OEIS NATIONAL REGISTRY

PAD Data Collection

Patient Label

OEIS PATIENT ID#_____

(Prior OEIS NR Entry? _____)

Demographics:

Height: _____ Weight: _____

Insurance: Primary _____ Secondary_____

Race: □ White □ Hispanic _____ □ African American □ Asian □ Other _____

Indications for Procedure/Symptoms:

□ Claudication ***Rutherford: R____ L ____**

□ Acute Limb Ischemia (severe hypo-perfusion for <2 week)

□ Minor Tissue Loss (non-healing wound/ulcer)

□ Major Tissue Loss (foot no longer salvageable)

□ Critical Limb Ischemia (>2 week ischemic rest pain, non-healing wound/ulcer d/t PAD)

***Non-Invasive Test:**

□ ABI: Right _____ Left _____ (**OR** Non-Compressible _____ If NC, TBI : **R**_____ **L** _____)

□ Ultrasound

□ CT Angiogram

□ MRA

□ Prior Angiography

Patient History:

□ CAD □ MI

□ CHF

□ TIA or CVA □ Carotid Artery Disease (□ Carotid Endarterectomy □ Carotid Stenting)

□ HTN (□ Controlled BP <140/90 OR □ Uncontrolled)

□ Was the patient counselled to follow up with PCP? Yes or No

□ Prior Amputation: R ___ L ____ Major (BKA) ____ Minor _____ (foot or toe)

□ CKD (CLASS :_____)

□ Hypercholesterolemia

□ Diabetes (□ Type 1 OR □ Type 2)

□ *** Tobacco Abuse** (□ Current OR □ Former) □ **Was the patient counselled on Tobacco cessation? Yes or No**

***Flu Vacccine: _____ month/year** ***Pneumonia Vaccine: _____month/year**

□ History of Bleeding or Clotting Disorder

□ Hx of Lower Extremity Bypass OR Percutaneous Intervention

□ **Is the patient participating in a leg exercise program**? Cilostazol/Pletal trial? Y/N

YES: □ Structured OR □ Unstructured ?

NO: □ Unwilling OR □ Unable ?

***Patient Medications:**

□ ***Antiplatelet Therapy**: □ Aspirin □ Clopidogrel □ Prasugrel □ Ticagrelor

□ Anticoagulation: _____

□ ***Statin**: _____ □ ***Other Lipid Therapy** : _____

□ Beta Blocker : _____

□ ACE/ARB : _____

If NO for any of the above, please specify the reason:

□ Never Prescribed □ Non-compliance □ Significant Side Effects □ Contraindication □ Patient Preference

Creatinine _____ Hgb _____

PROCEDURE DATA:

***Rutherford: R____ L ____** (If not noted on the front page)

ASA Class: _____

□ Sheath Size: _____ Fr □ Access Artery : _____ (□ Contra OR □ Antegrade)

□ Closure Device: _____

Lesion #1	Lesion #2	Lesion #3
□ Right □ Left □ Lesion Site _____ □ Proximal □ Mid □ Distal □ **Stenosis % - PRE**: _____% □ De Novo □ Restenotic □ In-stent □ Calcified Lesion : (□ Mild □ Mod □Severe) □Thrombus □ IVUS: (□ diagnostic only) (□ to guide decision making) □ **Lesion Length** _____ cm □ Patent BTK Vessels Prior to Tx: (<50 % stenosis) □ 0 □ 1 □ 2 □ 3 □ **POST Atherectomy -** _____ % **stenosis** □ **FINAL stenosis % -** _____% *Attach any stickers here:* *(atherectomy/balloon/stent)* *-Or write in the devices used*	□ Right □ Left □ Lesion Site _____ □ Proximal □ Mid □ Distal □ **Stenosis % - PRE**: _____% □ De Novo □ Restenotic □ In-stent □ Calcified Lesion : (□ Mild □ Mod □Severe) □Thrombus □ IVUS: (□ diagnostic only) (□ to guide decision making) □ Lesion Length _____ cm □ Patent BTK Vessels Prior to Tx: (<50 % stenosis) □ 0 □ 1 □ 2 □ 3 □ **POST Atherectomy -** _____ % **stenosis** □ **FINAL stenosis % -** _____% *Attach any stickers here:* *(atherectomy/balloon/stent)* *-Or write in the devices used*	□ Right □ Left □ Lesion Site _____ □ Proximal □ Mid □ Distal □ **Stenosis % - PRE**: _____% □ De Novo □ Restenotic □ In-stent □ Calcified Lesion : (□ Mild □ Mod □Severe) □Thrombus □ IVUS: (□ diagnostic only) (□ to guide decision making) □ Lesion Length _____ cm □ Patent BTK Vessels Prior to Tx: (<50 % stenosis) □ 0 □ 1 □ 2 □ 3 □ **POST Atherectomy -** _____ % **stenosis** □ **FINAL stenosis % -** _____% *Attach any stickers here:* *(atherectomy/balloon/stent)* *-Or write in the devices used*

Procedure Conclusion:

Conscious Sedation**:** □ Yes □ No EBL: _____mL

Amount of Contrast Used: _____ mL Was CO2 Used? _____

Flouro Time _____minutes Cumulative Air Kerma (mGy) _____ Dose Area Product _____

Duration of procedure: Start time _____ End Time _____ Time Pt left Room _____

***Was Antiplatelet or Statin/Lipid Therapy prescribed?_____**

Any procedural complications: _____

*** Emergent Transfer ?** _____

*** Fields required for Quality Measures** **^This form is not comprehensive for data collection** v.4 rev. 7/2017