

# NATIONAL CARDIOVASCULAR DISEASE DATABASE (ACS REGISTRY) NOTIFICATION FORM

For NCVD Use only:

Centre:

ID:

**Instruction: Complete this form to notify all ACS admissions at your centre to NCVD ACS Registry. Where check boxes  are provided, please check (✓) one or more boxes. Where radio buttons  are provided, check (✓) only one option.**

A. Reporting Centre: \_\_\_\_\_

B. Date of Admission (dd/mm/yy):

## SECTION 1: DEMOGRAPHICS

<b>1. Patient Name:</b> <small>(as per MyKad / Other ID)</small>			<b>2. Hospital RN:</b>	
<b>3. Identification Card Number:</b>	<b>MyKad:</b> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>			
	<b>Other ID Document No.:</b> <input style="width: 100px; height: 15px;" type="text"/>	<b>Specify type:</b> <small>(eg. Passport, armed force ID, Old IC)</small>	<input style="width: 100px; height: 15px;" type="text"/>	
<b>4. Gender:</b>	<input type="radio"/> Male <input type="radio"/> Female	<b>5. Nationality:</b>	<input type="radio"/> Malaysian <input type="radio"/> Non Malaysian	
<b>6a. Date of birth:</b> <small>(dd/mm/yy)</small>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(write DOB as 01/01/yy if age is known)</small>	<b>6b. Age on admission:</b>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(auto calculate)</small>	
<b>7. Ethnic Group:</b>	<input type="radio"/> Malay <input type="radio"/> Punjabi <input type="radio"/> Melanau <input type="radio"/> Bidayuh <input type="radio"/> Foreigner, specify country of origin: <input type="radio"/> Chinese <input type="radio"/> Orang Asli <input type="radio"/> Murut <input type="radio"/> Iban <input type="radio"/> Indian <input type="radio"/> Kadazan Dusun <input type="radio"/> Bajau <input type="radio"/> Other Malaysian, specify:			
<b>8. Contact Number:</b>	(1): <input style="width: 100px; height: 15px;" type="text"/>	(2): <input style="width: 100px; height: 15px;" type="text"/>		

## SECTION 2 : STATUS BEFORE EVENT

<b>1. Smoking status:</b>	<input type="radio"/> Never <input type="radio"/> Former (quit >30 days) <input type="radio"/> Current (any tobacco use within last 30 days) <input type="radio"/> Not Available			
<b>2. Status of Aspirin use:</b>	<input type="radio"/> Never <input type="radio"/> Used less than 7 days previously <input type="radio"/> Used more than or equal to 7 days previously			
<b>3. Medical history:</b>				
a) Dyslipidaemia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	g) Chronic Angina (≥2 weeks)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
b) Hypertension	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	h) New onset angina (<2 weeks)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
c) Diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	i) History of heart failure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
		<input type="checkbox"/> OHA <input type="checkbox"/> Insulin <input type="checkbox"/> Non pharmacology therapy/diet therapy		
d) Family history of premature cardiovascular disease <small>(1st degree relative with either MI or stroke; &lt;55 y/o if Male &amp; &lt;65 y/o if Female)</small>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	k) Chronic renal disease <small>(eGFR &lt;60 ml/min per 1.73m<sup>2</sup>)</small>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
e) Myocardial Infarction History	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	l) Cerebrovascular disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
f) Documented CAD <small>(presence of &gt;50% stenosis on CTA, angiogram or ischaemia on functional Cardiac Imaging such as nuclear, MRI, echo). Positive treadmill test or high Calcium score alone are not sufficient.)</small>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	m) Peripheral vascular disease	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not known	
		n) None of the above	<input type="checkbox"/>	

## SECTION 3 : ONSET

<b>1a. Date of onset of ACS symptoms:</b>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(dd/mm/yy)</small> <input type="checkbox"/> Not Available	<b>1b. Time of onset of ACS symptoms:</b> <small>(in 24 hr clock)</small>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(hh:mm)</small> <input type="checkbox"/> Not Available
<b>2a. Date patient presented:</b>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(dd/mm/yy)</small> <input type="checkbox"/> Not Available	<b>2b. Time patient presented:</b> <small>(in 24 hr clock)</small>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <small>(hh:mm)</small> <input type="checkbox"/> Not Available
<b>3. Was patient transferred from another centre?</b>		<input type="radio"/> Yes <input type="radio"/> No	

## SECTION 4 : CLINICAL PRESENTATION & EXAMINATION

<b>1. Number of distinct episodes of angina in past 24h:</b>	<input type="checkbox"/> Not Available	<b>2. Heart rate at presentation:</b>	<input style="width: 40px; height: 15px;" type="text"/>	beats / min
<b>3. Blood pressure at presentation:</b>	<b>a. Systolic:</b> <input style="width: 40px; height: 15px;" type="text"/>	<b>b. Diastolic:</b> <input style="width: 40px; height: 15px;" type="text"/>	mmHg	
<b>4. Anthropometric:</b> <small>(if not measured, please tick as 'Not Available')</small>	<b>a. Height:</b> <input style="width: 40px; height: 15px;" type="text"/>	(m) <input type="checkbox"/> Not Available	<b>BMI:</b>	<small>(auto calculate)</small>
	<b>b. Weight:</b> <input style="width: 40px; height: 15px;" type="text"/>	(kg) <input type="checkbox"/> Not Available		
	<b>c. Waist Circumference:</b> <input style="width: 40px; height: 15px;" type="text"/>	(cm) <input type="checkbox"/> Not Available	<b>WHR:</b>	<small>(auto calculate)</small>
	<b>d. Hip Circumference:</b> <input style="width: 40px; height: 15px;" type="text"/>	(cm) <input type="checkbox"/> Not Available		
<b>5. Killip classification:</b>	<input type="radio"/> Killip I <small>(no clinical signs of heart failure)</small> <input type="radio"/> Killip II <small>(rales or crackles in the lungs, an S<sub>3</sub>, and elevated jugular venous pressure)</small> <input type="radio"/> Killip III <small>(frank acute pulmonary oedema)</small> <input type="radio"/> Killip IV <small>(cardiogenic shock or hypotension [measured as systolic blood pressure &lt;90 mmHg], and evidence of peripheral vasoconstriction [oliguria, cyanosis or sweating])</small> <input type="radio"/> Not Applicable/ Not Available			

a. Patient Name:		b. Reporting Centre:	
c. Identification Card No.:		d. Hospital RN:	

**SECTION 5: BASELINE INVESTIGATION (values obtained within 48 hours from admission)**

	Absolute Value	Unit	Reference Upper Limit	Check (√) if not done
1. Peak CK-MB:		Unit/L		<input type="radio"/> Not done
2. Peak CK:		Unit/L		<input type="radio"/> Not done
3. Peak Troponin:	a. T n T:	<input type="radio"/> +ve <input type="radio"/> -ve OR <input type="text"/>	ng/mL or mcg/L	<input type="radio"/> Not done
	b. T n I:	<input type="radio"/> +ve <input type="radio"/> -ve OR <input type="text"/>	ng/mL or mcg/L	<input type="radio"/> Not done
4. Lipid Profile (Fasting):	a. Total Cholesterol:		mmol/L	<input type="radio"/> Not done
	b. HDL-C:		mmol/L	<input type="radio"/> Not done
	c. LDL-C:		mmol/L	<input type="radio"/> Not done
	d. Triglyceride:		mmol/L	<input type="radio"/> Not done
5. Fasting blood glucose:		mmol/L		<input type="radio"/> Not done
6. HbA1c		%		<input type="radio"/> Not done
7. Left Ventricular Ejection Fraction:		%		<input type="radio"/> Not done

**SECTION 6: ELECTROCARDIOGRAPHY (ECG)**

1. ECG abnormalities type: <i>(Check one or more boxes)</i>	<input type="checkbox"/> ST-segment elevation $\geq 1\text{mm}$ (0.1mV) in $\geq 2$ contiguous limb leads	<input type="checkbox"/> Bundle branch block (BBB)
	<input type="checkbox"/> ST-segment elevation $\geq 2\text{mm}$ (0.2mV) in $\geq 2$ contiguous frontal leads or chest leads	<input type="checkbox"/> Atrial Fibrillation
	<input type="checkbox"/> ST-segment depression $\geq 0.5\text{mm}$ (0.05mV) in $\geq 2$ contiguous leads	<input type="checkbox"/> Non-specific
	<input type="checkbox"/> T-wave inversion $\geq 1\text{mm}$ (0.1mV)	<input type="checkbox"/> None <input type="checkbox"/> Not stated/ inadequately described
2. ECG abnormalities location: <i>(Check one or more boxes)</i>	<input type="checkbox"/> Inferior leads: II, III, aVF	<input type="checkbox"/> Right ventricle: ST elevation in lead V4R
	<input type="checkbox"/> Anterior leads: V1 to V4	<input type="checkbox"/> None
	<input type="checkbox"/> Lateral leads: I, aVL, V5 to V6	<input type="checkbox"/> Not stated/ inadequately described
	<input type="checkbox"/> True posterior: V1, V2	

**SECTION 7: CLINICAL DIAGNOSIS AT ADMISSION**

1. <u>Acute Coronary Syndrome stratum:</u>	<input type="radio"/> STEMI	<input type="radio"/> NSTEMI	<input type="radio"/> Unstable Angina (UA)
2a. TIMI Risk Score for NSTEMI/ UA:	<input type="text"/>	<i>(auto calculate)</i>	2b. TIMI Risk Score for STEMI:
			<input type="text"/>
			<i>(auto calculate)</i>

**SECTION 8: FIBRINOLYTIC THERAPY (Following Section is applicable for STEMI only)**

1. <u>Fibrinolytic therapy status:</u>	<input type="radio"/> Given at this centre $\rightarrow$ <i>(Please proceed to number 2 and 3 below)</i>	<input type="radio"/> Not given—missed thrombolysis			
	<input type="radio"/> Given at another centre prior to transfer here	<input type="radio"/> Not given—patient refusal			
	<input type="radio"/> Not given—proceeded directly to primary angioplasty	<input type="radio"/> Not given—contraindicated			
	2. Fibrinolytic drug used: <input type="radio"/> Streptokinase <input type="radio"/> Others (t-PA, r-PA, TNK t-PA)				
Fill in (2) and (3) only if you check 'Given at this centre' in no. (1) above	3. <u>Intravenous fibrinolytic therapy:</u>	a. Date: <i>(dd/mm/yy)</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	b. Time: <i>(in 24 hr clock)</i>	<input type="text"/> : <input type="text"/> <i>(hh:mm)</i>
	4. Door to Needle time:	<input type="checkbox"/> Not Available	<input type="checkbox"/> Not Available	<i>(minutes) Auto calculated—(time patient presented to time of fibrinolytic therapy given)</i>	

**SECTION 9: INVASIVE THERAPEUTIC PROCEDURES**

1. <u>Did patient undergo cardiac catheterization on this admission at your centre?</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No-transferred to another centre
2. Did patient undergo Percutaneous Coronary intervention (PCI) on this admission?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not applicable
	a. For STEMI	<input type="radio"/> Urgent $\rightarrow$	<input type="radio"/> Primary PCI <input type="radio"/> Rescue PCI <input type="radio"/> Pharmacoinvasive
	<input type="radio"/>	$\rightarrow$ <input type="radio"/> Elective $\rightarrow$	i) Delayed Routine PCI? <input type="radio"/> Yes <input type="radio"/> No
			ii) Delayed Selective PCI? <input type="radio"/> Yes <input type="radio"/> No
3. First balloon inflation (for Primary PCI):	a. Date: <i>(dd/mm/yy)</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	b. Time: <i>(in 24 hr clock)</i>
			<input type="text"/> : <input type="text"/> <i>(hh:mm)</i>
4. Door to balloon time (for Primary PCI only):	<input type="text"/>	<i>(minutes) Auto calculated—(time patient presented to time of first angio balloon inflation)</i>	
5. Did patient undergo CABG on this admission?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not applicable

a. Patient Name:		b. Reporting Centre:	
c. Identification Card No.:		d. Hospital RN:	

**SECTION 10: PHARMACOLOGICAL THERAPY**

Group	Given during admission		Given at discharge	
1. ASA	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
2. Ticlopidine	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
3. Clopidogrel	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
4. Prasugrel	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
5. Ticagrelor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
6. Other antiplatelet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
7. GP receptor inhibitor	<input type="radio"/> Yes	<input type="radio"/> No		
8. Unfrac heparin	<input type="radio"/> Yes	<input type="radio"/> No		
9. LMWH	<input type="radio"/> Yes	<input type="radio"/> No		
10. Fondaparinux	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
11. Oral anticoagulant (Warfarin)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
12. Oral anticoagulant (NOAC)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
13. Beta blocker	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
14. ACE inhibitor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
15. Angiotensin II receptor blocker	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
16. ARNI	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
17. Statin	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
18. Other lipid lowering agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
19. PCSK9 inhibitor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
20. Diuretics	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
21. Calcium antagonist	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
22. Oral hypoglycaemic agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
23. SGLT2i	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
24. Insulin	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
25. Anti-arrhythmic agent	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No

**SECTION 11: IN HOSPITAL OUTCOME**

1. Number of overnight stays:	a. CCU (days):		<input type="checkbox"/> Not Available
	b. ICU/CICU (days):		<input type="checkbox"/> Not Available
2. Outcome:	<input type="radio"/> Discharged →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
	<input type="radio"/> Transferred to other hospital →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
		b) Name of hospital:	
	<input type="radio"/> Died →	a) <u>Date:</u> (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
		b) <u>Cause of death:</u>	<input type="radio"/> Cardiac <input type="radio"/> Non Cardiac
3. Total number of overnight stays:		(auto calculate)	
4. <u>Final diagnosis at discharge:</u>	<input type="radio"/> STEMI <input type="radio"/> NSTEMI <input type="radio"/> UA		
5. <u>Bleeding Complication:</u> (TIMI criteria)	<input type="radio"/> Major (Any intracranial bleed or other bleeding ≥ 5g/dL Hb drop) <input type="radio"/> Minor (Non-CNS bleeding with 3-5g/dL Hb drop) <input type="radio"/> Minimal (Non-CNS bleeding, non-overt bleeding, < 3g/dL Hb drop) <input type="radio"/> None <input type="radio"/> Not stated / Inadequately described		