctional Rhythm
- **PM**: Pacemaker
- **PST**: Paroxysmal Supraventricular Tachycardia
- **SB**: Sinus Bradycardia
- **SR**: Sinus Rhythm
- **ST**: Sinus Tachycardia
- **SVT**: Supraventricular Tachycardia
- **VT**: Ventricular Tachycardia with Pulses
- **OT**: Other
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
**1st HEART RATE UPON ROSC**

**Definition**
First documented heart rate upon ROSC

**Field Values**
- Up to three-digit numeric value
- **ND:** Not Documented

**Additional Information**
- Value cannot be greater than 300

**Uses**
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
1st SYSTOLIC BLOOD PRESSURE UPON ROSC

Definition
First documented systolic blood pressure recorded upon ROSC

Field Values
• Up to three-digit numeric value
• ND: Not Documented

Additional Information
• Value cannot be greater than 300

Uses
• Provides documentation of assessment
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• EMS Report Form
• Base Hospital Form
• ED Records
• Progress Notes
• Other Hospital Records
**1ST TEMPERATURE UPON ROSC**

**Definition**
First documented core temperature, in Celsius, recorded upon ROSC

**Field Values**
- Up to four-digit numeric value
- **ND:** Not Documented

**Additional Information**
- Core temperature is measured via bladder, esophageal, or rectal methods
- Document to the 10th of a degree (e.g. 37.0°C)

**Uses**
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
1st END TIDAL CO₂ UPON ROSC

Definition
1st end tidal CO₂ recorded immediately following ROSC

Field Values
- Up to three-digit numeric value
- **ND**: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
1st pH VALUE UPON ROSC

Definition
1st pH value resulted within two hours of ROSC

Field Values
- Up to three-digit numeric value
- **ND:** Not Documented

Additional Information
- Document to the 100th of a degree (e.g. 7.00)
- Value cannot be less than 6.5 or greater than 8

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Lab Records
- ED Records
- Progress Notes
- Other Hospital Records
1st LACTATE VALUE UPON ROSC

Definition
1st lactate or lactic acid value resulted within two hours of ROSC

Field Values
- Up to three-digit numeric value
- ND: Not Documented

Additional Information
- Document to the 10th of a degree (e.g. 10.0)

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Lab Records
- ED Records
- Progress Notes
- Other Hospital Records
LACTATE VALUE UNITS

Definition
The units associated with the lactate or lactic acid value that is resulted within two hours of ROSC

Field Values
- mmol  mmol/L
- mg    mg/dl
- mEQ   mEQ/L

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Lab Records
- ED Records
- Progress Notes
- Other Hospital Records
TOTAL GLASGOW COMA SCALE (GCS) UPON ROSC

Definition
Checkbox indicating the first documented GCS upon ROSC

Field Values
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- ND: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records
VASOPRESSORS IVP?

**Definition**
Checkbox indicating whether the patient received epinephrine or vasopressin via intravenous push (IVP) during cardiac arrest

**Field Values**
- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Report Form
- Base Hospital Form
- ED Records
- Medication Records
- Progress Notes
- Other Hospital Records
Definition
Checkbox indicating whether vasopressors via continuous intravenous infusion were initiated post-ROSC in the ED or cath lab

Field Values
• Y: Yes
• N: No
• ND: Not Documented

Additional Information
• Vasopressors include Dopamine, Epinephrine, Norepinephrine (Levophed), Phenylephrine, and Vasopressin

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• EMS Report Form
• Base Hospital Form
• ED Records
• Medication Records
• Progress Notes
• Other Hospital Records
TOTAL GCS AT DISCHARGE

Definition
Checkbox indicating the patient’s GCS at time of discharge from the acute care unit at your facility

Field Values
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- ND: Not Documented

Additional Information
- If the patient expired, GCS is “3”

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet
CPC SCALE AT DISCHARGE

Definition
Checkbox indicating the patient’s Cerebral Performance Categories (CPC) scale upon discharge from the acute care unit at your facility

Field Values

<table>
<thead>
<tr>
<th>Cerebral Performance Categories Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Good cerebral performance – conscious, alert, able to work, might have mild neurologic or psychologic deficit.</td>
<td></td>
</tr>
<tr>
<td>2 Moderate cerebral disability – conscious, sufficient cerebral function for independent activities of daily life. Able to work in sheltered environment.</td>
<td></td>
</tr>
<tr>
<td>3 Severe cerebral disability – conscious, dependent on others for daily support because of impaired brain function. Range from ambulatory state to severe dementia or paralysis.</td>
<td></td>
</tr>
<tr>
<td>4 Coma or vegetative state – any degree of coma without the presence of all brain death criteria. Unawareness, even if appears awake (vegetative state) without interaction with environment; may have spontaneous eye opening and sleep/awake cycles. Cerebral unresponsiveness.</td>
<td></td>
</tr>
<tr>
<td>5 Brain death: apnea, areflexia, EEG silence, etc.</td>
<td></td>
</tr>
<tr>
<td>ND Not Documented</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information
- If the patient expired, CPC is “5”
- The CPC Scale at discharge may be performed by a physician, trained RN, or occupational therapist
- SRC Clinical Director/RN data extractor may calculate only if not performed by above personnel

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet
Definition
Checkbox indicating whether a CPC scale 2, 3, or 4 at discharge is a change in the patient’s baseline functional status

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet
TTM
**TTM INITIATED?**

**Definition**
Checkbox indicating whether Targeted Temperature Management (TTM) measures were initiated to actively cool and/or maintain the patient at a temperature of 32-36 degrees Celsius.

**Field Values**
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

**Uses**
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- ED Records
- Progress Notes
- Other Hospital Records
CONTRAINDICATIONS TO TTM? (LIST ALL THAT APPLY)

Definition
Checkbox indicating why TTM measures were not initiated

Field Values
- 17: Age < 18yrs
- 30: Core temperature < 30 degrees Celsius
- AR: Awake/Responsive to verbal commands
- BL: Active Bleeding
- CO: Pre-existing coma
- DN: DNR
- EX: Patient expired
- HT: Major head trauma
- NO: None listed
- PG: Pregnancy
- PH: Persistent hypotension
- SS: Septic Shock
- TI: End stage terminal illness
- UA: Uncontrolled/recurrent ventricular dysrhythmia

Additional Information
- Enter multiple selections, if applicable, by pressing down and holding the "Ctrl" key while making your selections
- Pre-existing coma refers to being in a comatose state prior to cardiac arrest due to a pre-existing condition, neurologic dysfunction, or severe dementia
- Persistent hypotension refers to patients who continue to be hypotensive despite interventions, including IV fluids, vasopressors, or an intra-aortic balloon pump
- Uncontrolled/recurrent ventricular dysrhythmia refers to recurrent ventricular fibrillation or ventricular tachycardia

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
TTM INITIATED DATE

Definition
Date TTM measures were initiated

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form
TTM INITIATED TIME

Definition
Time of day TTM measures were initiated

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form
TTM INITIATED LOCATION

Definition
Checkbox indicating where the patient was when TTM measures were initiated

Field Values
• P: Pre-SRC
• S: SRC ED
• C: Cath Lab
• I: ICU
• ND: Not Documented

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• ED Records
• Progress Notes
• Other Hospital Records
• EMS Report Form
• Base Hospital Form
TTM MODALITY USED

Definition
Checkbox indicating type(s) of TTM measures initiated

Field Values
- **IP:** Ice Packs
- **ED:** External Cooling Device
- **CI:** Cold IV fluids
- **CD:** Central Vascular Cooling Device
- **OT:** Other
- **ND:** Not Documented

Additional Information
- Enter multiple selections, if applicable, by pressing down and holding the "Ctrl" key while making your selections

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- **ED Records**
- **Progress Notes**
- **Other Hospital Records**
- **EMS Report Form**
- **Base Hospital Form**
TARGET TEMPERATURE

Definition
Checkbox indicating the desired body temperature to be achieved by TTM measures, as ordered by the physician or per protocol

Field Values
- 32: 32 degrees Celsius
- 33: 33 degrees Celsius
- 34: 34 degrees Celsius
- 35: 35 degrees Celsius
- 36: 36 degrees Celsius
- SR: Specified range
- ND: Not Documented

Additional Information
- If “Specified Range” is marked, must document range in ‘Target Temperature Range’ field

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
TARGET TEMPERATURE RANGE

Definition
Field provided to indicate the range, in Celsius, of desired body temperature to be achieved by TTM measures, if applicable

Field Values
• Five-digit numeric value

Uses
• Provides documentation of care
• Assists with determination of appropriate treatment
• System evaluation and monitoring

Data Source Hierarchy
• ED Records
• Progress Notes
• Other Hospital Records
TARGET TEMPERATURE REACHED?

Definition
Checkbox indicating whether the desired body temperature was achieved by TTM measures

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
TARGET TEMPERATURE REACHED DATE

Definition
Date that desired body temperature was achieved by TTM measures

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
TARGET TEMPERATURE REACHED TIME

Definition
Time of day that desired body temperature was achieved by TTM measures

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
RE-WARMING INITIATED?

Definition
Checkbox indicating whether re-warming measures were initiated

Field Values
- **Y**: Yes
- **N**: No
- **ND**: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
RE-WARMING INIT DATE

Definition
Date that re-warming measures were initiated

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
RE-WARMING INIT TIME

Definition
Time of day that re-warming measures were initiated

Field Values
- Collected as HHMM
- Use 24-hour clock
- **ND**: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
PATIENT DIED DURING RE-WARMING?

Definition
Checkbox indicating whether the patient died during the re-warming process

Field Values
- Y: Yes
- N: No
- ND: Not Documented

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
RE-WARMING ENDED DATE

Definition
Date that re-warming measures were terminated

Field Values
- Collected as MMDDYYYY
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
RE-WARMING ENDED TIME

Definition
Time of day that re-warming measures were terminated

Field Values
- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records
ADVERSE EVENTS DURING TTM

Definition
Checkbox indicating whether any of the listed adverse events occurred during TTM – enter all that apply

Field Values
- **DY:** Dysrhythmia of VF/VT
- **CG:** Coagulopathy/bleeding
- **DV:** Deep vein thrombosis
- **NO:** None of the above adverse events were specified

Additional Information
- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections

Uses
- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- Progress Notes
- Other Hospital Records
- ED Records