NCTSD - National Congenital Heart Surgery Database (NCHSD)
PRE OPERATION

Instruction: i) Where check boxes ☐ are provided, check ☑ one or more boxes. Where radio buttons ○ are provided, check ⊙ one box only.
ii) Red asterisk (*) indicates the field is mandatory and must be filled.

GENERAL INFORMATION

01. *	**Reporting Centre**	
02. *	**Admission Date**	☐☐ / ☐☐ / ☐☐☐☐ *(dd/mm/yyyy)*
03.	**Episode Doctor**	**04. Episode No #**
05. *	**Admission Type**	○ Elective ○ Urgent ○ Emergency ○ Salvage
06. *	**GL Type**	○ Government ○ Full paying patients ○ Insurance ○ Not Available
07. *	**Referral**	○ Public Hospitals ○ Private Hospitals ○ Health Clinics ○ Not Available ○ Others, specify _____
08.	**Location**	

SECTION 1: DEMOGRAPHIC

01. *	**Patient Name**		
02.	**MRN**		
03. *	**Identification card number**	**MyKad/MyKid**	☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐
		Other document no.	
		Document type	○ MRN ○ Passport ○ Armed Force ID ○ Work Permit # ○ Mother's I/C ○ Father's I/C ○ Birth Certificate ○ Registration number ○ Others, specify _____
04. *	**Gender** IW	○ Male ○ Female	
05. *	**Date of Birth** W	☐☐ / ☐☐ / ☐☐☐☐ *(dd/mm/yyyy)*	06. * **Age at admission** W *(years)*
07. *	**Ethnic group** W	○ Malay ○ Chinese ○ Indian ○ Orang Asli ○ Bumiputra Sabah ○ Bumiputra Sarawak ○ Other Malaysian ○ Non-citizen	
		i. Other Malaysian	
		ii. Bumiputra Sabah	
		iii. Bumiputra Sarawak	
		iv. Non-citizen, specify country	

SECTION 2: RISK FACTOR

01. *	**Pre-operative Diagnosis** I	#1 _____ #2 _____ #3 _____ #4 _____
02. *	**Premature Birth** W	○ No ○ Yes, specify _____ *(weeks)* ○ Unknown
03. *	**Patient's first congenital surgery?** W (If No, Refer Section 2.1 Pre-operative Diagnosis)	○ Yes ○ No ○ Unknown
04. *	**Syndrome / Chromosomal abnormality** IW	○ No ○ Yes, specify Chromosomal ☐☐☐ ○ Unknown Syndrome ☐☐☐
05. *	**Non-cardiac congenital anatomic** IW	○ No ○ Yes, specify _____ ○ Unknown
06. *	**Previous History of Endocarditis**	○ Yes ○ No ○ Unknown
07. *	**Active Endocarditis**	○ Yes ○ No ○ Unknown
08.	**IE Duration treated**	_____ *(years)*
09.	**IE diagnose date (Referral Letter)**	☐☐ / ☐☐ / ☐☐☐☐ *(dd/mm/yyyy)*
10. *	**Nutritional Appearance** I	○ Normal ○ Malnourished ○ Emaciated ○ Overweight ○ Others, specify _____
11. *	**Allergies**	○ Yes, specify _____ ○ No ○ Unknown

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12. *	**Pre-operative Procedure** I	☐ Not Applicable ☐ Ballon atrioseptostomy ☐ Resuscitation before surgery ☐ Inotrope therapy before surgery ☐ Ventilation preoperatively ☐ Others, specify _____
13.	**Pre-operative heart rhythm**	☐ Sinus Rhythm ☐ Atrial fibrillation ☐ Prior VT / VF ☐ Complete heart block / paced ☐ Other abnormal rhythm, specify _____
14. *	**Pre-operative Ventilation**	○ No ○ Yes ○ Unknown
15. *	**Preoperative/Preprocedural mechanical circulatory support (IABP,VAD, ECMO, or CPS)**	○ No ○ Yes ○ Unknown
16. *	**Pre-operative Haematocrit** I	○ Yes, specify _____ *(%)* ○ Not Available
17. *	**Pre-operative Oxygen saturation** I	○ Yes, specify _____ *(%)* ○ Not Available
18. *	**Redo Operation** I	○ None ○ First ○ Second ○ Third ○ Others, specify _____
19. *	**Comorbidity**	○ No ○ Yes ○ Unknown **If Yes**: ○ None ○ Hyperlipidemia ○ Hypertension ○ Renal ○ DM ○ IHD ○ Respiratory: Restrictive lung ○ Skeletal anomaly ○ Respiratory: Asthma ○ Gout (Recurred) ○ Respiratory: COAD ○ Obesity ○ Respiratory: Lung Fibrosis ○ Others _____
20.	**Other risk factor**	a ☐ Cardio-pulmonary resuscitation b ☐ Shock, Persistent at time of surgery c ☐ Shock, Resolved at time of surgery d ☐ Necrotizing entero-colitis e ☐ Failure to Thrive f ☐ Greater than 2 hospital admissions for non cardiac infections in last 3 months g ☐ Coagulation Disorder h ☐ Neurological deficit i ☐ Seizure j ☐ Sepsis k ☐ Tracheostomy present l ☐ BAS before surgery m ☐ Others, specify _____

SECTION 3: INVESTIGATION

01.	**Physical examinations** I	a Patient height	*(cm)*	c BMI (auto-calculated)	
		b Patient weight	*(kg)*	d BSA (auto-calculated)	
02. *	**Left or right heart catheterization**	○ Never ○ This admission ○ Previous admission ○ Other hospital ○ Unknown			
03. *	**Date of catheterization**	☐☐ / ☐☐ / ☐☐☐☐ *(dd/mm/yyyy)* ○ Estimated date ○ Not applicable			
04.	**Surgical Plan**	**#1** _____ **#2** _____ **#3** _____			