



Health Record #: _____ Complete or place barcoded patient label here
 Patient Name: *(Print first, last)* _____
 DOB: mm / dd / yy Age: _____ Female Male
 OHIP #: _____ Version Code: _____
 Account #: _____ Date of Admission: mm / dd / yy

Surgical Services

Lower Extremity Occlusive Disease (LEOD) Vascular Registry Data Collection Form
Post-Procedure

POST-PROCEDURE	
ICU/Step Down Stay: <input type="checkbox"/> Yes <input type="checkbox"/> No	ICU/Step Down Stay Time: _____ days
Re-Do Procedure Prior to Discharge: <input type="checkbox"/> Yes* <input type="checkbox"/> No – If Yes*, indicate procedure: _____	
Target Vessel Patency: <input type="checkbox"/> Primary <input type="checkbox"/> Required surgical intervention <input type="checkbox"/> Required PVI	
Lab values prior to discharge:	
Creatinine: <input type="checkbox"/> Done <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	Creatinine: _____ µmol/L
eGFR (local lab value): _____ ml/min/1.73m ² <input type="checkbox"/> Not Available	
Complications Prior to Discharge: <input type="checkbox"/> Yes* <input type="checkbox"/> No – If Yes*, specify:	
Myocardial infarction: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes* Troponin Level: _____ Cardiac Troponin Level Max Reference Range: _____
Reduced renal function: <input type="checkbox"/> Yes <input type="checkbox"/> No	
New dialysis required: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent
Access site infection: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Resolved with antibiotic <input type="checkbox"/> Required operative drainage and/or antibiotic <input type="checkbox"/> Required major debridement and/or artery repair
Surgical site infection: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Superficial <input type="checkbox"/> Deep <input type="checkbox"/> Organ/Space
Respiratory: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Prompt recovery with medical management <input type="checkbox"/> Prolonged hospitalization or IV Antibiotic <input type="checkbox"/> Prolonged intubation, tracheostomy, reduced pulmonary function or O ₂ dependence
Bowel Ischemia: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes* <input type="checkbox"/> Recovered without Intervention <input type="checkbox"/> Recovered with IV Antibiotics or Total Parenteral Nutrition <input type="checkbox"/> Required Operative Procedure
Bowel Obstruction: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Recovered without Intervention <input type="checkbox"/> Required Laparotomy <input type="checkbox"/> Required Bowel Resection
Leg Ischemia: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Resolved with Conservative Medical Treatment <input type="checkbox"/> Required Intervention <input type="checkbox"/> Resulted in Limb Loss
Arterial Injury: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Single Injury Site <input type="checkbox"/> Multiple Injury Sites
Major Amputation: <input type="checkbox"/> Yes* <input type="checkbox"/> No	If Yes*, <input type="checkbox"/> Above Knee <input type="checkbox"/> Below Knee/Above Ankle

PVI = Peripheral Vascular Intervention





596 Davis Drive
Newmarket, ON L3Y 2P9

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<input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> DVT <input type="checkbox"/> CHF <input type="checkbox"/> Dysrhythmia <input type="checkbox"/> TIA				
<input type="checkbox"/> Stroke <input type="checkbox"/> Intracranial hemorrhage <input type="checkbox"/> Atherotromboembolism <input type="checkbox"/> Other: _____				
Discharged on ACE Inhibitor/ARB: <input type="checkbox"/> Yes <input type="checkbox"/> No Not discharged on ACE – Inhibitor/ARB – Reason: _____				
Discharged on Beta Blocker: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Discharged on P2Y12 Antagonist: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Discharged on Hyperlipidemia Medical Management: <input type="checkbox"/> Statin <input type="checkbox"/> Niacin <input type="checkbox"/> Fibrate <input type="checkbox"/> Ezetimibe <input type="checkbox"/> None				
Blood transfusion: <input type="checkbox"/> Yes* <input type="checkbox"/> No – If Yes*, indicate total amount PRBC transfused _____ units				
Discharge Date: <u>mm</u> / <u>dd</u> / <u>yy</u>				
Patient Discharge Location: <input type="checkbox"/> Home <input type="checkbox"/> Repatriated to referring facility <input type="checkbox"/> Transferred to other facility <input type="checkbox"/> Rehabilitation Unit at same hospital <input type="checkbox"/> Rehabilitation Unit – other facility				
Patient Status: Patient Died: <input type="checkbox"/> Yes* <input type="checkbox"/> No – If Yes*, Date of Death: <u>mm</u> / <u>dd</u> / <u>yy</u>				

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