OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
ABSTRACT REPORTING FORM for *IN-HOUSE TOOL USERS*
For use with discharges on 1/1/03 and after

Instructions: For a description of the data elements, refer to the appropriate section of CCORP Data Regulations (Sections 97170 through 97198, Title 22, California Code of Regulations).

1. MEDICAL RECORD NUMBER

2. Isolated CABG Yes / No

3. DATE OF SURGERY (mm/dd/yyyy)

4. DATE OF BIRTH (mm/dd/yyyy)

5. PATIENT AGE

6. GENDER Male / Female

7. RACE (*select one*) Caucasian, Hispanic, Asian, Black, Native American, Other

8. DATE OF DISCHARGE (mm/dd/yyyy)

9. DISCHARGE STATUS Alive / Dead

10. DATE OF DEATH (mm/dd/yyyy)

11a. RESPONSIBLE SURGEON NAME (RSN) - LAST

13. HT (cm)

11b. RESPONSIBLE SURGEON NAME - FIRST

11c. RESPONSIBLE SURGEON MIDDLE INITIAL

14. WT (kg)

12. RESPONSIBLE SURGEON CA LICENSE NUMBER

15. DIABETES Yes / No

16. HYPERTENSION Yes / No

17. PERIPHERAL VASCULAR DISEASE Yes / No

18. CEREBROVASCULAR DISEASE Yes / No

19. CEREBROVASCULAR ACCIDENT Yes / No

20. CEREBROVASCULAR ACCIDENT TIMING <=2 WEEKS >2 WEEKS

21. CHRONIC LUNG DISEASE No / Mild / Moderate / Severe

22. IMMUNOSUPPRESSIVE THERAPY Yes / No

23. HEPATIC FAILURE Yes / No

24. DIALYSIS Yes / No

25. LAST CREATININE LEVEL PRE-OP

26. LEFT MAIN DISEASE (%)

27. NUMBER DISEASED VESSELS None / One / Two / Three

28. MITRAL INSUFFICIENCY None / Trivial / Mild / Moderate / Severe

29. EJECTION FRACTION (%)

30. EJECTION FRACTION METHOD LV Gram / Echo, Radionuclide / Estimate

31. MYOCARDIAL INFARCTION Yes / No

32. MYOCARDIAL INFARCTION TIMING <= 6 Hours, > 6 Hours but < 24 Hours, 1-7 Days, 8-21 Days, > 21 days

33. ARRHYTHMIA Yes / No

34. ARRHYTHMIA TYPE ***(select one)***
Sustained VT/VF *(requiring cardioversion and/or amiodarone)*
Heart Block, or Atrial Fib/Flutter *(requiring medication)*

35. CARDIOGENIC SHOCK Yes / No

36. ANGINA Yes / No

37. ANGINA TYPE Stable / Unstable

38. CCS CLASSIFICATION 0 / I / II / III / IV

39. CONGESTIVE HEART FAILURE Yes / No

40. NYHA CLASSIFICATION I / II / III / IV

41. # PRIOR CARDIAC OPS (REQUIRING CP BYPASS)

42. # PRIOR CARDIAC OPS (WITHOUT CP BYPASS)

43. STATUS OF PROCEDURE ***(select one)*** Elective, Urgent, Emergent, Emergent/Salvage

44. CP BYPASS USED Yes / No

45. CONVERSION TO CP BYPASS Yes / No

46. PRIMARY INCISION ***(select one)***
Full Sternotomy, L. Ant. Thoracotomy, Partial Sternotomy, Xiphoid, Transverse Sternotomy, Epigastric, R. Vertical Parasternal, Subcostal, L. Vertical Parasternal, Posterolateral Thoracotomy

47. CARDIOPLEGIA Yes / No

48. PCI Yes / No

49. PCI INTERVAL < = 6 Hours > 6 Hours

50. INTERNAL MAMMARY ARTERY USED AS GRAFTS Left IMA / Right IMA / Both IMA / No IMA

51. OSHPD FACILITY ID NUMBER

NOTES: