



596 Davis Drive  
Newmarket, ON L3Y 2P9

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**  
Pre-Procedure

<b>PRE-PROCEDURE</b>		OFFICE PATIENT LABEL
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Aboriginal <input type="checkbox"/> South Asian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		
Height (cm): _____ Weight (kg): _____		
History of smoking: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current <input type="checkbox"/> Unknown		
Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Diabetes: <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes* ➡) Diabetes-Control: <input type="checkbox"/> Diet only <input type="checkbox"/> Oral <input type="checkbox"/> Insulin <input type="checkbox"/> Unknown <input type="checkbox"/> No Treatment		
Hyperlipidemia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
COPD: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Cerebral Vascular Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Previous Myocardial Infarction: <input type="checkbox"/> No <input type="checkbox"/> Yes, Within last 30 days <input type="checkbox"/> Yes, Greater than 30 days ago <input type="checkbox"/> Unknown		
Previous PCI: <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes* ➡) Date: <u>mm</u> / <u>dd</u> / <u>yy</u> (most recent)		
Previous CABG Procedure: <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes* ➡) Date: <u>mm</u> / <u>dd</u> / <u>yy</u> (most recent)		
History of Heart Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dye Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Previous Vascular Intervention: <input type="checkbox"/> None <input type="checkbox"/> Aorta <input type="checkbox"/> Carotid <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Mesenteric <input type="checkbox"/> Amputation PAD <input type="checkbox"/> Iliac <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Renal		
<b>Medication</b>		
ACE-Inhibitor/ARB: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Beta Blocker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
P2Y12 Antagonist: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Statin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Anticoagulant(s): <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown (If Yes* ➡) Indicate the type		
Acetylsalicylic Acid (ASA/aspirin): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Apixaban: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Clopidogrel: <input type="checkbox"/> Yes <input type="checkbox"/> No Heparin: <input type="checkbox"/> Yes <input type="checkbox"/> No Rivaroxaban: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Coumadin: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No		
ASA (aspirin) Within 36 Hours of Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

PVI = Peripheral Vascular Intervention





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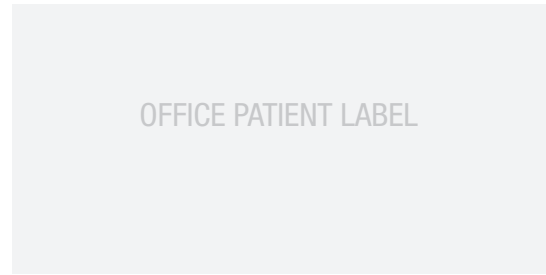
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**Lower Extremity Occlusive Disease (LEOD) Vascular Registry Data Collection Form**

*Pre-Procedure*

LVEF Assessment Method:  MUGA (Nuclear)  Echocardiogram  
 Ventriculogram (Coronary Angiogram)  
 LVEF Value:  Unknown  ≥ 50%  35-49%  20-34%  <20%  
 Date of LVEF Assessment: mm / dd / yy  Unknown  
 Creatinine:  Done  Not Done  Unknown  
 Creatinine: \_\_\_\_\_ μmol/L Hemoglobin: \_\_\_\_\_ g/L  
 eGFR (local lab value): \_\_\_\_\_ ml/min/1.73m<sup>2</sup>  Not Available



**PRE-PROCEDURE INVESTIGATION DATA**

Indication for Current Procedure:  Acute Ischemia  Asymptomatic  Major Tissue Loss  Rest/Night Pain  
 Aneurysm  Claudication  Minor Tissue Loss  Other: \_\_\_\_\_

Previous Vascular Procedure:

Left Leg

None  Amputation  Endovascular/Angioplasty  
 Surgery (Bypass/Endarterectomy)

Previous Amputation Location:  
 Above Knee  Below Knee  Foot

Previous Endovascular/Angioplasty – Target Vessel:  
 Inflow (aorta/iliac)  CFA  SFA  Popliteal  
 Tibial (or distal)

Previous Surgery – Target Vessel:  
 CIA  EIA  CFA  Infrainguinal

Right Leg

None  Amputation  Endovascular/Angioplasty  
 Surgery (Bypass/Endarterectomy)

Previous Amputation Location:  
 Above Knee  Below Knee  Foot

Previous Endovascular/Angioplasty – Target Vessel:  
 Inflow (aorta/iliac)  CFA  SFA  Popliteal  
 Tibial (or distal)

Previous Surgery – Target Vessel:  
 CIA  EIA  CFA  Infrainguinal

Ankle-Brachial Index (ABI):

Left Leg:  ABI value: \_\_\_\_\_  Unable to occlude (measure)  Unknown  Not applicable  
 Right Leg:  ABI value: \_\_\_\_\_  Unable to occlude (measure)  Unknown  Not applicable

Toe-Brachial (TBI):

Left Leg:  TBI value: \_\_\_\_\_  Unable to occlude (measure)  Unknown  Not applicable  
 Right Leg:  TBI value: \_\_\_\_\_  Unable to occlude (measure)  Unknown  Not applicable

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