

Stanford University School of Medicine
Research IT

STS/ACC TVT Registry

Codebook ▾

Data Dictionary Codebook

12/10/2019 10:10am

^ Collapse all instruments

#	Variable / Field Name	Field Label <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)				
Instrument: Demographics (demographics) ^ Collapse							
1	redcap_id	Redcap id <i>Redcap identifier</i>	text				
2	age	Age <i>Patient's age at time of procedure</i>	text				
3	sex	Sex <i>Indicate the patient's sex at birth. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>1</td><td>Male</td></tr> <tr><td>2</td><td>Female</td></tr> </table> Field Annotation: v2.1 SeqNo 2060	1	Male	2	Female
1	Male						
2	Female						
4	racewhite	Race - White <i>Indicate if the patient is White as determined by the patient/family. Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one. Target Value: The value on arrival at this facility No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2070	0	No	1	Yes
0	No						
1	Yes						
5	raceblack	Race - Black or African American <i>Indicate if the patient is Black/African American as determined by the patient/family. Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2071	0	No	1	Yes
0	No						
1	Yes						
6	raceasian	Race - Asian <i>Indicate if the patient is Asian as determined by the patient/family. Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2072	0	No	1	Yes
0	No						
1	Yes						
7	raceamindian	Race - American Indian or Alaskan Native <i>Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family. Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2073	0	No	1	Yes
0	No						
1	Yes						
8	racenathaw	Race - Native Hawaiian or Pacific Islander <i>Indicate if the patient is Native Hawaiian/Other Pacific Islander as determined by the patient/family. Note(s): If the patient has multiple race origins, specify them using the other race selections in addition to this one. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2074	0	No	1	Yes
0	No						
1	Yes						
9	hisporig	Hispanic or Latino Ethnicity <i>Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 2076	0	No	1	Yes
0	No						
1	Yes						
10	aux1	Auxiliary 1 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 2500				

	11	aux2	Auxiliary 2 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 2501						
	12	demographics_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr> <td>0</td> <td>Incomplete</td> </tr> <tr> <td>1</td> <td>Unverified</td> </tr> <tr> <td>2</td> <td>Complete</td> </tr> </table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete									
1	Unverified									
2	Complete									
Instrument: Phi (phi) ^ Collapse										
	13	lastname	Last Name <i>Indicate the patient's last name. Hyphenated names should be recorded with a hyphen. Target Value: The value on arrival at this facility</i>	text Field Annotation: v2.1 SeqNo 2000						
	14	firstname	First Name <i>Indicate the patient's first name. Target Value: The value on arrival at this facility</i>	text Field Annotation: v2.1 SeqNo 2010						
	15	midname	Middle Name <i>Indicate the patient's middle name. Note(s): It is acceptable to specify the patient's middle initial. If the patient does not have a middle name, leave field blank. If the patient has multiple middle names, enter all of the middle names sequentially. Target Value: The value on arrival at this facility</i>	text Field Annotation: v2.1 SeqNo 2020						
	16	patientid	Patient ID <i>Indicate the number created and automatically inserted by the software that uniquely identifies this patient. Target Value: The value on arrival at this facility</i>	text Field Annotation: v2.1 SeqNo 2040						
	17	mrn	Other ID <i>Indicate optional patient identifier, such as medical record number, that can be associated with the patient. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 2045						
	18	deid_jitter	Deid date offset value	text						
	19	dob	Birth Date <i>Indicate the patient's date of birth. Target Value: The value on arrival at this facility</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 2050						
	20	arrivaldate	Section Header: <i>Episode of Care</i> Arrival Date <i>Indicate the date the patient arrived at your facility. Target Value: N/A</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 3000						
	21	priorpacerdate	Section Header: <i>History & Risk Factors</i> Most Recent Pacemaker Date <i>Indicate the date the pacemaker was implanted. Note(s): If the month or day is unknown, enter 01 Target Value: The last value between birth and the first procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4012						
	22	priorpcidate	Most Recent PCI Date <i>Indicate the date of the most recent PCI. Note(s): If the month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4025						
	23	priorcabgdate	Most Recent CABG Date <i>Indicate the date of the most recent coronary artery bypass graft (CABG). Note(s): If month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4035						
	24	prioraorticvalvedate	Most Recent Aortic Valve Procedure Date <i>Indicate the date of the most recent prior aortic valve procedure. Note(s): If month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4065						
	25	priormvprocdade	Prior Mitral Valve Procedure Date <i>Indicate the date of the most recent prior mitral valve procedure, if performed. Target Value: Any occurrence between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4097						
	26	priorstrokedate	Most Recent Stroke Date <i>Indicate the date of the most recent stroke. Note(s): If the month or day is unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4125						
	27	sixminwalkdate	Section Header: <i>Pre-procedure Status</i> Six Minute Walk Test Date <i>Indicate the date the six minute walk test was performed. Target Value: The last value between 30 days prior to the procedure and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 5116						
	28	dxcathtdt	Diagnostic Catheterization Date <i>Indicate the date the diagnostic catheterization was performed. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 5505						

29	tvtprocedurestartdate	<p>Section Header: <i>Procedure Information</i></p> <p>Procedure Start Date</p> <p><i>Indicate the time the procedure started. Target Value: N/A</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 6041</p>										
30	tvtprocedurestopdate	<p>Procedure Stop Date</p> <p><i>Indicate the date the patient exits the procedure room. Target Value: The last value on current procedure</i></p>	<p>text (date_mdy)</p> <p>Field Annotation: v2.1 SeqNo 6045</p>										
31	mrr_procrmarrivaldate	<p>Procedure Room Arrival Date (Mitral Repair)</p> <p><i>Indicate the date the patient arrived into the procedure room. Target Value: The value on current procedure</i></p>	<p>text (date_mdy)</p> <p>Field Annotation: v2.1 SeqNo 26060</p>										
32	popttechdate	<p>Section Header: <i>Post-procedure Labs and Tests</i></p> <p>Post-Procedure Echocardiogram Date</p> <p><i>Indicate the date the echo was performed. Target Value: The value between end of procedure and discharge</i></p>	<p>text (date_mdy)</p> <p>Field Annotation: v2.1 SeqNo 8070</p>										
33	dcdate	<p>Section Header: <i>Discharge</i></p> <p>Discharge Date</p> <p><i>Indicate the date on which the patient was discharged from your facility. Note(s): If the deceased is an organ donor, code the Discharge Date as the date of the final organ harvest. Target Value: The value on discharge</i></p>	<p>text (date_mdy)</p> <p>Field Annotation: v2.1 SeqNo 9045</p>										
34	deathdate	<p>Death Date</p>	<p>text</p>										
35	phi_complete	<p>Section Header: <i>Form Status</i></p> <p>Complete?</p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete				
0	Incomplete												
1	Unverified												
2	Complete												
<p>Instrument: Episode Of Care (episode_of_care)</p>			<p>^ Collapse</p>										
36	arrivaldate_deid	<p>Section Header: <i>Episode of Care</i></p> <p>Arrival Date (Deid)</p> <p><i>Indicate the date the patient arrived at your facility. Target Value: N/A</i></p>	<p>text (date_mdy)</p> <p>Field Annotation: v2.1 SeqNo 3000</p>										
37	arrivaltime	<p>Arrival Time</p> <p><i>Indicate the time the patient arrived at your facility Note(s): Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours). If the patient came to your facility for an elective or outpatient procedure and the time was not documented, code the scheduled time of arrival. Target Value: N/A</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 3001</p>										
38	residence	<p>Residence on Arrival</p> <p><i>Indicate the primary residence of the patient prior to arrival. If the primary residence is not available, code not documented. Target Value: The value on arrival at this facility</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Home with no health-aid</td></tr> <tr><td>2</td><td>Home with health aid</td></tr> <tr><td>3</td><td>Long term care</td></tr> <tr><td>4</td><td>Other</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 3003</p>	1	Home with no health-aid	2	Home with health aid	3	Long term care	4	Other	5	Not Documented
1	Home with no health-aid												
2	Home with health aid												
3	Long term care												
4	Other												
5	Not Documented												
39	insprivate	<p>Insurance Payors - Private Health Insurance</p> <p><i>Indicate if the patient's insurance payor(s) included private health insurance. Note(s): A health maintenance organization (HMO) is considered private health insurance. Target Value: The value on arrival at this facility</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 3005</p>	0	No	1	Yes						
0	No												
1	Yes												
40	insmedicare	<p>Insurance Payors - Medicare</p> <p><i>Indicate if the patient's insurance payor(s) included Medicare. Target Value: The value on arrival at this facility</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 3006</p>	0	No	1	Yes						
0	No												
1	Yes												
41	insmedicaid	<p>Insurance Payors - Medicaid</p> <p><i>Indicate if the patient's insurance payor(s) included Medicaid. Target Value: The value on arrival at this facility</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 3007</p>	0	No	1	Yes						
0	No												
1	Yes												

42	insmilitary	Insurance Payors - Military Health Care <i>Indicate if the patient's insurance payor(s) included Military Health Care. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3008	0	No	1	Yes
0	No						
1	Yes						
43	insstate	Insurance Payors - State-Specific Plan (Non Medicaid) <i>Indicate if the patient's insurance payor(s) included State-Specific Plan (non Medicaid). Target Value: The value on arrival at this facility No Yes</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3009	0	No	1	Yes
0	No						
1	Yes						
44	insihs	Insurance Payors - Indian Health Service <i>Indicate if the patient's insurance payor(s) included Indian Health Service (IHS). Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3010	0	No	1	Yes
0	No						
1	Yes						
45	insnonus	Insurance Payors - Non-US Insurance <i>Indicate if the patient's insurance payor(s) included Non-US Insurance. Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3011	0	No	1	Yes
0	No						
1	Yes						
46	insnone	Insurance Payors - None <i>Indicate if the patient has no insurance payor(s). Target Value: The value on arrival at this facility</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3012	0	No	1	Yes
0	No						
1	Yes						
47	hic	Health Insurance Claim Number <i>Indicate the patient's Health Insurance Claim (HIC) number. Target Value: The value on arrival at this facility</i>	text Field Annotation: v2.1 SeqNo 3015				
48	aux3	Auxiliary 3 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3020				
49	aux4	Auxiliary 4 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3025				
50	enrolledstudy	Patient Enrolled in Research Study <i>Indicate if the patient is enrolled in a research study for the index procedure or the episode of care. Note(s): Code 'Yes' only for those patients enrolled in an STS/ACC TVT Registry research study. If the patient is in other studies unrelated to the TVT Registry, leave blank or Code 'No'. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 3030	0	No	1	Yes
0	No						
1	Yes						
51	studyname1	Research Study Name <i>Indicate the research study name as provided by the research study protocol or STS/ACC TVT Registry staff. Note(s): Study names must follow the format indicated by the research protocol or STS/ACC TVT Registry staff. Deviations may result in an error message. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3031				
52	studypid1	Research Study Patient ID <i>Indicate the research study patient identification number as assigned by the research protocol or STS/ACC TVT Registry staff. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3032				
53	studyname2	Research Study Name <i>Indicate the research study name as provided by the research study protocol or STS/ACC TVT Registry staff. Note(s): Study names must follow the format indicated by the research protocol or STS/ACC TVT Registry staff. Deviations may result in an error message. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3031				
54	studypid2	Research Study Patient ID <i>Indicate the research study patient identification number as assigned by the research protocol or STS/ACC TVT Registry staff. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3032				
55	studyname3	Research Study Name <i>Indicate the research study name as provided by the research study protocol or STS/ACC TVT Registry staff. Note(s): Study names must follow the format indicated by the research protocol or STS/ACC TVT Registry staff. Deviations may result in an error message. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3031				
56	studypid3	Research Study Patient ID <i>Indicate the research study patient identification number as assigned by the research protocol or STS/ACC TVT Registry staff. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3032				

57	studyname4	Research Study Name <i>Indicate the research study name as provided by the research study protocol or STS/ACC TVT Registry staff. Note(s): Study names must follow the format indicated by the research protocol or STS/ACC TVT Registry staff. Deviations may result in an error message. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3031						
58	studypid4	Research Study Patient ID <i>Indicate the research study patient identification number as assigned by the research protocol or STS/ACC TVT Registry staff. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3032						
59	studyname5	Research Study Name <i>Indicate the research study name as provided by the research study protocol or STS/ACC TVT Registry staff. Note(s): Study names must follow the format indicated by the research protocol or STS/ACC TVT Registry staff. Deviations may result in an error message. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3031						
60	studypid5	Research Study Patient ID <i>Indicate the research study patient identification number as assigned by the research protocol or STS/ACC TVT Registry staff. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 3032						
61	episode_of_care_complete	Section Header: Form Status Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete								
1	Unverified								
2	Complete								
Instrument: History Risk Factors (history_risk_factors) ^ Collapse									
62	infendo	Section Header: Cardiac History Infective Endocarditis <i>Indicate whether the patient has a history of infective endocarditis documented by one of the following: 1. Positive blood cultures 2. Vegetation on echocardiography and/or other diagnostic modality 3. Documented history of infective endocarditis Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4000	0	No	1	Yes		
0	No								
1	Yes								
63	infendty	Infective Endocarditis Type <i>Indicate the type of endocarditis. Target Value: The last value between birth and the procedure</i>	radio <table border="1"> <tr><td>1</td><td>Treated</td></tr> <tr><td>2</td><td>Active</td></tr> </table> Field Annotation: v2.1 SeqNo 4005	1	Treated	2	Active		
1	Treated								
2	Active								
64	priorhfadmit	Heart Failure Hospitalization Within Past Year <i>Indicate if the patient has been admitted to the hospital for an inpatient admission with a diagnosis of heart failure within the past year. Target Value: Any occurrence between one year prior to the procedure and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 4006	0	No	1	Yes	2	Not Documented
0	No								
1	Yes								
2	Not Documented								
65	pacemaker	Permanent Pacemaker <i>Indicate if the patient currently has a permanent pacemaker or had a permanent pacemaker that was implanted at any time prior to arrival at this facility. This includes patients that had a permanent pacemaker previously, but the device is no longer in place. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4010	0	No	1	Yes		
0	No								
1	Yes								
66	priorpacerdate_deid	Most Recent Pacemaker Date (Deid) <i>Indicate the date the pacemaker was implanted. Note(s): If the month or day is unknown, enter 01 Target Value: The last value between birth and the first procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4012						
67	crt	Cardiac Resynchronization Therapy <i>Indicate if the pacemaker type includes cardiac resynchronization therapy (CRT). A CRT is a biventricular pacemaker that sends electrical signals to both ventricles that resynchronizes the heart chambers and helps it pump more effectively. It may or may not have an atrial pacing wire. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4013	0	No	1	Yes		
0	No								
1	Yes								
68	previcd	Previous ICD <i>Indicate if the patient had a previous implantable cardioverter defibrillator (ICD). This includes patients that had an ICD previously, but the device is no longer in place. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4015	0	No	1	Yes		
0	No								
1	Yes								

69	crtcd	Cardiac Resynchronization Therapy Defibrillator <i>Indicate if the ICD includes a cardiac resynchronization therapy device. A cardiac resynchronization therapy defibrillator (CRT-D) has dual capabilities. It is a biventricular pacemaker that sends electrical signals to both ventricles as well as a defibrillator. It may or may not have an atrial pacing wire. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4016						
0	No													
1	Yes													
70	priorpci	Prior PCI <i>Indicate if the patient had a previous percutaneous coronary intervention. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4020						
0	No													
1	Yes													
71	priorpcideate_deid	Most Recent PCI Date (Deid) <i>Indicate the date of the most recent PCI. Note(s): If the month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4025											
72	priorcabg	Prior CABG <i>Indicate if the patient had a previous coronary artery bypass graft (CABG) surgery. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4030						
0	No													
1	Yes													
73	priorcabgdate_deid	Most Recent CABG Date (Deid) <i>Indicate the date of the most recent coronary artery bypass graft (CABG). Note(s): If month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4035											
74	prothcar	Prior Other Cardiac Surgery <i>Indicate if the patient had prior other cardiac surgery. Other cardiac surgery includes surgeries not otherwise specified in the cardiac history. It includes, but is not limited to: 1. Previous congenital heart surgery and/or percutaneous procedure (e.g. VSD, ASD, TOF and PFO repair). 2. Previous surgery on the thoracic aorta. 3. Previous intrapericardial or great vessel (e.g., aorta, superior vena cava, inferior vena cava, pulmonary arteries and veins) procedure performed. This may include, but is not limited to LVA, acquired VSD, SVR, TMR, cardiac trauma, pericardial window, pericardiectomy, cardiac tumor, myectomy or heart transplant. Note(s): Do not include aortic or non-aortic valve procedures. See Seq Num 4095, Prior Other Non-Aortic Valve Procedure and Seq Num 4060, Prior Aortic Valve Procedure. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4040						
0	No													
1	Yes													
75	numprevcardsurg	Number of Previous Cardiac Surgeries <i>Indicate the number of open heart cardiac surgeries the patient has had prior to this procedure. This includes open heart coronary artery bypass, or valve replacement/repairs. Note(s): Do not include other open chest surgical procedures (not accessing the heart, such as surgery on the thoracic aorta or lung) or other cardiac interventional procedures (such as a PCI, or balloon valvuloplasty). Target Value: The total between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td></tr> <tr><td>4</td><td>>=4</td></tr> </table>	0	0	1	1	2	2	3	3	4	>=4	Field Annotation: v2.1 SeqNo 4055
0	0													
1	1													
2	2													
3	3													
4	>=4													
76	prioraorticvalve	Section Header: <i>Aortic Valve</i> Prior Aortic Valve Procedure <i>Indicate whether the patient had a previous surgical or interventional replacement and/or repair of the aortic valve. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4060						
0	No													
1	Yes													
77	prioraorticvalvedate_deid	Most Recent Aortic Valve Procedure Date (Deid) <i>Indicate the date of the most recent prior aortic valve procedure. Note(s): If month or day are unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4065											
78	prevprocavreplace	Previous Aortic Valve Replacement - Surgical <i>Indicate whether a previous procedure included a surgical aortic valve replacement. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 4070						
0	No													
1	Yes													

79	prevprocavtype	Previous Aortic Valve Procedure Type <i>Indicate the type of aortic valve replacement. Target Value: The last value between birth and the procedure</i>	radio <table border="1"> <tr><td>1</td><td>Bioprosthetic stented</td></tr> <tr><td>2</td><td>Bioprosthetic stentless</td></tr> <tr><td>3</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 4075	1	Bioprosthetic stented	2	Bioprosthetic stentless	3	Not Documented				
1	Bioprosthetic stented												
2	Bioprosthetic stentless												
3	Not Documented												
80	prevprocavmodelid	Aortic Valve Model ID <i>Indicate the model ID of the prosthetic aortic valve. Target Value: The last value between birth and the procedure</i>	text Field Annotation: v2.1 SeqNo 4078										
81	prevprocavrepair	Previous Aortic Valve Repair - Surgical <i>Indicate whether a previous procedure included a surgical aortic valve repair. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4080	0	No	1	Yes						
0	No												
1	Yes												
82	prevprocavball	Previous Procedure - Aortic Valve Balloon Valvuloplasty <i>Indicate whether a previous procedure included an aortic balloon valvuloplasty. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4085	0	No	1	Yes						
0	No												
1	Yes												
83	prevproctcvrep	Previous Procedure - Aortic Valve Transcatheter Valve Replacement <i>Indicate whether a previous procedure included a transcatheter aortic valve replacement procedure. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4090	0	No	1	Yes						
0	No												
1	Yes												
84	prevproctcvint	Previous Procedure - Aortic Valve Transcatheter Valve Intervention <i>Indicate whether a previous procedure included a transcatheter aortic valve intervention (such as a procedure that deploys an occluder or plug for aortic regurgitation). Note(s): This does not include surgical aortic valve repair/replacements, transcatheter AV replacements or AV balloon valvuloplasties. Target Value: Any occurrence between birth and the procedure No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4091	0	No	1	Yes						
0	No												
1	Yes												
85	prevproctcvmodelid	Previous Procedure - AV Transcatheter Valve Model ID <i>Indicate the model ID implanted in the transcatheter aortic valve replacement procedure. Target Value: Any occurrence between birth and the procedure</i>	text Field Annotation: v2.1 SeqNo 4092										
86	priornonavproc	Section Header: Other Valve Prior Non-Aortic Valve Procedure <i>Indicate whether the patient had a previous surgical or interventional replacement and/or repair of a valve (excluding the aortic valve). Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4095	0	No	1	Yes						
0	No												
1	Yes												
87	priormvprocdate_deid	Prior Mitral Valve Procedure Date (Deid) <i>Indicate the date of the most recent prior mitral valve procedure, if performed. Target Value: Any occurrence between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4097										
88	prevprocmvreplace	Previous Procedure - Mitral Valve Replacement - Surgical <i>Indicate whether a previous procedure included a surgical mitral valve replacement. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4100	0	No	1	Yes						
0	No												
1	Yes												
89	prevprocmvreplacetype	Prior Non-Aortic Valve Procedure - Mitral Valve Type <i>Indicate the type of mitral valve replacement. Target Value: The last value between birth and the procedure</i>	radio <table border="1"> <tr><td>1</td><td>Mechanical</td></tr> <tr><td>2</td><td>Bioprosthetic (retired)</td></tr> <tr><td>3</td><td>Bioprosthetic stented</td></tr> <tr><td>4</td><td>Bioprosthetic stentless</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 4105	1	Mechanical	2	Bioprosthetic (retired)	3	Bioprosthetic stented	4	Bioprosthetic stentless	5	Not Documented
1	Mechanical												
2	Bioprosthetic (retired)												
3	Bioprosthetic stented												
4	Bioprosthetic stentless												
5	Not Documented												

90	prevprocmvreplacemodelid	Previous Procedure - Mitral Valve Replacement Model ID <i>Indicate the model ID of the prosthetic mitral valve. Target Value: The last value between birth and the procedure</i>	text Field Annotation: v2.1 SeqNo 4106												
91	prevprocmvrepair	Previous Procedure - Mitral Valve Repair - Surgical <i>Indicate whether a previous procedure included a surgical mitral valve repair. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4110	0	No	1	Yes								
0	No														
1	Yes														
92	priormaringsurg	Prior Mitral Annuloplasty Ring - Surgical <i>Indicate if the patient had a prior mitral annuloplasty ring implanted surgically. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes - partial</td> </tr> <tr> <td>2</td> <td>Yes - circumferential</td> </tr> <tr> <td>3</td> <td>Not documented</td> </tr> </table> Field Annotation: v2.1 SeqNo 4111	0	No	1	Yes - partial	2	Yes - circumferential	3	Not documented				
0	No														
1	Yes - partial														
2	Yes - circumferential														
3	Not documented														
93	priortmvr	Prior Mitral Valve Transcatheter Intervention <i>Indicate whether a previous procedure included a transcatheter mitral valve intervention. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4112	0	No	1	Yes								
0	No														
1	Yes														
94	priortmvrtype	Prior Mitral Transcatheter Type <i>Indicate the type of transcatheter mitral valve intervention. Target Value: Any occurrence between birth and the procedure</i>	dropdown <table border="1"> <tr> <td>1</td> <td>Leaflet clip</td> </tr> <tr> <td>2</td> <td>Direct annuloplasty intervention</td> </tr> <tr> <td>3</td> <td>Coronary sinus based intervention</td> </tr> <tr> <td>4</td> <td>Valve-in-native valve</td> </tr> <tr> <td>5</td> <td>Valve-in-valve</td> </tr> <tr> <td>6</td> <td>Other</td> </tr> </table> Field Annotation: v2.1 SeqNo 4113	1	Leaflet clip	2	Direct annuloplasty intervention	3	Coronary sinus based intervention	4	Valve-in-native valve	5	Valve-in-valve	6	Other
1	Leaflet clip														
2	Direct annuloplasty intervention														
3	Coronary sinus based intervention														
4	Valve-in-native valve														
5	Valve-in-valve														
6	Other														
95	priormitralringmodelid	Valve or Ring Model <i>Indicate the model ID of the prosthetic mitral valve. Target Value: The value between birth and the procedure</i>	text Field Annotation: v2.1 SeqNo 4116												
96	priortricuspidproc	Prior Tricuspid Valve Replacement/Repair <i>Indicate if the patient had a prior tricuspid valve replacement or repair. Target Value: Any occurrence between birth and the procedure No Yes</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4118	0	No	1	Yes								
0	No														
1	Yes														
97	priorpulmonicproc	Prior Pulmonic Valve Replacement/Repair <i>Indicate if the patient had a prior pulmonic valve replacement or repair. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4119	0	No	1	Yes								
0	No														
1	Yes														
98	priorstroke	Section Header: <i>Other History and Risk Factors</i> Prior Stroke <i>Indicate if the patient has a history of a stroke. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4120	0	No	1	Yes								
0	No														
1	Yes														
99	priorstrokedate_deid	Most Recent Stroke Date (Deid) <i>Indicate the date of the most recent stroke. Note(s): If the month or day is unknown, enter 01. Target Value: The last value between birth and the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 4125												
100	cvdtia	Transient Ischemic Attack <i>Indicate if the patient has a history of a transient ischemic attack. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 4130	0	No	1	Yes								
0	No														
1	Yes														

101	cvdcarsten	Carotid Stenosis Assessment <i>Indicate which carotid artery was determined from any diagnostic test to be greater or equal to 50% stenotic. Target Value: The highest value between birth and the procedure</i>	dropdown <table border="1"> <tr><td>1</td><td>None</td></tr> <tr><td>2</td><td>Right</td></tr> <tr><td>3</td><td>Left</td></tr> <tr><td>4</td><td>Both</td></tr> <tr><td>5</td><td>Not assessed</td></tr> </table> Field Annotation: v2.1 SeqNo 4135	1	None	2	Right	3	Left	4	Both	5	Not assessed
1	None												
2	Right												
3	Left												
4	Both												
5	Not assessed												
102	cvdpcarsurg	Prior Carotid Artery Surgery or Stent <i>Indicate whether the patient has a history of previous carotid artery surgery and/or stenting. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4140	0	No	1	Yes						
0	No												
1	Yes												
103	cvdstenrt	Severity of Stenosis - Right Carotid Artery <i>Indicate the best estimate of the most severe percent stenosis in the right carotid artery. Target Value: The highest value between birth and the procedure</i>	radio <table border="1"> <tr><td>3</td><td>50%-79%</td></tr> <tr><td>1</td><td>80% to 99%</td></tr> <tr><td>2</td><td>100 %</td></tr> <tr><td>4</td><td>Stenosis % not available</td></tr> </table> Field Annotation: v2.1 SeqNo 4141	3	50%-79%	1	80% to 99%	2	100 %	4	Stenosis % not available		
3	50%-79%												
1	80% to 99%												
2	100 %												
4	Stenosis % not available												
104	cvdstenlft	Severity of Stenosis - Left Carotid Artery <i>Indicate the best estimate of the most severe percent stenosis in the left carotid artery. Target Value: The highest value between birth and the procedure</i>	radio <table border="1"> <tr><td>3</td><td>50%-79%</td></tr> <tr><td>1</td><td>80% to 99%</td></tr> <tr><td>2</td><td>100 %</td></tr> <tr><td>4</td><td>Stenosis % not available</td></tr> </table> Field Annotation: v2.1 SeqNo 4142	3	50%-79%	1	80% to 99%	2	100 %	4	Stenosis % not available		
3	50%-79%												
1	80% to 99%												
2	100 %												
4	Stenosis % not available												
105	priorpad	Peripheral Arterial Disease <i>Indicate if the patient has a history of peripheral arterial disease (PAD) (includes upper and lower extremity, renal, mesenteric, and abdominal aortic systems). Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4145	0	No	1	Yes						
0	No												
1	Yes												
106	smoker	Current/Recent Smoker (w/in 1 year) <i>Indicate if the patient has smoked cigarettes anytime during the year prior. Target Value: Any occurrence between 1 year prior to the procedure and the procedure No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4150	0	No	1	Yes						
0	No												
1	Yes												
107	hypertension	Hypertension <i>Indicate whether the patient has a diagnosis of hypertension. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4155	0	No	1	Yes						
0	No												
1	Yes												
108	diabetes	Diabetes Mellitus <i>Indicate if the patient has a history of diabetes mellitus regardless of duration of disease or need for antidiabetic agents. Target Value: Any occurrence between birth and the procedure No Yes</i>	dropdown <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 4165	0	No	1	Yes						
0	No												
1	Yes												

109	diabetescontrol	<p>Diabetes Therapy Indicate the most aggressive diabetes control therapy. Note(s): Patients placed on a pre-procedure diabetic pathway of insulin drip after arrival but were not on insulin therapy (treated by diet or oral method) are not coded as insulin treatment. If a patient had a pancreatic transplant, code 'other', since the insulin from the new pancreas is not exogenous insulin. Do not include 'non-insulin' injectables that may improve blood sugar (such as Byetta) as insulin treatment. Target Value: The last value between birth and prior to the procedure</p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>None</td></tr> <tr><td>2</td><td>Diet</td></tr> <tr><td>3</td><td>Oral</td></tr> <tr><td>4</td><td>Insulin</td></tr> <tr><td>5</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4170</p>	1	None	2	Diet	3	Oral	4	Insulin	5	Other
1	None												
2	Diet												
3	Oral												
4	Insulin												
5	Other												
110	currentdialysis	<p>Currently on Dialysis Indicate if the patient is currently undergoing either hemodialysis or peritoneal dialysis on an ongoing basis as a result of renal failure. Note(s): If the patient is receiving continuous veno-venous hemofiltration (CVVH) as a result of renal failure (and not as treatment to remove fluid for heart failure), code 'yes'. Target Value: The value on the procedure</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4175</p>	0	No	1	Yes						
0	No												
1	Yes												
111	chrlungd	<p>Chronic Lung Disease Indicate if the patient has a history of chronic lung disease, and severity, if present. Target Value: The value on the procedure</p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4180</p>	1	None	2	Mild	3	Moderate	4	Severe		
1	None												
2	Mild												
3	Moderate												
4	Severe												
112	hmo2	<p>Home Oxygen Indicate whether patient uses supplemental oxygen at home. Target Value: The value on arrival at this facility</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4181</p>	0	No	1	Yes						
0	No												
1	Yes												
113	hostilechest	<p>Hostile Chest Indicate if the patient has a medical condition that precludes an open chest procedure and that is documented in the medical record. This can include any of the following or other reasons that make redo operation through sternotomy or right anterior thoracotomy prohibitively hazardous: 1. Evidence of abnormal chest wall anatomy due to severe kyphoscoliosis or other skeletal abnormalities (including thoracoplasty, Potts' disease, sternal bone destruction, evidence of indetectable plane between posterior sternal table and important mediastinal structures) 2. Complications from prior surgery 3. Prior radiation involving the mediastinum/thoracic, or evidence of severe radiation damage (e.g., skin burns, bone destruction, muscle loss, lung fibrosis or esophageal stricture) 4. History of multiple recurrent pleural effusions causing internal adhesions. 5. Chronic, ongoing open skin defects or extremely severe soft tissue atrophy. 6. Complete absence of reconstructive options based on plastic surgeon consult. Target Value: The value on the procedure</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4182</p>	0	No	1	Yes						
0	No												
1	Yes												
114	immsupp	<p>Immunocompromise Present Indicate whether immunocompromise is present due to immunosuppressive medication therapy. This includes, but is not limited to systemic steroid therapy, anti-rejection medications and chemotherapy. This does not include topical steroid applications, one time systemic therapy, inhaled steroid therapy or preprocedure protocol. Target Value: The value between 30 days prior to the procedure and the procedure</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 4185</p>	0	No	1	Yes						
0	No												
1	Yes												
115	priormedhome_asa_alone	<p>Section Header: Home Medications Aspirin (alone)</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes						
0	No												
1	Yes												
116	priormedhome_betablock	Beta Blocker (any)	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes						
0	No												
1	Yes												
117	priormedhome_acei_arb	ACE or ARB (any)	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes						
0	No												
1	Yes												

118	priormedhome_aldo	Aldosterone Antagonists	radio 0 No 1 Yes
119	priormedhome_loop_diur	Loop diuretic	radio 0 No 1 Yes
120	priormedhome_thiazides	Diuretics - Thiazides	radio 0 No 1 Yes
121	priormedhome_diur_other	Diuretics (not otherwise specified)	radio 0 No 1 Yes
122	priormedhome_anticoag_any	Anticoagulants (any)	radio 0 No 1 Yes
123	priormedhome_asa_dual	Aspirin (dual antiplatelet therapy)	radio 0 No 1 Yes
124	priormedhome_med_dose	Loop diuretic Dose (mg)	text
125	history_risk_factors_complete	Section Header: <i>Form Status</i> Complete?	dropdown 0 Incomplete 1 Unverified 2 Complete

Instrument: **Preprocedure Status** (preprocedure_status)[^ Collapse](#)

126	cadpresentation	CAD Presentation <i>Indicate the patient's coronary artery disease (CAD) presentation. Choose the worst status. Target Value: The highest value between 7 days prior to the procedure and the procedure</i>	dropdown 1 No Sxs, no angina 2 Sx unlikely to be ischemic 3 Stable angina 4 Unstable angina 5 Non-STEMI 6 STEMI Field Annotation: v2.1 SeqNo 5000
127	priormi	Prior MI <i>Indicate if the patient has had at least one documented previous myocardial infarction. Target Value: Any occurrence between birth and the procedure</i>	radio 0 No 1 Yes Field Annotation: v2.1 SeqNo 5005
128	miwhen	Prior MI Timeframe <i>Indicate the timeframe of the myocardial infarction. Target Value: The last value between birth and the procedure</i>	radio 1 < 30 Days 2 >= 30 Days Field Annotation: v2.1 SeqNo 5010
129	cardiomyopathy	Cardiomyopathy <i>Indicate if the patient has a history of cardiomyopathy. Target Value: Any occurrence between birth and the procedure</i>	radio 0 No 1 Yes - Ischemic 2 Yes - Non-ischemic Field Annotation: v2.1 SeqNo 5012

130	prior2weekshf	Heart Failure w/in 2 Weeks <i>Indicate if there is physician documentation or report that the patient has been in a state of heart failure within the past 2 weeks. Target Value: Any occurrence between 2 weeks prior to the procedure and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5020	0	No	1	Yes				
0	No										
1	Yes										
131	prior2weeknyha	NYHA Class w/in 2 Weeks <i>Indicate the patient's functional class, coded as the New York Heart Association (NYHA) classification within the past 2 weeks. Target Value: The highest value between 2 weeks prior to the procedure and the procedure</i>	dropdown <table border="1"> <tr><td>1</td><td>Class I</td></tr> <tr><td>2</td><td>Class II</td></tr> <tr><td>3</td><td>Class III</td></tr> <tr><td>4</td><td>Class IV</td></tr> </table> Field Annotation: v2.1 SeqNo 5025	1	Class I	2	Class II	3	Class III	4	Class IV
1	Class I										
2	Class II										
3	Class III										
4	Class IV										
132	priorcardioshock	Cardiogenic Shock w/in 24 Hours <i>Indicate if the patient has been in a state of cardiogenic shock within 24 hrs of procedure. Target Value: Any occurrence between 24 hours prior to the procedure and up to the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5030	0	No	1	Yes				
0	No										
1	Yes										
133	priorcardiacarrest	Cardiac Arrest w/in 24 Hours <i>Indicate if the patient has had an episode of cardiac arrest within 24 hours of the procedure. Target Value: Any occurrence between 24 hours prior to the procedure and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5035	0	No	1	Yes				
0	No										
1	Yes										
134	cardiacproc30days	Cardiac Procedure w/in 30 Days <i>Indicate if the patient has had an interventional, transcatheter or surgical cardiac procedure within 30 days prior to the procedure. Target Value: Any occurrence between 30 days prior to the procedure and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5040	0	No	1	Yes				
0	No										
1	Yes										
135	porcelainaorta	Porcelain Aorta <i>Indicate if the patient has a porcelain aorta as documented by findings on a chest x-ray, CT scan, fluoroscopy at the time of cardiac catheterization or noted during previous cardiothoracic surgery. Target Value: Any occurrence between birth and the procedure No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5045	0	No	1	Yes				
0	No										
1	Yes										
136	afibflutter	Atrial Fibrillation/Flutter <i>Indicate if the patient has a history of atrial fibrillation and/or atrial flutter documented in the medical record. Target Value: Any occurrence between birth and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5050	0	No	1	Yes				
0	No										
1	Yes										
137	afibclass	Atrial Fibrillation Classification <i>Indicate whether AFib/Aflutter is paroxysmal or continuous/persistent within 30 days prior to the procedure Target Value: The value between 30 days prior to procedure and procedure</i>	dropdown <table border="1"> <tr><td>1</td><td>None</td></tr> <tr><td>2</td><td>Persistent</td></tr> <tr><td>3</td><td>Paroxysmal</td></tr> </table> Field Annotation: v2.1 SeqNo 5052	1	None	2	Persistent	3	Paroxysmal		
1	None										
2	Persistent										
3	Paroxysmal										
138	conductiondefect	Conduction Defect <i>Indicate if the patient has a conduction defect as evidenced by a right or left bundle branch block, sick sinus syndrome, or 1st, 2nd or 3rd degree heart block on ECG. Target Value: Any occurrence on Procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5055	0	No	1	Yes				
0	No										
1	Yes										
139	fivemwalktest	Five Meter Walk Test Performed <i>Indicate whether the five meter walk test was performed. Target Value: The last value between 30 days prior to the procedure and the procedure</i>	radio <table border="1"> <tr><td>0</td><td>Not performed</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Unable to walk</td></tr> </table> Field Annotation: v2.1 SeqNo 5085	0	Not performed	1	Yes	2	Unable to walk		
0	Not performed										
1	Yes										
2	Unable to walk										

140	fivemwalk1	Five Meter Walk Time 1 Indicate the time in seconds it takes the patient to walk 5 meters for the first of three tests. Target Value: The last value between 30 days prior to the procedure and the procedure	text Field Annotation: v2.1 SeqNo 5090												
141	fivemwalk2	Five Meter Walk Time 2 Indicate the time in seconds it takes the patient to walk 5 meters for the second of three tests. Target Value: The last value between 30 days prior to the procedure and the procedure	text Field Annotation: v2.1 SeqNo 5095												
142	fivemwalk3	Five Meter Walk Time 3 Indicate the time in seconds it takes the patient to walk 5 meters for the third of three tests. Target Value: The last value between 30 days prior to the procedure and the procedure	text Field Annotation: v2.1 SeqNo 5100												
143	stsriskscore	Aortic Valve Replacement - STS Risk Score Indicate the patient's predicted risk of mortality for surgical aortic valve replacement as determined by the Heart Team and based on the Society for Thoracic Surgeon's risk model. Target Value: The value on current procedure	text Field Annotation: v2.1 SeqNo 5105												
144	stsriskmvreplace	Mitral Valve Replacement - STS Risk Score Indicate the patient's predicted risk of mortality for surgical mitral valve replacement as determined by the Heart Team and based on the Society for Thoracic Surgeon's risk model. Target Value: The value on current procedure	text Field Annotation: v2.1 SeqNo 5106												
145	stsriskmvrepair	Mitral Valve Repair - STS Risk Score Indicate the patient's predicted risk of mortality for surgical mitral valve repair as determined by the Heart Team and based on the Society for Thoracic Surgeon's risk model. Note(s): If LA volume index is documented, LA volume is not required. Need to add a requirement that if one is coded the other can be null. Target Value: The value on current procedure	text Field Annotation: v2.1 SeqNo 5107												
146	sixminwalkperf	Six Minute Walk Test Performed Indicate whether the six minute walk test was performed. Target Value: The last value between 30 days prior to the procedure and the procedure	dropdown <table border="1"> <tr><td>1</td><td>Performed</td></tr> <tr><td>2</td><td>Not Performed - non cardiac reason</td></tr> <tr><td>3</td><td>Not performed - cardiac reason</td></tr> <tr><td>4</td><td>Not performed - patient not willing to walk</td></tr> <tr><td>5</td><td>Not performed by site</td></tr> </table> Field Annotation: v2.1 SeqNo 5115	1	Performed	2	Not Performed - non cardiac reason	3	Not performed - cardiac reason	4	Not performed - patient not willing to walk	5	Not performed by site		
1	Performed														
2	Not Performed - non cardiac reason														
3	Not performed - cardiac reason														
4	Not performed - patient not willing to walk														
5	Not performed by site														
147	sixminwalkdate_deid	Six Minute Walk Test Date Indicate the date the six minute walk test was performed. Target Value: The last value between 30 days prior to the procedure and the procedure	text (date_mdy) Field Annotation: v2.1 SeqNo 5116												
148	sixminwalkdist	Total Distance Indicate the total distance, in feet, the patient walked. Target Value: The last value between 30 days prior to the procedure and the procedure	text Field Annotation: v2.1 SeqNo 5117												
149	kccq12_performed	KCCQ-12 Patient Questionnaire Performed Indicate if the baseline Kansas City Cardiomyopathy Questionnaire (KCCQ-12) was performed. Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: Any occurrence on start of procedure	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5169	0	No	1	Yes								
0	No														
1	Yes														
150	kccq12_1a	KCCQ-12 Question 1a Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1a. Heart Failure Limitation - Showering/bathing Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure	dropdown <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> Field Annotation: v2.1 SeqNo 5170	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity
1	Extremely limited														
2	Quite a bit limited														
3	Moderately limited														
4	Slightly limited														
5	Not at all limited														
6	Limited for other reasons or did not do the activity														

151	kccq12_1b	<p>KCCQ-12 Question 1b <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1b. Heart Failure Limitation - Walking 1 block on level ground Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5171</p>	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity		
1	Extremely limited																
2	Quite a bit limited																
3	Moderately limited																
4	Slightly limited																
5	Not at all limited																
6	Limited for other reasons or did not do the activity																
152	kccq12_1c	<p>KCCQ-12 Question 1c <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1c. Heart Failure Limitation - Hurrying or jogging Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5172</p>	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity		
1	Extremely limited																
2	Quite a bit limited																
3	Moderately limited																
4	Slightly limited																
5	Not at all limited																
6	Limited for other reasons or did not do the activity																
153	kccq12_2	<p>KCCQ-12 Question 2 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 2. Symptom Frequency - swelling in legs Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Every morning</td></tr> <tr><td>2</td><td>3 or more times per week but not every day</td></tr> <tr><td>3</td><td>1-2 times per week</td></tr> <tr><td>4</td><td>Less than once a week</td></tr> <tr><td>5</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5173</p>	1	Every morning	2	3 or more times per week but not every day	3	1-2 times per week	4	Less than once a week	5	Never over the past 2 weeks				
1	Every morning																
2	3 or more times per week but not every day																
3	1-2 times per week																
4	Less than once a week																
5	Never over the past 2 weeks																
154	kccq12_3	<p>KCCQ-12 Question 3 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 3. Symptom Frequency - fatigue Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>All of the time</td></tr> <tr><td>2</td><td>Several times per day</td></tr> <tr><td>3</td><td>At least once a day</td></tr> <tr><td>4</td><td>3 or more times per week but not every day</td></tr> <tr><td>5</td><td>1-2 times per week</td></tr> <tr><td>6</td><td>Less than once a week</td></tr> <tr><td>7</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5174</p>	1	All of the time	2	Several times per day	3	At least once a day	4	3 or more times per week but not every day	5	1-2 times per week	6	Less than once a week	7	Never over the past 2 weeks
1	All of the time																
2	Several times per day																
3	At least once a day																
4	3 or more times per week but not every day																
5	1-2 times per week																
6	Less than once a week																
7	Never over the past 2 weeks																
155	kccq12_4	<p>KCCQ-12 Question 4 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 4. Symptom Frequency - shortness of breath Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>All of the time</td></tr> <tr><td>2</td><td>Several times per day</td></tr> <tr><td>3</td><td>At least once a day</td></tr> <tr><td>4</td><td>3 or more times per week but not every day</td></tr> <tr><td>5</td><td>1-2 times per week</td></tr> <tr><td>6</td><td>Less than once a week</td></tr> <tr><td>7</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5175</p>	1	All of the time	2	Several times per day	3	At least once a day	4	3 or more times per week but not every day	5	1-2 times per week	6	Less than once a week	7	Never over the past 2 weeks
1	All of the time																
2	Several times per day																
3	At least once a day																
4	3 or more times per week but not every day																
5	1-2 times per week																
6	Less than once a week																
7	Never over the past 2 weeks																

156	kccq12_5	<p>KCCQ-12 Question 5 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 5. Symptom Frequency - sleep sitting up due to shortness of breath Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Every night</td></tr> <tr><td>2</td><td>3 or more times per week but not every day</td></tr> <tr><td>3</td><td>1-2 times per week</td></tr> <tr><td>4</td><td>Less than once a week</td></tr> <tr><td>5</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5176</p>	1	Every night	2	3 or more times per week but not every day	3	1-2 times per week	4	Less than once a week	5	Never over the past 2 weeks		
1	Every night														
2	3 or more times per week but not every day														
3	1-2 times per week														
4	Less than once a week														
5	Never over the past 2 weeks														
157	kccq12_6	<p>KCCQ-12 Question 6 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 6. Quality of Life - effect on enjoyment of life due to heart failure Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>It has extremely limited my enjoyment of life</td></tr> <tr><td>2</td><td>It has limited my enjoyment of life quite a bit</td></tr> <tr><td>3</td><td>It has moderately limited my enjoyment of life</td></tr> <tr><td>4</td><td>It has slightly limited my enjoyment of life</td></tr> <tr><td>5</td><td>It has not limited my enjoyment of life at all</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5177</p>	1	It has extremely limited my enjoyment of life	2	It has limited my enjoyment of life quite a bit	3	It has moderately limited my enjoyment of life	4	It has slightly limited my enjoyment of life	5	It has not limited my enjoyment of life at all		
1	It has extremely limited my enjoyment of life														
2	It has limited my enjoyment of life quite a bit														
3	It has moderately limited my enjoyment of life														
4	It has slightly limited my enjoyment of life														
5	It has not limited my enjoyment of life at all														
158	kccq12_7	<p>KCCQ-12 Question 7 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 7. Quality of life - remaining life with heart failure Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Not at all satisfied</td></tr> <tr><td>2</td><td>Mostly dissatisfied</td></tr> <tr><td>3</td><td>Somewhat satisfied</td></tr> <tr><td>4</td><td>Mostly satisfied</td></tr> <tr><td>5</td><td>Completely satisfied</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5178</p>	1	Not at all satisfied	2	Mostly dissatisfied	3	Somewhat satisfied	4	Mostly satisfied	5	Completely satisfied		
1	Not at all satisfied														
2	Mostly dissatisfied														
3	Somewhat satisfied														
4	Mostly satisfied														
5	Completely satisfied														
159	kccq12_8a	<p>KCCQ-12 Question 8a <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8a. Social limitation - hobbies, recreational activities Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5179</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														
160	kccq12_8b	<p>KCCQ-12 Question 8b <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8b. Social limitation - working or doing household chores Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5180</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														
161	kccq12_8c	<p>KCCQ-12 Question 8c <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8c. Social limitation - visiting family or friends Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 5182, KCCQ-12 Overall Summary Score. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5181</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														

162	kccq12_overall	KCCQ Overall Summary Score <i>(Auto Calculated) This field is auto-populated by your application. Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Overall Summary Score. Note(s): The 12 patient responses are reduced into four summary scores (Physical Limitation Score, Symptom Frequency Score, Quality of Life Score, Social Limitation Score). The four summary scores are used to calculate the Overall Summary Score. For more information, please refer to the KCCQ-12 Scoring Instructions document provided by the STS/ACC TVT Registry. Target Value: The value on start of procedure</i>	text Field Annotation: v2.1 SeqNo 5182				
163	height	Section Header: Clinical Data (closest to the procedure) Height <i>Indicate the patient's height in centimeters. Target Value: The first value between arrival at this facility and the procedure</i>	text Field Annotation: v2.1 SeqNo 5200				
164	weight	Weight <i>Indicate the patient's weight in kilograms. Target Value: The last value between arrival at this facility and the procedure</i>	text Field Annotation: v2.1 SeqNo 5205				
165	preprochgb	Pre-Procedure Hemoglobin <i>Indicate the preprocedure hemoglobin level in g/dL. Target Value: The last value between 30 days prior to procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5250				
166	preprochgbnd	Pre-Procedure Hemoglobin Not Drawn <i>Indicate if a pre-procedure hemoglobin level was not drawn. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5251	0	No	1	Yes
0	No						
1	Yes						
167	preproccreat	Pre-Procedure Creatinine <i>Indicate the creatinine level closest to the date and time prior to the procedure but prior to anesthetic management (induction area, cath lab or operating room), in mg/dL. Note(s): A creatinine level should be collected on all patients, even if they have no prior history. A creatinine value is a high predictor of a patient's outcome and is used in the predicted risk models. Target Value: The last value between 30 days prior to procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5255				
168	preproccreatnd	Pre-Procedure Creatinine Not Drawn <i>Indicate if a preprocedure creatinine level was not drawn. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5256	0	No	1	Yes
0	No						
1	Yes						
169	platelets	Platelet Count <i>Indicate the pre-procedure platelet count in microliters. Target Value: The last value between 30 days prior to procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5260				
170	plateletnd	Platelet Count Not Drawn <i>Indicate if a platelet count was not drawn prior to the procedure. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5261	0	No	1	Yes
0	No						
1	Yes						
171	inr	INR <i>Indicate the pre-procedure International Normalized Ratio (INR). Target Value: The last value between 30 days prior to procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5265				
172	inrnd	INR Not Drawn <i>Indicate if the pre-procedure International Normalized Ratio (INR) was not drawn. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5266	0	No	1	Yes
0	No						
1	Yes						
173	totalbumin	Albumin <i>Indicate the total albumin (in g/dL) closest to the date and time prior to the procedure but prior to anesthetic management (induction area, cath lab or operating room). Target Value: The last value between 30 days prior to procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5270				
174	totalbuminnd	Total Albumin Not Drawn <i>Indicate if the total albumin level was not drawn. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5271	0	No	1	Yes
0	No						
1	Yes						

175	totblbrn	Bilirubin Indicate the total bilirubin (in mg/dL) closest to the date and time prior to the procedure but prior to anesthetic management (induction area, cath lab or operating room). Target Value: The last value between 30 days prior to procedure and start of the procedure	text Field Annotation: v2.1 SeqNo 5275								
176	totblbrnnd	Total Bilirubin Not Drawn Indicate if the total bilirubin level was not drawn. Code "Yes" if the lab was not drawn.	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5276	0	No	1	Yes				
0	No										
1	Yes										
177	bnp	BNP Indicate the patient's brain natriuretic peptide (BNP) level in pg/ml. Note(s): If BNP was not drawn, leave blank and code 'Yes' for BNP or NT-proBNP or Not Drawn. Target Value: The last value between 6 months prior to the procedure and start of the procedure	text Field Annotation: v2.1 SeqNo 5277								
178	ntprobnp	NT-proBNP Indicate the patient's NT-pro- brain natriuretic peptide (BNP) level in pg/ml. Note(s): If NT-proBNP was not drawn, leave blank and code 'Yes' for BNP or NTproBNP Not Drawn. Target Value: The last value between 6 months prior to the procedure and start of the procedure	text Field Annotation: v2.1 SeqNo 5278								
179	bnpnd	BNP or NT-proBNP Not Drawn Indicate if a BNP or NT-proBNP level was not drawn. Code "Yes" if the lab was not drawn.	dropdown <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5279	0	No	1	Yes				
0	No										
1	Yes										
180	fev1	Forced Expiratory Volume (FEV1) % Predicted Indicate the FEV1 % predicted from the most recent pulmonary function test prior to procedure Target Value: The last value between 6 months prior to the procedure and start of the procedure	text Field Annotation: v2.1 SeqNo 5280								
181	fev1na	Forced Expiratory Volume (FEV1) % Predicted Not Performed Indicate whether % predicted Forced Expiratory Volume (FEV1) was not performed or the patient did not have a pulmonary function test prior to the procedure. Target Value: N/A	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5281	0	No	1	Yes				
0	No										
1	Yes										
182	dlcopred	Adjusted DLCO Indicate the adjusted value of % predicted diffusion capacity of the lung for carbon monoxide (DLCO) value obtained for the patient. This is reported in charts as DLCO/NA% (adjusted value) or D/Vasb (for volume surface body area). Target Value: The last value between 6 months prior to the procedure and start of the procedure	text Field Annotation: v2.1 SeqNo 5285								
183	dlcona	DLCO Not Performed Indicate if a lung diffusion test (DLCO) was not performed Target Value: N/A	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5286	0	No	1	Yes				
0	No										
1	Yes										
184	nvpqrs	QRS Duration (Non-Ventricular Paced Complex) Indicate the duration of the non-ventricular paced or intrinsic QRS complex, in milliseconds, that was derived from the surface electrocardiogram (ECG). Surface ECGs are obtained from the surface of the body and do not include intracardiac ECGs. Note(s): Do not code QRS measurements from an intracardiac ECG. If more than one ECG is available, code the value on the ECG closest to the procedure. Target Value: The last value between birth and prior to the first procedure.	text Field Annotation: v2.1 SeqNo 5290								
185	vpqrs	Only Ventricular Paced QRS Complexes Present Indicate if there were only ventricular paced QRS complexes present. Note(s): If the patient has some intrinsic ventricular complexes present, code 'No'. Target Value: The last value between birth and prior to the first procedure.	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5291	0	No	1	Yes				
0	No										
1	Yes										
186	preprocmed_unfrac_heparin	Section Header: Medications (administered within 24 hours prior to the procedure) Unfractionated Heparin (any) Indicate whether the patient received the medication within 24 hours preceding the procedure.	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> <tr> <td>2</td> <td>Contraindicated</td> </tr> <tr> <td>3</td> <td>Blinded</td> </tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										

187	preprocmed_asa_any	Aspirin (any) <i>Indicate whether the patient received the medication within 24 hours preceding the procedure.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
188	preprocmed_thromb	Direct Thrombin Inhibitor (other) <i>Indicate whether the patient received the medication within 24 hours preceding the procedure.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
189	preprocmed_anticoag_other	Anticoagulants (other) <i>Indicate whether the patient received the medication within 24 hours preceding the procedure.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
190	preprocmed_inotr_pos	Inotropes (positive) <i>Indicate whether the patient received the medication within 24 hours preceding the procedure.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
191	preprocmed_anticoag_any	Anticoagulants (any) <i>Indicate whether the patient received the medication within 24 hours preceding the procedure.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
192	dxcatchper	Section Header: <i>Diagnostic Cath Finding</i> Diagnostic Catheterization <i>Indicate whether diagnostic cardiac catheterization was performed. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5500	0	No	1	Yes				
0	No										
1	Yes										
193	dxcatchdt_deid	Diagnostic Catheterization Date (Deid) <i>Indicate the date the diagnostic catheterization was performed. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 5505								
194	numdisv	Number of Diseased Vessels <i>Indicate the number of diseased major native coronary vessel systems: LAD system, Circumflex system, and/or Right system with >= 50% narrowing of any vessel preoperatively. Note(s): Left main disease (>=50%) is counted as TWO vessels (LAD and Circumflex, which may include a Ramus Intermedius). For example, left main and RCA would count as three total. Target Value: The highest value between birth and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td></tr> </table> Field Annotation: v2.1 SeqNo 5506	0	None	1	1	2	2	3	3
0	None										
1	1										
2	2										
3	3										
195	lmaindis	Left Main >=50% <i>Indicate whether the patient has Left Main Coronary Disease. Left Main Coronary Disease is present when there is >= 50% compromise of vessel diameter preoperatively. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5507	0	No	1	Yes				
0	No										
1	Yes										
196	proxlad	Prox LAD >=70% <i>Indicate whether the percent luminal narrowing of the proximal left anterior descending artery at the point of maximal stenosis is greater than or equal to 70%. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5508	0	No	1	Yes				
0	No										
1	Yes										

197	lvefna	Left Ventricle Ejection Fraction Not Assessed <i>Indicate whether the left ventricular ejection fraction was not assessed or not measured prior to the induction of anesthesia. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5566
0	No							
1	Yes							
198	lvef	Left Ventricle Ejection Fraction <i>Indicate the percentage of the blood emptied from the left ventricle at the end of the contraction. Note(s): Use the most recent determination prior to the surgical intervention documented on a diagnostic report. Enter a percentage in the range of 1 - 99. If a percentage range is reported, report a whole number using the 'mean' (i.e., 50-55%, is reported as 53%). If only a descriptive value is reported, (i.e., normal), enter the corresponding percentage value from the list below: Normal = 60% Good function = 50% Mildly reduced = 45% Fair function = 40% Moderately reduced = 30% Poor function = 25% Severely reduced = 20% Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5565					
199	cona	Cardiac Output Not Performed <i>Indicate whether the cardiac output was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5569
0	No							
1	Yes							
200	cardiacoutput	Cardiac Output <i>Indicate the cardiac output in L/min, documented by pre-procedure diagnostic cardiac cath findings. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5567					
201	rvsys	Right Ventricular Systolic Pressure <i>Indicate the highest right ventricular systolic pressure in mmHg recorded prior to the start of the procedure. Note(s): If a value is available from both echo and cardiac cath, code the value from the cardiac cath. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5568					
202	pcwpm	Pulmonary Capillary Wedge Pressure Not Measured <i>Indicate if the pulmonary capillary wedge pressure was not measured pre-procedure. Target Value: N/A No Yes</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5591
0	No							
1	Yes							
203	pcwp	Pulmonary Capillary Wedge Pressure <i>Indicate the pre-procedure pulmonary capillary wedge pressure, in mmHg. Note(s): If more than one PCWP is available, code the value determined by cardiac catheterization. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5590					
204	papmeanm	Pulmonary Artery Pressure (Mean) Not Measured <i>Indicate if the pre-procedure pulmonary artery mean pressure was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5594
0	No							
1	Yes							
205	papmean	Pulmonary Artery Pressure (Mean) <i>Indicate the pre-procedure pulmonary artery mean pressure, in mmHg. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5593					
206	papsysm	Pulmonary Artery Pressure (Systolic) Not Measured <i>Indicate if the pre-procedure pulmonary artery systolic pressure was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5597
0	No							
1	Yes							
207	papsys	Pulmonary Artery Pressure (Systolic) <i>Indicate if the pre-procedure pulmonary artery systolic pressure, in mmHg. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5596					
208	rapnm	Right Atrial Pressure/CVP (Mean) Not Measured <i>Indicate if the pre-procedure right atrial pressure or central venous pressure (CVP) was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table>	0	No	1	Yes	Field Annotation: v2.1 SeqNo 5599
0	No							
1	Yes							

209	rapmean	Right Atrial Pressure/CVP (Mean) <i>Indicate the pre-procedure right atrial pressure or central venous pressure (CVP), in mmHg. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5598				
210	lvidsnm	Section Header: Echocardiogram Findings Left Ventricular Internal Systolic Dimension Not Measured <i>Indicate if the left ventricular internal systolic dimension was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5608	0	No	1	Yes
0	No						
1	Yes						
211	lvids	Left Ventricular Internal Systolic Dimension <i>Indicate the pre-procedure left ventricular internal systolic dimension in cm. Note(s): If more than one LV internal systolic diameter is available, code the value determined by echocardiography. Using a 2D method, it is recommended that LV internal dimensions (LVIDd and LVIDs, respectively) be measured at the level of the LV minor dimension, at the mitral chordae level. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5595				
212	lviddnm	Left Ventricular Internal Diastolic Dimension Not Measured <i>Indicate if the left ventricular internal diastolic dimension was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5609	0	No	1	Yes
0	No						
1	Yes						
213	lvidd	Left Ventricular Internal Diastolic Dimension <i>Indicate the pre-procedure left ventricular internal diastolic dimension in cm. If more than one LV internal diastolic diameter is available, code the value determined by echocardiography. Note(s): Using a 2D method, it is recommended that LV internal dimensions (LVIDd and LVIDs, respectively) be measured at the level of the LV minor dimension, at the mitral chordae level. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5600				
214	lvesvnm	Left Ventricular End Systolic Volume Not Measured <i>Indicate if the left ventricular end systolic volume was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5602	0	No	1	Yes
0	No						
1	Yes						
215	lvesv	Left Ventricular End Systolic Volume <i>Indicate the left ventricular end systolic volume in ml, documented by pre-procedure echocardiogram. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5601				
216	lvedvnm	Left Ventricular End Diastolic Volume Not Measured <i>Indicate if the left ventricular end diastolic volume was not measured pre-procedure. Target Value: N/A</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5604	0	No	1	Yes
0	No						
1	Yes						
217	lvedv	Left Ventricular End Diastolic Volume <i>Indicate the left ventricular end diastolic volume in ml, documented by pre-procedure echocardiogram. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5603				
218	septalwall	Septal Wall Thickness <i>Indicate the pre-procedure septal wall thickness, in cm, measured at end-diastole. Note(s): If more than one septal wall thickness is available, code the value determined by echocardiography. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5605				
219	laval	Left Atrial Volume <i>Indicate the left atrial volume in ml, documented by pre-procedure echocardiogram. Note(s): If LA volume is documented, LA volume index is not required. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5606				
220	lavalindex	Left Atrial Volume Index <i>Indicate the left atrial volume index in mL/m², documented by pre-procedure echocardiogram. Note(s): If the left atrial volume is documented, leave this field blank. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5607				

221	posteriorwall	<p>Posterior Wall Thickness <i>Indicate the pre-procedure posterior wall thickness, in cm, measured at end-diastole. Note(s): If more than one posterior wall thickness is available, code the value determined by echocardiography. Target Value: The last value between 12 months prior to the procedure and start of the procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 5610</p>																				
222	vdinsufa	<p>Section Header: Aortic Valve Disease Aortic Regurgitation <i>Indicate the severity of aortic valve regurgitation. Note(s): Code mild-moderate as mild and moderate-severe as moderate. Reference: Bonow, R.O., et al. 2008 Focused Updated Incorporated into ACC/AHA 2006 Guidelines for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Task force on Practice Guidelines. JACC, vol 52, No. 13, 2008, p. e1-e142. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5630</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe										
0	None																						
1	Trace/Trivial																						
2	Mild																						
3	Moderate																						
4	Severe																						
223	vdaoet	<p>Aortic Valve Disease - Disease Etiology <i>Indicate primary etiology of aortic valve disease. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Degenerative</td></tr> <tr><td>2</td><td>Endocarditis</td></tr> <tr><td>3</td><td>Congenital</td></tr> <tr><td>4</td><td>Rheumatic fever</td></tr> <tr><td>5</td><td>Primary aortic disease</td></tr> <tr><td>6</td><td>LV outflow tract obstruction</td></tr> <tr><td>7</td><td>Supravalvular aortic stenosis</td></tr> <tr><td>8</td><td>Tumor</td></tr> <tr><td>9</td><td>Trauma</td></tr> <tr><td>10</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5620</p>	1	Degenerative	2	Endocarditis	3	Congenital	4	Rheumatic fever	5	Primary aortic disease	6	LV outflow tract obstruction	7	Supravalvular aortic stenosis	8	Tumor	9	Trauma	10	Other
1	Degenerative																						
2	Endocarditis																						
3	Congenital																						
4	Rheumatic fever																						
5	Primary aortic disease																						
6	LV outflow tract obstruction																						
7	Supravalvular aortic stenosis																						
8	Tumor																						
9	Trauma																						
10	Other																						
224	avdmorphology	<p>Aortic Valve Disease - Valve Morphology <i>Indicate the morphology of the aortic valve. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Unicuspid</td></tr> <tr><td>2</td><td>Bicuspid</td></tr> <tr><td>3</td><td>Tricuspid</td></tr> <tr><td>4</td><td>Quadracuspid</td></tr> <tr><td>5</td><td>Uncertain</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5640</p>	1	Unicuspid	2	Bicuspid	3	Tricuspid	4	Quadracuspid	5	Uncertain										
1	Unicuspid																						
2	Bicuspid																						
3	Tricuspid																						
4	Quadracuspid																						
5	Uncertain																						
225	avdannularcalc	<p>Aortic Valve Disease - Annular Calcification <i>Indicate if annular calcification is present on the aortic valve. Code yes if echo reports document calcificaton in the aortic valve leaflets, aorta adjacent to the AV, leaflets or the left ventricular outflow tract (LVOT), or if echo reports document AV calcific degeneration. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5645</p>	0	No	1	Yes																
0	No																						
1	Yes																						
226	avdpeakvelocity	<p>Aortic Valve Disease - AV Peak Velocity (CW) <i>Indicate the aortic valve peak velocity, in meters per second, as determined by continuous wave (CW) spectral velocity recording on echocardiography. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 5650</p>																				
227	avdannulussize	<p>Aortic Valve Disease - AV Annulus Size <i>Indicate the size, in mm, of the aortic valve annulus. Note(s): If more than one size is reported, code the mean. Target Value: The last value between 12 months prior to the procedure and prior to valve implant</i></p>	<p>text Field Annotation: v2.1 SeqNo 5655</p>																				
228	avdannulussizemethod	<p>Aortic Valve Disease - AV Annulus Size Assessment Method <i>Indicate the method used to assess the aortic valve annulus size. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>TTE</td></tr> <tr><td>2</td><td>TEE</td></tr> <tr><td>3</td><td>CTA</td></tr> <tr><td>4</td><td>Angiography</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5660</p>	1	TTE	2	TEE	3	CTA	4	Angiography												
1	TTE																						
2	TEE																						
3	CTA																						
4	Angiography																						

229	vdstena	Aortic Stenosis <i>Indicate whether aortic stenosis is present. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5665	0	No	1	Yes										
0	No																
1	Yes																
230	vdava	Aortic Stenosis - AV Area <i>Indicate the smallest aortic valve area (in cm squared) obtained from an echocardiogram or cath report. Target Value: The lowest value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5670														
231	vdgrada	Aortic Stenosis - AV Mean Gradient <i>Indicate the highest MEAN gradient (in mmHg) across the aortic valve obtained from an echocardiogram or angiogram preoperatively. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5675														
232	avdstenosispeakgradient	Aortic Stenosis - AV Peak Gradient <i>Indicate the aortic valve peak gradient in mmHg. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5680														
233	vdinsuft	Section Header: <i>Tricuspid Valve Disease</i> Tricuspid Valve Regurgitation <i>Indicate whether there is evidence of tricuspid valve regurgitation. Enter level of valve function associated with highest risk (i.e., worst performance). Note(s): Code mild-moderate as mild and moderate-severe as moderate Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>None</td> </tr> <tr> <td>1</td> <td>Trace/Trivial</td> </tr> <tr> <td>2</td> <td>Mild</td> </tr> <tr> <td>3</td> <td>Moderate</td> </tr> <tr> <td>4</td> <td>Severe</td> </tr> </table> Field Annotation: v2.1 SeqNo 5735	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe				
0	None																
1	Trace/Trivial																
2	Mild																
3	Moderate																
4	Severe																
234	vdmit	Section Header: <i>Mitral Valve Disease</i> Mitral Valve Disease <i>Indicate whether mitral valve disease is present. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 5685	0	No	1	Yes										
0	No																
1	Yes																
235	vdinsufm	MV Regurgitation <i>Indicate the severity of mitral valve regurgitation according to the American Society of Echocardiography Guidelines integrated approach. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>None</td> </tr> <tr> <td>1</td> <td>Trace/Trivial</td> </tr> <tr> <td>2</td> <td>Mild</td> </tr> <tr> <td>3</td> <td>Moderate</td> </tr> <tr> <td>5</td> <td>Moderate-Severe</td> </tr> <tr> <td>6</td> <td>Severe</td> </tr> <tr> <td>4</td> <td>Severe (retired)</td> </tr> </table> Field Annotation: v2.1 SeqNo 5695	0	None	1	Trace/Trivial	2	Mild	3	Moderate	5	Moderate-Severe	6	Severe	4	Severe (retired)
0	None																
1	Trace/Trivial																
2	Mild																
3	Moderate																
5	Moderate-Severe																
6	Severe																
4	Severe (retired)																
236	vdinsufmpara	Paravalvular Severity <i>Indicate the severity of paravalvular mitral regurgitation. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>None</td> </tr> <tr> <td>1</td> <td>Mild</td> </tr> <tr> <td>3</td> <td>Moderate</td> </tr> <tr> <td>4</td> <td>Severe</td> </tr> <tr> <td>5</td> <td>Not Documented</td> </tr> </table> Field Annotation: v2.1 SeqNo 5696	0	None	1	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
1	Mild																
3	Moderate																
4	Severe																
5	Not Documented																

237	vdinsufmv	Valvular Severity <i>Indicate the severity of valvular mitral regurgitation. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5697</p>	0	None	1	Mild	3	Moderate	4	Severe	5	Not Documented
0	None												
1	Mild												
3	Moderate												
4	Severe												
5	Not Documented												
238	vdmiteoa	Effective Orifice Area (EOA) <i>Indicate the effective orifice area (EOA), in cm2. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	text										
239	vdmiteoa_moa	Method of Assessment <i>Indicate the method used to assess the effective orifice area. If multiple methods are available, code the 3D planimetry method first, then PISA. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>1</td><td>3D planimetry</td></tr> <tr><td>2</td><td>PISA</td></tr> <tr><td>3</td><td>Quantitative doppler</td></tr> <tr><td>4</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5699</p>	1	3D planimetry	2	PISA	3	Quantitative doppler	4	Other		
1	3D planimetry												
2	PISA												
3	Quantitative doppler												
4	Other												
240	vdstenm	Mitral Valve Disease - Mitral Valve Stenosis <i>Indicate whether mitral stenosis is present. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5705</p>	0	No	1	Yes						
0	No												
1	Yes												
241	vdmva	Mitral Valve Stenosis - Mitral Valve Area <i>Indicate the smallest mitral valve area in centimeters squared. Note(s): If more than one measurement is available, code the area from the echocardiogram. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	text Field Annotation: v2.1 SeqNo 5710										
242	vdgradm	Mitral Valve Mean Gradient <i>Indicate the highest mean gradient (in mm Hg) across the mitral valve. Note(s): If more than one measurement is available, code the area from the echocardiogram. Target Value: The highest value between 12 months prior to the procedure and start of the procedure</i>	text										
243	vdmprosvetio	Prosthetic Mitral Valve Dysfunction Etiology <i>Indicate the etiology of the prosthetic mitral valve dysfunction. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>1</td><td>Primary/degenerative bioprosthetic valve failure</td></tr> <tr><td>2</td><td>Pannus formation</td></tr> <tr><td>3</td><td>Thrombus formation</td></tr> <tr><td>4</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5742</p>	1	Primary/degenerative bioprosthetic valve failure	2	Pannus formation	3	Thrombus formation	4	Other		
1	Primary/degenerative bioprosthetic valve failure												
2	Pannus formation												
3	Thrombus formation												
4	Other												
244	mvdetiofmr	Section Header: <i>Mitral Valve Disease Etiology</i> Functional Mitral Regurgitation <i>Indicate if the mitral valve disease etiology was functional. Typically the valve structures (i.e., leaflets and chord tendinae) are normal in functional mitral regurgitation, but a variety of diseases (such as a prior myocardial infarction or cardiomyopathy) compromises the leaflets ability to coapt (i.e. form a tight seal when closed) and results in mitral regurgitation. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5745</p>	0	No	1	Yes						
0	No												
1	Yes												
245	mvdetiodmr	Degenerative Mitral Regurgitation <i>Indicate if the mitral valve disease etiology was degenerative. Degenerative mitral valve disease is due to multiple conditions that lead to abnormal leaflets and/or chordae that result and mitral regurgitation. The leaflets may prolapse or flail into the left atrium. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5746</p>	0	No	1	Yes						
0	No												
1	Yes												
246	mvdetioinflam	Post-Inflammatory <i>Indicate if the mitral valve disease etiology was post - inflammatory. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	<table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 5747</p>	0	No	1	Yes						
0	No												
1	Yes												

247	mvdetioendoc	Endocarditis <i>Indicate if the mitral valve disease etiology was endocarditis. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1" data-bbox="1042 107 1118 191"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5748	0	No	1	Yes										
0	No																
1	Yes																
248	mvdetioother	Other/Indeterminate <i>Indicate if the mitral valve disease etiology was indeterminant or not otherwise specified. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1" data-bbox="1042 281 1118 365"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5749	0	No	1	Yes										
0	No																
1	Yes																
249	fmrtype	Functional Mitral Regurgitation Type <i>Indicate the type of functional mitral regurgitation. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	dropdown <table border="1" data-bbox="1042 459 1526 768"> <tr><td>1</td><td>Ischemic-acute, post infarction</td></tr> <tr><td>2</td><td>Ischemic-chronic</td></tr> <tr><td>3</td><td>Non-ischemic dilated cardiomyopathy</td></tr> <tr><td>4</td><td>Restrictive cardiomyopathy</td></tr> <tr><td>5</td><td>Hypertrophic cardiomyopathy</td></tr> <tr><td>6</td><td>Pure annular dilation (with normal left ventricular systolic function)</td></tr> <tr><td>7</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5755	1	Ischemic-acute, post infarction	2	Ischemic-chronic	3	Non-ischemic dilated cardiomyopathy	4	Restrictive cardiomyopathy	5	Hypertrophic cardiomyopathy	6	Pure annular dilation (with normal left ventricular systolic function)	7	Not Documented
1	Ischemic-acute, post infarction																
2	Ischemic-chronic																
3	Non-ischemic dilated cardiomyopathy																
4	Restrictive cardiomyopathy																
5	Hypertrophic cardiomyopathy																
6	Pure annular dilation (with normal left ventricular systolic function)																
7	Not Documented																
250	mvdleafpro	Leaflet Prolapse <i>Indicate if there was leaflet prolapse. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1" data-bbox="1042 863 1245 1066"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Anterior</td></tr> <tr><td>2</td><td>Posterior</td></tr> <tr><td>3</td><td>Bi-leaflet</td></tr> <tr><td>4</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5760	0	None	1	Anterior	2	Posterior	3	Bi-leaflet	4	Not Documented				
0	None																
1	Anterior																
2	Posterior																
3	Bi-leaflet																
4	Not Documented																
251	mvdleafflail	Leaflet Flail <i>Indicate if there was leaflet flail. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1" data-bbox="1042 1159 1245 1362"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Anterior</td></tr> <tr><td>2</td><td>Posterior</td></tr> <tr><td>3</td><td>Bi-leaflet</td></tr> <tr><td>4</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5765	0	None	1	Anterior	2	Posterior	3	Bi-leaflet	4	Not Documented				
0	None																
1	Anterior																
2	Posterior																
3	Bi-leaflet																
4	Not Documented																
252	inflamtype	Inflammatory Type <i>Indicate type of inflammatory mitral valve disease. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	dropdown <table border="1" data-bbox="1042 1455 1325 1698"> <tr><td>1</td><td>Idiopathic</td></tr> <tr><td>2</td><td>Prior radiation therapy</td></tr> <tr><td>3</td><td>Collagen vascular disease</td></tr> <tr><td>4</td><td>Drug induced</td></tr> <tr><td>5</td><td>History of rheumatic fever</td></tr> <tr><td>6</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5770	1	Idiopathic	2	Prior radiation therapy	3	Collagen vascular disease	4	Drug induced	5	History of rheumatic fever	6	Not Documented		
1	Idiopathic																
2	Prior radiation therapy																
3	Collagen vascular disease																
4	Drug induced																
5	History of rheumatic fever																
6	Not Documented																

253	mvdleafth	Leaflet Tethering <i>Indicate if there was leaflet tethering. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Anterior</td></tr> <tr><td>2</td><td>Posterior</td></tr> <tr><td>3</td><td>Bi-leaflet</td></tr> <tr><td>4</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5775	0	None	1	Anterior	2	Posterior	3	Bi-leaflet	4	Not Documented
0	None												
1	Anterior												
2	Posterior												
3	Bi-leaflet												
4	Not Documented												
254	manncalc	Mitral Annular Calcification <i>Indicate if there was mitral annular calcification. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5800	0	No	1	Yes	2	Not Documented				
0	No												
1	Yes												
2	Not Documented												
255	mleafcalc	Mitral Leaflet Calcification <i>Indicate if there was mitral leaflet calcification. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5810	0	No	1	Yes	2	Not Documented				
0	No												
1	Yes												
2	Not Documented												
256	carpentier	Carpentier's Functional Class of Mitral Regurgitation <i>Indicate the Carpentier's Functional Class of mitral regurgitation. Target Value: Any occurrence between 12 months prior to the procedure and start of the procedure</i>	radio <table border="1"> <tr><td>1</td><td>Type I</td></tr> <tr><td>2</td><td>Type II</td></tr> <tr><td>3</td><td>Type IIIa</td></tr> <tr><td>4</td><td>Type IIIb</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 5820	1	Type I	2	Type II	3	Type IIIa	4	Type IIIb	5	Not Documented
1	Type I												
2	Type II												
3	Type IIIa												
4	Type IIIb												
5	Not Documented												
257	mrrindfrail	Section Header: <i>Leaflet Clip Procedure Reasons/Indications</i> Leaflet Indication - Frailty <i>Indicate if the indication for the leaflet clip procedure was frailty. Frailty must be assessed by an in-person consultation by a cardiac surgeon. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5900	0	No	1	Yes						
0	No												
1	Yes												
258	mrrindhostile	Leaflet Indication - Hostile Chest <i>Indicate if the indication for the leaflet clip procedure was hostile chest. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5901	0	No	1	Yes						
0	No												
1	Yes												
259	mrrindliver	Leaflet Indication - Severe Liver Disease (Cirrhosis or MELD score >12) <i>Indicate if the indication for the leaflet clip procedure was severe liver disease, documented by cirrhosis or a "model for end-stage liver disease (MELD) score >12 (which quantifies end stage liver disease). Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5902	0	No	1	Yes						
0	No												
1	Yes												
260	mrrindpa	Leaflet Indication - Porcelain Aorta <i>Indicate if the indication for the leaflet clip procedure was porcelain aorta or extensively calcified ascending aorta. Porcelain aorta must be documented by findings on a chest x-ray, CT scan, fluoroscopy at the time of cardiac catheterization or noted during previous cardiothoracic surgery. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5903	0	No	1	Yes						
0	No												
1	Yes												
261	mrrindopm8	Leaflet Indication - Predicted STS MV Replacement Operative Mortality Risk >=8% <i>Indicate if the indication for the leaflet clip procedure was a predicted risk of mortality for surgical mitral valve replacement of >=8% as determined by the Heart Team and based on the Society for Thoracic Surgeon's risk model. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 5904	0	No	1	Yes						
0	No												
1	Yes												

262	mrrindopm6	Leaflet Indication - Predicted STS MV Repair Operative Mortality Risk >=6% <i>Indicate if the indication for the leaflet clip procedure was a predicted risk of mortality for surgical mitral valve repair of >=6% as determined by the Heart Team and based on the Society for Thoracic Surgeon's risk model. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5905
263	mrrindunusual	Leaflet Indication - Unusual Extenuating Circumstances <i>Indicate if the indication for the leaflet clip procedure was an unusual extenuating circumstance resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5906
264	mrrindrvidsfx	Other Extenuating Circumstance - Right Ventricular Dysfunction with Severe TR <i>Indicate if the unusual extenuating circumstance included right ventricular dysfunction with severe tricuspid regurgitation resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5907
265	mrrindchemo	Other Extenuating Circumstance - Chemotherapy for Malignancy <i>Indicate if the unusual extenuating circumstance included chemotherapy for malignancy resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5908
266	mrrindbleed	Other Extenuating Circumstance - Major Bleeding Diathesis <i>Indicate if the unusual extenuating circumstance included major bleeding diathesis resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5909
267	mrrindimmob	Other Extenuating Circumstance - Immobility <i>Indicate if the unusual extenuating circumstance included immobility resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5910
268	mrrindaids	Other Extenuating Circumstance - AIDS <i>Indicate if the unusual extenuating circumstance included acquired immunodeficiency syndrome (AIDS) resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5911
269	mrrinddem	Other Extenuating Circumstance - Severe Dementia <i>Indicate if the unusual extenuating circumstance included severe dementia resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5912
270	mrrindaspir	Other Extenuating Circumstance - High Risk of Aspiration <i>Indicate if the unusual extenuating circumstance included that the patient is at high risk for aspiration resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5913
271	mrrindima	Other Extenuating Circumstance - IMA at High Risk of Injury <i>Indicate if the unusual extenuating circumstance includes the patient having an internal mammary artery (IMA) at high risk for injury resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5914
272	mrrindother	Other Extenuating Circumstance - Other <i>Indicate if the unusual extenuating circumstance includes a reason, not otherwise specified resulting in prohibitive risk for mitral valve surgery. Target Value: The value on current procedure</i>	radio <input type="checkbox"/> No <input type="checkbox"/> Yes Field Annotation: v2.1 SeqNo 5915

	273	mrrindspecify	Other - Specify Reason Why Patient is Prohibitive Risk <i>Indicate if the patient is having a leaflet clip for an 'other indication of unusual extenuating circumstance which was not otherwise specified' describe the reason why the patient is at prohibitive risk. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 5916								
	274	preprocedure_status_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete		
0	Incomplete											
1	Unverified											
2	Complete											
Instrument: Procedure Information (procedure_information) ^ Collapse												
	275	tvtopa_lastname	TVT Operator A Last Name <i>Indicate the last name of TVT implant operator A. Note(s): At least one operator is required. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6000								
	276	tvtopa_firstname	TVT Operator A First Name <i>Indicate the first name of TVT implant operator A. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6005								
	277	tvtopa_midname	TVT Operator A Middle Name <i>Indicate the middle name of TVT implant operator A. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6010								
	278	tvtopa_npi	TVT Operator A NPI <i>Indicate the National Provider Identifier (NPI) of TVT implant operator A. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6015								
	279	tvtopb_lastname	TVT Operator B Last Name <i>Indicate the last name of TVT implant operator B. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6020								
	280	tvtopb_firstname	TVT Operator B First Name <i>Indicate the first name of TVT implant operator B. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6025								
	281	tvtopb_midname	TVT Operator B Middle Name <i>Indicate the middle name of TVT implant operator B. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6030								
	282	tvtopb_npi	TVT Operator B NPI <i>Indicate the National Provider Identifier (NPI) of TVT implant operator B. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 6035								
	283	tvtprocedurestartdate_deid	Procedure Start Date (Deid) <i>Indicate the date of the procedure. The index procedure is defined as the initial transcatheter valve procedure of the hospitalization. Target Value: The value on current procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 6040								
	284	tvtprocedurestarttime	Procedure Start Time <i>Indicate the time the patient exits the procedure room. Note(s): Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours). Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 6046								
	285	tvtprocedurestopdate_deid	Procedure Stop Date (Deid) <i>Indicate the date the patient exits the procedure room. Target Value: The last value on current procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 6045								
	286	tvtprocedurestoptime	Procedure Stop Time <i>Indicate the time the patient exits the procedure room. Note(s): Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (00:00 hours). Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 6046								
	287	status	Procedure Status <i>Indicate the clinical status of the patient prior to the procedure. Target Value: The highest value on current procedure</i>	dropdown <table border="1"> <tr><td>1</td><td>Elective</td></tr> <tr><td>2</td><td>Urgent</td></tr> <tr><td>3</td><td>Emergency</td></tr> <tr><td>4</td><td>Salvage</td></tr> </table> Field Annotation: v2.1 SeqNo 6055	1	Elective	2	Urgent	3	Emergency	4	Salvage
1	Elective											
2	Urgent											
3	Emergency											
4	Salvage											
	288	proctavr	Procedure - Transcatheter Aortic Valve Replacement (TAVR) <i>Indicate if a transcatheter aortic valve replacement procedure was being performed. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 6600	0	No	1	Yes				
0	No											
1	Yes											

289	proctmvr	Procedure - Transcatheter Mitral Valve Replacement <i>Indicate if a transcatheter mitral valve replacement procedure was being performed. Target Value: The value on current procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 6601	0	No	1	Yes				
0	No										
1	Yes										
290	procleafclip	Procedure - Mitral Leaflet Clip Procedure <i>Indicate if a mitral leaflet clip procedure was being performed. Target Value: The value on current procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 6602	0	No	1	Yes				
0	No										
1	Yes										
291	otherproc	Other Procedure Performed Concurrently <i>Indicate if an other procedure was performed concurrently. Target Value: The value on current procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes - PCI</td> </tr> <tr> <td>2</td> <td>Yes - Other</td> </tr> </table> Field Annotation: v2.1 SeqNo 6620	0	No	1	Yes - PCI	2	Yes - Other		
0	No										
1	Yes - PCI										
2	Yes - Other										
292	cpb	CardioPulmonary Bypass Used <i>Indicate if cardiopulmonary bypass or coronary perfusion was used during the procedure. Target Value: Any occurrence on the procedure</i>	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> Field Annotation: v2.1 SeqNo 6100	0	No	1	Yes				
0	No										
1	Yes										
293	cpbstatus	CardioPulmonary Bypass Status <i>Indicate if the use of cardiopulmonary bypass was elective or emergent. Target Value: The value on current procedure</i>	radio <table border="1"> <tr> <td>1</td> <td>Elective</td> </tr> <tr> <td>2</td> <td>Emergent</td> </tr> </table> Field Annotation: v2.1 SeqNo 6101	1	Elective	2	Emergent				
1	Elective										
2	Emergent										
294	perfustm	Cardiopulmonary Bypass Time <i>Indicate the total number of minutes that systemic return is diverted into the cardiopulmonary bypass (CPB) circuit and returned to the systemic system. This time period (Cardiopulmonary Bypass Time) includes all periods of cerebral perfusion and sucker bypass. This time period (Cardiopulmonary Bypass Time) excludes any circulatory arrest and modified ultrafiltration periods. If more than one period of CPB is required during the procedure, the sum of all the CPB periods will equal the total number of CPB minutes. Target Value: The total between start of the procedure and end of the procedure</i>	text Field Annotation: v2.1 SeqNo 6105								
295	anesthesiatype	Anesthesia Type <i>Indicate the type of anesthesia used for the procedure. Target Value: The value on start of procedure</i>	radio <table border="1"> <tr> <td>1</td> <td>Moderate sedation</td> </tr> <tr> <td>2</td> <td>General anesthesia</td> </tr> <tr> <td>3</td> <td>Epidural</td> </tr> <tr> <td>4</td> <td>Combination</td> </tr> </table> Field Annotation: v2.1 SeqNo 6110	1	Moderate sedation	2	General anesthesia	3	Epidural	4	Combination
1	Moderate sedation										
2	General anesthesia										
3	Epidural										
4	Combination										
296	intraproc_unfrac_heparin	Section Header: INTRA-PROCEDURE MEDICATIONS (ADMINISTERED DURING THE PROCEDURE) Unfractionated Heparin (any)	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> <tr> <td>2</td> <td>Contraindicated</td> </tr> <tr> <td>3</td> <td>Blinded</td> </tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
297	intraproc_thromb	Direct Thrombin Inhibitor (other)	radio <table border="1"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> <tr> <td>2</td> <td>Contraindicated</td> </tr> <tr> <td>3</td> <td>Blinded</td> </tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										

298	intraproc_anticoag_other	Anticoagulants (other)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
299	intraproc_inotr_pos	Inotropes (positive)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded
0	No										
1	Yes										
2	Contraindicated										
3	Blinded										
300	fluoromethod	Section Header: <i>Post Implant - Radiation</i> Radiation Dose Measurement Method <i>Indicate the method used to collect the radiation dose. Target Value: The value on current procedure</i> Single Plane Biplane	text <table border="1"> <tr><td>1</td><td>Single Plane</td></tr> <tr><td>2</td><td>Biplane</td></tr> </table> Field Annotation: v2.1 SeqNo 6455	1	Single Plane	2	Biplane				
1	Single Plane										
2	Biplane										
301	flurotime	Fluoroscopy Time <i>Indicate the total fluoroscopy time recorded to the nearest 0.1 minute. Note(s): Please collect Fluoroscopy Time, Reference Air Kerma and Kerma Area Product values, if available. Target Value: The total between start of the procedure and end of the procedure</i>	text Field Annotation: v2.1 SeqNo 6460								
302	fluorodosekerm	Fluoroscopy Dose - Cumulative Air Kerma <i>Indicate the total radiation dose (Cumulative Air Kerma, or Reference Air Kerma) recorded to the nearest milligrays (mGy). The value recorded should include the total dose for the lab visit. Note(s): Please collect Fluoroscopy Time, Cumulative Air Kerma and Dose Area Product values, if available. If biplane equipment is used, collect the total dose of both planes and add them together. Target Value: The total between start of the procedure and end of the procedure</i>	text Field Annotation: v2.1 SeqNo 6465								
303	fluorodosedap	Fluoroscopy Dose - Dose Area Product <i>Indicate the total radiation Dose Area Product (kerma area product) to the nearest integer. The value recorded should include the total dose for the lab visit. Note(s): Please collect Fluoroscopy Time, Cumulative Air Kerma and Dose Area Product values, if available. If biplane equipment is used, collect the total dose of both planes and add them together. Target Value: The total between start of the procedure and end of the procedure</i>	text Field Annotation: v2.1 SeqNo 6470								
304	fluorodosedapunit	Dose Area Product Units <i>Indicate the units reported for radiation Dose Area Product (Kerma area product). Target Value: N/A</i>	radio <table border="1"> <tr><td>1</td><td>Gy-cm2</td></tr> <tr><td>2</td><td>cGy-cm2</td></tr> <tr><td>3</td><td>mGy-cm2</td></tr> <tr><td>4</td><td>uGy-M2</td></tr> </table> Field Annotation: v2.1 SeqNo 6475	1	Gy-cm2	2	cGy-cm2	3	mGy-cm2	4	uGy-M2
1	Gy-cm2										
2	cGy-cm2										
3	mGy-cm2										
4	uGy-M2										
305	aux11	Auxiliary 11 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 29325								
306	aux12	Auxiliary 12 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 29330								
307	procedure_information_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete		
0	Incomplete										
1	Unverified										
2	Complete										
Instrument: Tavr Procedure (tavr_procedure)			^ Collapse								
308	tvtprocedureindication	Section Header: <i>TAVR</i> Primary Procedure Indication <i>Indicate the PRIMARY indication for the procedure. (Choose the most significant if more than one is present.) Target Value: The value on current procedure</i>	dropdown <table border="1"> <tr><td>1</td><td>Primary Aortic Stenosis</td></tr> <tr><td>2</td><td>Primary Aortic Insufficiency</td></tr> <tr><td>3</td><td>Mixed AS/AI</td></tr> <tr><td>4</td><td>Failed Bioprosthetic Valve</td></tr> </table> Field Annotation: v2.1 SeqNo 6060	1	Primary Aortic Stenosis	2	Primary Aortic Insufficiency	3	Mixed AS/AI	4	Failed Bioprosthetic Valve
1	Primary Aortic Stenosis										
2	Primary Aortic Insufficiency										
3	Mixed AS/AI										
4	Failed Bioprosthetic Valve										

309	tvlocation	<p>Procedure Location <i>Indicate the location where the procedure was performed. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Hybrid OR Suite</td></tr> <tr><td>2</td><td>Hybrid Cath Lab Suite</td></tr> <tr><td>3</td><td>Cath Lab</td></tr> <tr><td>4</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6050</p>	1	Hybrid OR Suite	2	Hybrid Cath Lab Suite	3	Cath Lab	4	Other										
1	Hybrid OR Suite																				
2	Hybrid Cath Lab Suite																				
3	Cath Lab																				
4	Other																				
310	valveinvalve	<p>Valve-in-Valve Procedure <i>Indicate if a 'valve-in-valve' procedure was performed during the procedure. Note(s): A 'valve-in-valve' procedure implies that the patient has a previously implanted bioprosthetic valve, and the procedure you are documenting is now an additional bioprosthetic valve replacement. Target Value: Any occurrence on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6065</p>	0	No	1	Yes														
0	No																				
1	Yes																				
311	valveinvalvestatus	<p>Valve-in-Valve Status <i>Indicate the status of the valve-in-valve procedure. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Elective</td></tr> <tr><td>2</td><td>Immediate intraprocedure</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6070</p>	1	Elective	2	Immediate intraprocedure														
1	Elective																				
2	Immediate intraprocedure																				
312	operatorreason	<p>Operator Reason for Procedure <i>Indicate the operator's reason for the transcatheter valve replacement procedure. Refer to the data specification for definitions.</i></p>	<p>dropdown</p> <table border="1"> <tr><td>9</td><td>Low Risk</td></tr> <tr><td>8</td><td>Intermediate Risk</td></tr> <tr><td>6</td><td>High risk</td></tr> <tr><td>7</td><td>Inoperable/Extreme Risk</td></tr> <tr><td>1</td><td>Patient preference (retired)</td></tr> <tr><td>2</td><td>Inoperable (technical) (retired)</td></tr> <tr><td>4</td><td>Prohibitive risk (debilitated/deconditioned patient) (retired)</td></tr> <tr><td>3</td><td>Prohibitive risk (co-morbid conditions) (retired)</td></tr> <tr><td>5</td><td>Other (retired)</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6071</p>	9	Low Risk	8	Intermediate Risk	6	High risk	7	Inoperable/Extreme Risk	1	Patient preference (retired)	2	Inoperable (technical) (retired)	4	Prohibitive risk (debilitated/deconditioned patient) (retired)	3	Prohibitive risk (co-morbid conditions) (retired)	5	Other (retired)
9	Low Risk																				
8	Intermediate Risk																				
6	High risk																				
7	Inoperable/Extreme Risk																				
1	Patient preference (retired)																				
2	Inoperable (technical) (retired)																				
4	Prohibitive risk (debilitated/deconditioned patient) (retired)																				
3	Prohibitive risk (co-morbid conditions) (retired)																				
5	Other (retired)																				
313	evalavrsuit	<p>Evaluation of Suitability for Open AVR by Two Surgeons <i>Indicate if two surgeons evaluated the suitability for open heart aortic valve replacement surgery. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6072</p>	0	No	1	Yes														
0	No																				
1	Yes																				
314	procedureabort	<p>Procedure Aborted <i>Indicate whether the current case was canceled or aborted after patient entered the procedure location. Target Value: Any occurrence on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6075</p>	0	No	1	Yes														
0	No																				
1	Yes																				
315	procedureabortreason	<p>Procedure Aborted Reason <i>Indicate the reason why the current aortic procedure was canceled or aborted. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>7</td><td>Access related issue</td></tr> <tr><td>5</td><td>Navigation issue after successful access</td></tr> <tr><td>8</td><td>New clinical findings</td></tr> <tr><td>9</td><td>Device or delivery system malfunction</td></tr> <tr><td>10</td><td>Patient status/complication of procedure</td></tr> <tr><td>11</td><td>Consent issue</td></tr> <tr><td>12</td><td>System issue</td></tr> <tr><td>6</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6080</p>	7	Access related issue	5	Navigation issue after successful access	8	New clinical findings	9	Device or delivery system malfunction	10	Patient status/complication of procedure	11	Consent issue	12	System issue	6	Other		
7	Access related issue																				
5	Navigation issue after successful access																				
8	New clinical findings																				
9	Device or delivery system malfunction																				
10	Patient status/complication of procedure																				
11	Consent issue																				
12	System issue																				
6	Other																				

316	procedureabortion	<p>Procedure Aborted Action <i>Indicate the reason or action take as a result of the aborted aortic procedure. Target Value: The value on current procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Balloon valvuloplasty</td></tr> <tr><td>2</td><td>Rescheduled transcatheter procedure</td></tr> <tr><td>3</td><td>Conversion to open heart surgery</td></tr> <tr><td>4</td><td>Converted to medical therapy</td></tr> <tr><td>5</td><td>Converted to clinical trial</td></tr> <tr><td>6</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6082</p>	1	Balloon valvuloplasty	2	Rescheduled transcatheter procedure	3	Conversion to open heart surgery	4	Converted to medical therapy	5	Converted to clinical trial	6	Other		
1	Balloon valvuloplasty																
2	Rescheduled transcatheter procedure																
3	Conversion to open heart surgery																
4	Converted to medical therapy																
5	Converted to clinical trial																
6	Other																
317	convsurgaccess	<p>Conversion to Open Heart Surgery <i>Indicate if conversion to open heart surgical access was required. Note(s): Open heart surgical access is the creation of an incision to open the chest and provide direct access to the heart. It may or may not involve placing the patient on cardiopulmonary bypass. Target Value: Any occurrence on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6085</p>	0	No	1	Yes										
0	No																
1	Yes																
318	convsurgaccessreason	<p>Conversion to Open Heart Surgery Reason (Aortic) <i>Indicate the reason for conversion to open heart surgical access (aortic procedures). Target Value: The value on current procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Valve dislodged to aorta</td></tr> <tr><td>2</td><td>Valve dislodged to left ventricle</td></tr> <tr><td>3</td><td>Ventricular rupture</td></tr> <tr><td>4</td><td>Annulus rupture</td></tr> <tr><td>5</td><td>Aortic dissection</td></tr> <tr><td>6</td><td>Coronary occlusion</td></tr> <tr><td>7</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6090</p>	1	Valve dislodged to aorta	2	Valve dislodged to left ventricle	3	Ventricular rupture	4	Annulus rupture	5	Aortic dissection	6	Coronary occlusion	7	Other
1	Valve dislodged to aorta																
2	Valve dislodged to left ventricle																
3	Ventricular rupture																
4	Annulus rupture																
5	Aortic dissection																
6	Coronary occlusion																
7	Other																
319	preprocmechassist	<p>Mechanical Assist Device in Place at Start of Procedure <i>Indicate if that patient had a mechanical assist device in place at the start of the procedure. Target Value: The value on start of procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>No</td></tr> <tr><td>2</td><td>Yes - IABP</td></tr> <tr><td>3</td><td>Yes - Catheter-based assist device</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6095</p>	1	No	2	Yes - IABP	3	Yes - Catheter-based assist device								
1	No																
2	Yes - IABP																
3	Yes - Catheter-based assist device																
320	contrastvol	<p>Section Header: <i>TAVR Post Implant</i> Contrast Volume <i>Indicate the volume of contrast (ionic and non-ionic) used in milliliters (ml). The volume recorded should be the total volume for the procedure. Target Value: The total between start of the procedure and end of the procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6450</p>														
321	post_meanavgrad	<p>Post-Implant Mean Aortic Valve Gradient <i>Indicate the post-implant mean aortic valve gradient in mmHg. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6385</p>														
322	postcalcavarea	<p>Post-Implant Calculated Aortic Valve Area <i>Indicate the post-implant calculated aortic valve area, in centimeters squared. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6395</p>														
323	aux5	<p>Auxiliary 5 <i>Reserved for future use. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 6505</p>														
324	aux6	<p>Auxiliary 6 <i>Reserved for future use. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 6510</p>														
325	tavr_procedure_complete	<p>Section Header: <i>Form Status</i> Complete?</p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete								
0	Incomplete																
1	Unverified																
2	Complete																
Instrument: Tavr Device (tavr_device)			^ Collapse														
326	tvtdvicecounter	<p>Device Counter <i>This is a software-assigned value. The counter will start at one and be incremented by one for each device or system used. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 6220</p>														
327	tvtdviceid	<p>Device Id</p>	<p>text</p>														

328	tvaccesssite	<p>Valve Sheath Access Site (Aortic) <i>Indicate the access site for the valve sheath. Target Value: Any occurrence on current procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Femoral</td></tr> <tr><td>2</td><td>Auxillary</td></tr> <tr><td>3</td><td>Transapical</td></tr> <tr><td>4</td><td>Transaortic</td></tr> <tr><td>5</td><td>Subclavian</td></tr> <tr><td>7</td><td>Transiliac</td></tr> <tr><td>8</td><td>Transeptal</td></tr> <tr><td>9</td><td>Transcarotid</td></tr> <tr><td>6</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6200</p>	1	Femoral	2	Auxillary	3	Transapical	4	Transaortic	5	Subclavian	7	Transiliac	8	Transeptal	9	Transcarotid	6	Other
1	Femoral																				
2	Auxillary																				
3	Transapical																				
4	Transaortic																				
5	Subclavian																				
7	Transiliac																				
8	Transeptal																				
9	Transcarotid																				
6	Other																				
329	tvaccessmethod	<p>Valve Sheath Access Method <i>Indicate the access method used to deliver the valve sheath. Target Value: Any occurrence on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Percutaneous</td></tr> <tr><td>2</td><td>Cutdown</td></tr> <tr><td>3</td><td>Mini thoracotomy</td></tr> <tr><td>4</td><td>Mini sternotomy</td></tr> <tr><td>5</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6205</p>	1	Percutaneous	2	Cutdown	3	Mini thoracotomy	4	Mini sternotomy	5	Other								
1	Percutaneous																				
2	Cutdown																				
3	Mini thoracotomy																				
4	Mini sternotomy																				
5	Other																				
330	valvesheathdelivery	<p>Valve Sheath Delivery Size <i>Indicate the size, in french, of the valve sheath delivery system. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6210</p>																		
331	tvdeviceserno	<p>Device Serial Number <i>Indicate the serial number of all valves attempted or implanted into the patient. Note(s): Serial numbers are only required for valves. If a kit is used, specify the serial number of the valve used from the kit. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6230</p>																		
332	deviceimplantsuccessful	<p>Device Implanted Successfully <i>Indicate if there is correct positioning of a single prosthetic heart valve in the proper anatomical location.</i></p>	<p>yesno</p> <table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6232</p>	1	Yes	0	No														
1	Yes																				
0	No																				
333	tvdevicesuccess	<p>Device Success <i>Indicate if the device deployment was successful, as defined by the Standardized Endpoint Definitions for Transcatheter Aortic Valve Implantation Clinical Trials (JACC, 2011, vol 57, No 3). Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6235</p>	0	No	1	Yes														
0	No																				
1	Yes																				
334	valve_udirectid	<p>Valve Device UDI Direct Identifier <i>[Reserved for Future Use] Indicate the direct identifier portion of the Unique Device Identifier (UDI) associated with the device used during the procedure. This ID is provided by the device manufacturer, and is either a GTIN or HIBCC number. Note(s): The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits. - GTIN / GS1 standard: numeric, 12 - 14 characters - HIBCC standard: alphanumeric, 25 characters - ISBT-128: alphanumeric, 25 characters If a device was not used, leave blank. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6236</p>																		
335	valve_udilotnum	<p>Valve Device UDI Lot Number <i>[Reserved for Future Use] Indicate the lot number associated with the device used to close the access site. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 6237</p>																		
336	valve_udiexpdate	<p>Valve Device UDI Expiration Date <i>[Reserved for Future Use] Indicate the expiration date associated with the device used to close the access site. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system. Target Value: The value on current procedure</i></p>	<p>text (date_mdy) Field Annotation: v2.1 SeqNo 6238</p>																		

337	tavr_device_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete								
1	Unverified								
2	Complete								
Instrument: Mrr Procedure (mrr_procedure) ^ Collapse									
338	mrr_procrmarrivaldate_deid	Section Header: <i>Mitral Leaflet Clip</i> Procedure Room Arrival Date (Mitral Repair) (Deid) <i>Indicate the date the patient arrived into the procedure room. Target Value: The value on current procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 26060						
339	mrr_procrmarrivaltime	Procedure Room Arrival Time (Mitral Repair) <i>Indicate the time the patient arrived into the procedure room. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26061						
340	anesthstarttime	Anesthesia Induction Time <i>Indicate the time of anesthesia induction. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26070						
341	anesthstoptime	Anesthesia Discontinuation Time <i>Indicate the time of anesthesia discontinuation. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26071						
342	accessstarttime	Procedure Access (Or TEE) Start Time <i>Indicate the time of intravascular catheter or transesophageal echocardiogram (TEE) probe insertion (whichever is first) Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26075						
343	accessstoptime	Procedure Access (Or TEE) Stop Time <i>Indicate the time the last catheter, or transesophageal echocardiogram probe was removed (whichever was last). Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26076						
344	septalaccessstarttime	Transseptal Access Start Time <i>Indicate the time the septum was accessed. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26080						
345	septumcrosstime	Septum Crossed Time <i>Indicate the time the septum was crossed. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26081						
346	sgcseptime	Steerable Guiding Cath in Intra-Atrial Septum Time <i>Indicate the time the steerable guiding catheter was in the intra-atrial septum. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26086						
347	delretrtime	Delivery System Retracted Time <i>Indicate the time the last delivery system was retracted into the steerable guiding catheter. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26091						
348	sgcremovetime	Steerable Guiding Cath Device Removal (From Femoral Vein) <i>Indicate the time the steerable guiding catheter was retracted from the femoral vein. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26096						
349	mrr_convsurgaccess	Conversion to Open Heart Surgery (Mitral Repair) <i>Indicate if conversion to open heart surgical access was required. Target Value: Any occurrence on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 26105	0	No	1	Yes		
0	No								
1	Yes								
350	mrr_mvsupport	Mechanical Assist Device (Mitral Repair) <i>Indicate if the patient was placed on a mechanical assist device. Target Value: The value between arrival and discharge</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 26140	0	No	1	Yes		
0	No								
1	Yes								
351	mrr_supporttiming	Mechanical Assist Device Timing (Mitral Repair) <i>Indicate when the mechanical assist device was inserted. Target Value: The value between arrival and discharge</i>	radio <table border="1"> <tr><td>1</td><td>Pre-procedure</td></tr> <tr><td>2</td><td>Intraprocedure</td></tr> <tr><td>3</td><td>Postprocedure</td></tr> </table> Field Annotation: v2.1 SeqNo 26141	1	Pre-procedure	2	Intraprocedure	3	Postprocedure
1	Pre-procedure								
2	Intraprocedure								
3	Postprocedure								

352	mrr_supporttype	Mechanical Assist Device Type (Mitral Repair) <i>Indicate the type of mechanical assist device that was inserted. Target Value: N/A IABP Catheter-based assist device</i>	dropdown <table border="1"> <tr><td>1</td><td>IABP</td></tr> <tr><td>2</td><td>Catheter-based assist device</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 26142</p>	1	IABP	2	Catheter-based assist device								
1	IABP														
2	Catheter-based assist device														
353	mrr_post_mr	Post-Implant Mitral Regurgitation (Mitral Repair) <i>Indicate the severity of mitral valve regurgitation. Note(s): Code mild-moderate as mild. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Moderate-severe</td></tr> <tr><td>5</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 26285</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Moderate-severe	5	Severe
0	None														
1	Trace/Trivial														
2	Mild														
3	Moderate														
4	Moderate-severe														
5	Severe														
354	mrr_post_gradm	Post-Implant MV Mean Gradient (Mitral Repair) <i>Indicate the mitral valve mean gradient, in mm Hg. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26290												
355	aux9	Auxiliary 9 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 26325												
356	aux10	Auxiliary 10 <i>Reserved for future use. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 26330												
357	mrr_procedure_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete						
0	Incomplete														
1	Unverified														
2	Complete														
Instrument: Mitral Clip Device (mitral_clip_device)			^ Collapse												
358	mrr_counter	Leaflet Clip Counter (Mitral Repair) <i>The leaflet clip counter is used to distinguish between multiple leaflet clips attempted or deployed. Note(s): The software-assigned leaflet clip counter should start at one and be incremented by one for each clip. The leaflet clip counter is reset back to one for each new Leaflet Clip procedure. The leaflet clip counter is used to distinguish between multiple clips used during a procedure. At least one clip must be specified for each leaflet clip procedure. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 26240												
359	leafaccess	Leaflet Clip Guiding Cath Access Site <i>Indicate the leaflet clip guiding catheter access site. Target Value: The value on current procedure</i>	radio <table border="1"> <tr><td>1</td><td>Right femoral vein</td></tr> <tr><td>2</td><td>Left femoral vein</td></tr> <tr><td>3</td><td>Jugular vein</td></tr> <tr><td>4</td><td>Other vein</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 6212</p>	1	Right femoral vein	2	Left femoral vein	3	Jugular vein	4	Other vein				
1	Right femoral vein														
2	Left femoral vein														
3	Jugular vein														
4	Other vein														
360	steerableguideused	Steerable Guide Model ID <i>Indicate the steerable guide cath model ID utilized during the current procedure. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26180												
361	mrr_guideserno	Steerable Guide Cath Serial Number <i>Indicate the manufacturer serial number for the steerable guide used during the procedure. Target Value: The value on the current procedure</i>	text Field Annotation: v2.1 SeqNo 26182												
362	leafletclipused	Leaflet Clip Model ID (Mitral Repair) <i>Indicate all leaflet clip model IDs utilized during the current procedure. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26245												
363	mrr_leafletclipnum	Leaflet Clip Serial Number (Mitral Repair) <i>Indicate the leaflet clip delivery system serial number. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 26250												

364	mrr_udirectid	<p>Leaflet Clip UDI Direct Identifier (Mitral Repair) <i>[Reserved for Future Use] Indicate the direct identifier portion of the Unique Device Identifier (UDI) associated with the device used during the procedure. This ID is provided by the device manufacturer, and is either a GTIN or HIBBC number. Note(s): The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits. - GTIN / GS1 standard: numeric, 12 - 14 characters - HIBCC standard: alphanumeric, 25 characters - ISBT-128: alphanumeric, 25 characters If a device was not used, leave blank. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 26255</p>														
365	mrr_udilotnum	<p>Leaflet Clip UDI Lot Number (Mitral Repair) <i>[Reserved for Future Use] Indicate the lot number associated with the device used during the leaflet clip procedure. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process. Target Value: The value on current procedure</i></p>	<p>text Field Annotation: v2.1 SeqNo 26260</p>														
366	mrr_udiexpdate	<p>Leaflet Clip UDI Expiration Date (Mitral Repair) <i>[Reserved for Future Use] Indicate the expiration date associated with the leaflet clip device used during the procedure. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system. Target Value: The value on current procedure</i></p>	<p>text (date_mdy) Field Annotation: v2.1 SeqNo 26265</p>														
367	mrr_loc	<p>Location (Mitral Repair) <i>Indicate the location on the mitral valve where the leaflet clip was attached.</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>A1P1</td></tr> <tr><td>2</td><td>A2P2</td></tr> <tr><td>3</td><td>A3P3</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 26270</p>	1	A1P1	2	A2P2	3	A3P3								
1	A1P1																
2	A2P2																
3	A3P3																
368	mrr_leafletclipdeploy	<p>Leaflet Clip Deployed (Mitral Repair) <i>Indicate if the leaflet clip was deployed.</i></p>	<p>yesno</p> <table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 26275</p>	1	Yes	0	No										
1	Yes																
0	No																
369	mrr_leafletclipnotdeploy	<p>Leaflet Clip Reason Not Deployed (Mitral Repair) <i>Indicate the reason why the leaflet clip was not deployed.</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Inability to grasp leaflets</td></tr> <tr><td>2</td><td>Inability to reduce mitral regurgitation</td></tr> <tr><td>3</td><td>Mitral stenosis</td></tr> <tr><td>4</td><td>Mitral valve injury</td></tr> <tr><td>5</td><td>Device malfunction</td></tr> <tr><td>6</td><td>Adverse event</td></tr> <tr><td>7</td><td>Other</td></tr> </table>	1	Inability to grasp leaflets	2	Inability to reduce mitral regurgitation	3	Mitral stenosis	4	Mitral valve injury	5	Device malfunction	6	Adverse event	7	Other
1	Inability to grasp leaflets																
2	Inability to reduce mitral regurgitation																
3	Mitral stenosis																
4	Mitral valve injury																
5	Device malfunction																
6	Adverse event																
7	Other																
370	mitral_clip_device_complete	<p>Section Header: <i>Form Status</i> Complete?</p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete								
0	Incomplete																
1	Unverified																
2	Complete																
<p>Instrument: Mvr Procedure (mvr_procedure)</p>			<p>^ Collapse</p>														
371	mvr_operatorreason	<p>Section Header: <i>Mitral Valve in Valve or Valve in Ring</i> Mitral Replacement - Operator Reason for Procedure <i>Indicate the operator's reason for the transcatheter valve replacement procedure. Note(s): If choosing between multiple reasons, choose the 'most important' or 'highest significant' reason or factor. Target Value: The value on current procedure</i></p>	<p>dropdown</p> <table border="1"> <tr><td>9</td><td>Low Risk</td></tr> <tr><td>8</td><td>Intermediate Risk</td></tr> <tr><td>6</td><td>High risk</td></tr> <tr><td>7</td><td>Inoperable/Extreme Risk</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29115</p>	9	Low Risk	8	Intermediate Risk	6	High risk	7	Inoperable/Extreme Risk						
9	Low Risk																
8	Intermediate Risk																
6	High risk																
7	Inoperable/Extreme Risk																

372	mvr_procedureabort	<p>Mitral Replacement - Procedure Aborted <i>Indicate whether the current case was canceled or aborted after patient entered the procedure location. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1" data-bbox="1042 109 1118 191"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29120</p>	0	No	1	Yes														
0	No																				
1	Yes																				
373	mvr_procedureabortreason	<p>Mitral Replacement - Procedure Aborted Reason <i>Indicate the reason why the current aortic procedure was canceled or aborted. Target Value: The value on current procedure</i></p>	<p>dropdown</p> <table border="1" data-bbox="1042 283 1468 646"> <tr> <td>5</td> <td>Navigation issue after successful access</td> </tr> <tr> <td>7</td> <td>Other Access related issue</td> </tr> <tr> <td>8</td> <td>New clinical findings</td> </tr> <tr> <td>9</td> <td>Device or delivery system malfunction</td> </tr> <tr> <td>10</td> <td>Patient status/complication of procedure</td> </tr> <tr> <td>11</td> <td>Consent issue</td> </tr> <tr> <td>12</td> <td>System issue</td> </tr> <tr> <td>13</td> <td>Transseptal access related</td> </tr> <tr> <td>6</td> <td>Other</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29125</p>	5	Navigation issue after successful access	7	Other Access related issue	8	New clinical findings	9	Device or delivery system malfunction	10	Patient status/complication of procedure	11	Consent issue	12	System issue	13	Transseptal access related	6	Other
5	Navigation issue after successful access																				
7	Other Access related issue																				
8	New clinical findings																				
9	Device or delivery system malfunction																				
10	Patient status/complication of procedure																				
11	Consent issue																				
12	System issue																				
13	Transseptal access related																				
6	Other																				
374	mvr_procedureabortaction	<p>Mitral Replacement - Procedure Aborted Action <i>Indicate the reason or action take as a result of the aborted aortic procedure. Target Value: The value on the current procedure</i></p>	<p>dropdown</p> <table border="1" data-bbox="1042 741 1430 1022"> <tr> <td>1</td> <td>Balloon Valvuloplasty</td> </tr> <tr> <td>2</td> <td>Rescheduled transcatheter procedure</td> </tr> <tr> <td>3</td> <td>Conversion to open heart surgery</td> </tr> <tr> <td>4</td> <td>Converted to medical therapy</td> </tr> <tr> <td>5</td> <td>Converted to clinical trial</td> </tr> <tr> <td>7</td> <td>Open heart surgery scheduled</td> </tr> <tr> <td>6</td> <td>Other</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29127</p>	1	Balloon Valvuloplasty	2	Rescheduled transcatheter procedure	3	Conversion to open heart surgery	4	Converted to medical therapy	5	Converted to clinical trial	7	Open heart surgery scheduled	6	Other				
1	Balloon Valvuloplasty																				
2	Rescheduled transcatheter procedure																				
3	Conversion to open heart surgery																				
4	Converted to medical therapy																				
5	Converted to clinical trial																				
7	Open heart surgery scheduled																				
6	Other																				
375	mvr_convsurgaccess	<p>Mitral Replacement - Conversion to Open Heart Surgery <i>Indicate if conversion to open heart surgical access was required. Note(s): Open heart surgical access is the creation of an incision to open the chest and provide direct access to the heart. It may or may not involve placing the patient on cardiopulmonary bypass. Target Value: Any occurrence on current procedure</i></p>	<p>radio</p> <table border="1" data-bbox="1042 1119 1118 1201"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29130</p>	0	No	1	Yes														
0	No																				
1	Yes																				
376	mvr_convsurgmitral	<p>Mitral Replacement - Conversion to Open Heart Surgery Reason <i>Indicate the reason for conversion to open heart surgical access (mitral procedures). Target Value: The value on current procedure Access related problem/injury Inability to position device Valve injury Device embolization Tamponade/bleeding in the heart Other</i></p>	<p>dropdown</p> <table border="1" data-bbox="1042 1293 1390 1535"> <tr> <td>1</td> <td>Access related problem/injury</td> </tr> <tr> <td>2</td> <td>Inability to position device</td> </tr> <tr> <td>3</td> <td>Valve injury</td> </tr> <tr> <td>4</td> <td>Device embolization</td> </tr> <tr> <td>5</td> <td>Tamponade/bleeding in the heart</td> </tr> <tr> <td>6</td> <td>Other</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29135</p>	1	Access related problem/injury	2	Inability to position device	3	Valve injury	4	Device embolization	5	Tamponade/bleeding in the heart	6	Other						
1	Access related problem/injury																				
2	Inability to position device																				
3	Valve injury																				
4	Device embolization																				
5	Tamponade/bleeding in the heart																				
6	Other																				
377	mvr_mvsupport	<p>Mitral Replacement - Mechanical Assist Device <i>Indicate if the patient was placed on a mechanical assist device. Target Value: The value between arrival and discharge</i></p>	<p>radio</p> <table border="1" data-bbox="1042 1629 1118 1711"> <tr> <td>0</td> <td>No</td> </tr> <tr> <td>1</td> <td>Yes</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29140</p>	0	No	1	Yes														
0	No																				
1	Yes																				
378	mvr_mvsupporttiming	<p>Mitral Replacement - Mechanical Assist Device Timing <i>Indicate when the mechanical assist device was inserted. Target Value: The first value between arrival and discharge</i></p>	<p>radio</p> <table border="1" data-bbox="1042 1808 1224 1923"> <tr> <td>1</td> <td>Pre-procedure</td> </tr> <tr> <td>2</td> <td>Intraprocedure</td> </tr> <tr> <td>3</td> <td>Postprocedure</td> </tr> </table> <p>Field Annotation: v2.1 SeqNo 29145</p>	1	Pre-procedure	2	Intraprocedure	3	Postprocedure												
1	Pre-procedure																				
2	Intraprocedure																				
3	Postprocedure																				

379	mvr_mvsupporttype	<p>Mechanical Assist Device Type <i>Indicate the type of mechanical assist device that was inserted. Target Value: N/A IABP Catheter-based assist device</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>IABP</td></tr> <tr><td>2</td><td>Catheter-based assist device</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29146</p>	1	IABP	2	Catheter-based assist device								
1	IABP														
2	Catheter-based assist device														
380	mvaccesssite	<p>Mitral Replacement - Procedure Access Site <i>Indicate the access site used to perform the mitral procedure. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Transseptal</td></tr> <tr><td>2</td><td>Transapical</td></tr> <tr><td>3</td><td>Direct left atrium</td></tr> <tr><td>4</td><td>Femoral artery</td></tr> <tr><td>5</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29180</p>	1	Transseptal	2	Transapical	3	Direct left atrium	4	Femoral artery	5	Other		
1	Transseptal														
2	Transapical														
3	Direct left atrium														
4	Femoral artery														
5	Other														
381	mvr_mvpreballoon	<p>Pre-Implant Balloon Inflation Performed <i>Indicate if pre-implant balloon inflation was performed. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29185</p>	0	No	1	Yes								
0	No														
1	Yes														
382	mvr_mvhemdet	<p>Significant Hemodynamic Deterioration After Inflation <i>Indicate if significant hemodynamic deterioration occurred after inflation. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29190</p>	0	No	1	Yes								
0	No														
1	Yes														
383	mvr_mvpostballoon	<p>Post-Implant Balloon Inflation Performed <i>Indicate if post-implant balloon inflation was performed. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29195</p>	0	No	1	Yes								
0	No														
1	Yes														
384	mvr_devimpsuccessful	<p>Mitral Replacement - Device Implanted Successfully <i>Indicate if there is correct positioning of a single prosthetic heart valve in the proper anatomical location.</i></p>	<p>yesno</p> <table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29225</p>	1	Yes	0	No								
1	Yes														
0	No														
385	mvr_post_mr	<p>Mitral Replacement - Post-Implant Mitral Regurgitation <i>Indicate the severity of mitral valve regurgitation. Target Value: The value on current procedure</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Moderate-severe</td></tr> <tr><td>5</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 29285</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Moderate-severe	5	Severe
0	None														
1	Trace/Trivial														
2	Mild														
3	Moderate														
4	Moderate-severe														
5	Severe														
386	mvr_post_meanmvgrad	<p>Mitral Replacement - Post-Implant MV Mean Gradient <i>Indicate the mitral valve mean gradient, in mm Hg. Target Value: The value on current procedure</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 29290</p>												
387	mvr_contrastvol	<p>Mitral Replacement - Contrast Volume <i>Indicate the volume of contrast (ionic and non-ionic) used in milliliters (ml). The volume recorded should be the total volume for the procedure. Target Value: The total between start of the procedure and end of the procedure</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 29295</p>												
388	mvr_procedure_complete	<p>Section Header: Form Status Complete?</p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete						
0	Incomplete														
1	Unverified														
2	Complete														

Instrument: **Tmvr Device** (tmvr_device)

[^ Collapse](#)

	389	mvr_devicecounter	MVR - Device Counter <i>This is a software-assigned value. The counter will start at one and be incremented by one for each device or system used. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 29200						
	390	mvr_deviceid	MVR - Device Used <i>Indicate all devices (valves, sheaths and delivery systems) utilized during the current procedure. If the valve, sheath and delivery system were separate components, code the manufacturer, model name and number for the sheath and delivery system as well as the manufacturer, model name and number, and serial number for all valves attempted and deployed during the procedure. Note(s): Specify the devices in the order they were used. If a kit is used, do not code the separate components within the kit. Specify the serial number of the valve used from the kit. If more than one valve is placed (valve-in-valve) during the procedure, specify all devices and corresponding serial numbers (Seq Num 29205). Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 29201						
	391	mvr_deviceserno	MVR - Device Serial Number <i>Indicate the serial number of all valves attempted or implanted into the patient. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 29205						
	392	mvr_valve_udirectid	MVR - Valve Device UDI Direct Identifier <i>[Reserved for Future Use] Indicate the direct identifier portion of the Unique Device Identifier (UDI) associated with the device used during the procedure. This ID is provided by the device manufacturer, and is either a GTIN or HIBCC number. Note(s): The direct identifier portion of the UDI (unique device identifier) is provided by the manufacturer, specified at the unit of use. This is not the package barcode. The value should be mapped from your supply chain or inventory management system into this field. Depending on the device and manufacturer, this number could be between 12 to 25 digits. - GTIN / GS1 standard: numeric, 12 - 14 characters - HIBCC standard: alphanumeric, 25 characters - IBSB-128: alphanumeric, 25 characters If a device was not used, leave blank. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 29210						
	393	mvr_valve_udilotnum	MVR - Valve Device UDI Lot Number <i>[Reserved for Future Use] Indicate the lot number associated with the device used to close the access site. This lot number is provided by the device manufacturer, and should be available within your supply chain or EHR system. Lot numbers indicate the specific manufacturing source or process. Target Value: The value on current procedure</i>	text Field Annotation: v2.1 SeqNo 29215						
	394	mvr_valve_udiexpdate	MVR - Valve Device UDI Expiration Date <i>[Reserved for Future Use] Indicate the expiration date associated with the device used to close the access site. This expiration date is provided by the device manufacturer, and should be available within your supply chain or EHR system. Target Value: The value on current procedure</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 29220						
	395	tmvr_device_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete									
1	Unverified									
2	Complete									
Instrument: Postop (postop) ^ Collapse										
	396	postprochgb	Section Header: <i>Post Procedure Labs</i> Post-Procedure Hemoglobin <i>Indicate the lowest post-procedure hemoglobin level in g/dL. Target Value: The lowest value between end of procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8040						
	397	postprochgbnd	Post-Procedure Hemoglobin Not Drawn <i>Indicate if a post procedure hemoglobin level was not drawn. Code "Yes" if the lab was not drawn.</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 8041	0	No	1	Yes		
0	No									
1	Yes									
	398	postproccreat	Post-Procedure Creatinine Level <i>Indicate the highest postoperative creatinine level, in mg/dL. If more than one level is obtained, code the highest level. Target Value: The highest value between end of procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8050						
	399	postproccreatnd	Post-Procedure Creatinine Level Not Drawn <i>Indicate if a post procedure creatinine level was not drawn. Code "Yes" if the lab was not drawn.</i>	dropdown <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 8051	0	No	1	Yes		
0	No									
1	Yes									
	400	dc_creat	Discharge Creatinine <i>Indicate the last post-procedure creatinine level documented in the medical record prior to discharge, in mg/dL. Target Value: The last value between end of procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8055						

401	dc_creatnd	<p>Discharge Creatinine Not Drawn <i>Indicate if a discharge creatinine level was not drawn. Code "Yes" if the lab was not drawn.</i></p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8056</p>	0	No	1	Yes						
0	No												
1	Yes												
402	popckg	<p>Post-Procedure 12 Lead ECG <i>Indicate the post procedure 12 lead ECG findings, if performed. If more than one ECG is performed, document the findings from the ECG closest to discharge. Target Value: The last value between end of procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Not performed</td></tr> <tr><td>2</td><td>No significant changes</td></tr> <tr><td>3</td><td>New pathological Q-wave or LBBB</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8060</p>	1	Not performed	2	No significant changes	3	New pathological Q-wave or LBBB				
1	Not performed												
2	No significant changes												
3	New pathological Q-wave or LBBB												
403	popptech	<p>Section Header: <i>Post Procedure Echo</i> Post-Procedure Echocardiogram <i>Indicate whether an echo (and the type of echo) was performed postoperatively prior to discharge. Note(s): If both types of echos were performed, code 'Yes - Transesophageal Echocardiogram'. Target Value: Any occurrence between end of the procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Not Performed</td></tr> <tr><td>2</td><td>Yes - TTE</td></tr> <tr><td>3</td><td>Yes - TEE</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8065</p>	1	Not Performed	2	Yes - TTE	3	Yes - TEE				
1	Not Performed												
2	Yes - TTE												
3	Yes - TEE												
404	popptechdate_deid	<p>Post-Procedure Echocardiogram Date (Deid) <i>Indicate the date the echo was performed. Target Value: The value between end of procedure and discharge</i></p>	<p>text (date_mdy) Field Annotation: v2.1 SeqNo 8070</p>										
405	popptar	<p>Post-Procedure Aortic Regurgitation <i>Indicate the highest level of aortic regurgitation found on the echocardiogram. Note(s): Code mild-moderate as mild and moderate-severe as moderate. Reference: Bonow, R.O, et al. 2008 Focused Updated Incorporated into ACC/AHA 2006 Guidelines for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology /American Heart Association Task force on Practice Guidelines. JACC, vol 52, No. 13, 2008, p. e1-e142. Target Value: The highest value between end of procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8095</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe
0	None												
1	Trace/Trivial												
2	Mild												
3	Moderate												
4	Severe												
406	post_aorticvalveinsuffperi	<p>TAVR - Paravalvular Severity <i>Indicate the highest severity of paravalvular aortic insufficiency. Target Value: The highest value between end of procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8106</p>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented
0	None												
2	Mild												
3	Moderate												
4	Severe												
5	Not Documented												
407	post_aorticvalveinsuffcent	<p>TAVR - Valvular Severity <i>Indicate the highest severity of central aortic insufficiency. Target Value: The highest value between end of procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8107</p>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented
0	None												
2	Mild												
3	Moderate												
4	Severe												
5	Not Documented												
408	post_aorticstenosis	<p>Post-Procedure Aortic Stenosis <i>Indicate whether aortic stenosis is present. Target Value: Any occurrence between end of the procedure and discharge</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 8080</p>	0	No	1	Yes						
0	No												
1	Yes												
409	post_aorticvalvearea	<p>Post-Procedure Aortic Valve Area <i>Indicate the smallest aortic valve area (in cm2) obtained from an echocardiogram. Target Value: The lowest value between end of procedure and discharge</i></p>	<p>text Field Annotation: v2.1 SeqNo 8085</p>										

410	post_avpeakvelocity	Post-Procedure Aortic Valve Peak Velocity <i>Indicate the aortic valve peak velocity in meters per second, as determined by continuous wave (CW) spectral velocity recording on echocardiography. Target Value: The highest value between end procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8086														
411	post_avmeangradient	Post-Procedure Aortic Valve Mean Gradient <i>Indicate the aortic valve mean gradient in mmHg obtained from echocardiogram. Target Value: The highest value between end of procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8090														
412	poptmr	Post-Procedure Mitral Regurgitation <i>Indicate the highest level of mitral regurgitation found on echocardiogram prior to discharge. Note(s): Code mild-moderate as mild. Target Value: The highest value between end of procedure and discharge</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>1+/Mild</td></tr> <tr><td>3</td><td>2+/Moderate</td></tr> <tr><td>5</td><td>3+/Moderate-Severe</td></tr> <tr><td>6</td><td>4+/Severe</td></tr> <tr><td>4</td><td>Severe (retired)</td></tr> </table> Field Annotation: v2.1 SeqNo 8075	0	None	1	Trace/Trivial	2	1+/Mild	3	2+/Moderate	5	3+/Moderate-Severe	6	4+/Severe	4	Severe (retired)
0	None																
1	Trace/Trivial																
2	1+/Mild																
3	2+/Moderate																
5	3+/Moderate-Severe																
6	4+/Severe																
4	Severe (retired)																
413	post_paramr	Mitral Replacement - Paravalvular Severity <i>Indicate the highest severity of paravalvular mitral regurgitation. Target Value: The highest value between end of current procedure and discharge</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 8112	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
2	Mild																
3	Moderate																
4	Severe																
5	Not Documented																
414	post_valvmr	Mitral Replacement - Valvular Severity <i>Indicate the highest severity of valvular mitral aortic regurgitation. Target Value: The highest value between end of current procedure and discharge</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> Field Annotation: v2.1 SeqNo 8115	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
2	Mild																
3	Moderate																
4	Severe																
5	Not Documented																
415	post_mvaoa	Effective Orifice Area (EOA) <i>Indicate the effective orifice area (EOA), in cm². Target Value: The highest value on discharge</i>	text Field Annotation: v2.1 SeqNo 8122														
416	post_eoamethod	EOA Method Of Assessment <i>Indicate the method used to measure the effective orifice area. Target Value: The highest value between end of current procedure and discharge</i>	radio <table border="1"> <tr><td>1</td><td>3D Planimetry</td></tr> <tr><td>2</td><td>PISA</td></tr> <tr><td>3</td><td>Quantitative Doppler</td></tr> <tr><td>4</td><td>Other</td></tr> </table> Field Annotation: v2.1 SeqNo 8125	1	3D Planimetry	2	PISA	3	Quantitative Doppler	4	Other						
1	3D Planimetry																
2	PISA																
3	Quantitative Doppler																
4	Other																
417	post_mvmeangrad	Mitral Valve Mean Gradient <i>Indicate the highest mean gradient (in mm Hg) across the mitral valve. Target Value: The highest value between end of current procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 8130														
418	post_mvarea	Mitral Valve Area <i>Indicate the smallest mitral valve area in centimeters squared. Target Value: (None)</i>	text Field Annotation: v2.1 SeqNo 8135														
419	post_lvot	Left Ventricular Outflow Tract Gradient (Peak) <i>Indicate the peak gradient of the left ventricular outflow tract. Target Value: The highest value between end of current procedure and discharge.</i>	text														

	420	post_sam	Systolic Anterior Motion Present <i>Indicate if systolic anterior motion was present. Target Value: Any occurrence between end of current procedure and discharge.</i>	radio 0 No 1 Yes
	421	postop_complete	Section Header: <i>Form Status</i> Complete?	dropdown 0 Incomplete 1 Unverified 2 Complete
Instrument: Hospital Event (hospital_event) ^ Collapse				
	422	ce_eventoccurred	Section Header: <i>Adverse Events</i> Intra or Post Procedure Event Occurred <i>Indicate if any intra or post procedure event occurred. Target Value: Any occurrence between start of the procedure and discharge</i>	radio 0 No 1 Yes Field Annotation: v2.1 SeqNo 7300
	423	ce_eventdate_deid	Intra or Post Procedure Event Date (Deid) <i>Indicate the date of any adverse events, interventions, or surgical procedures that occurred intra or post procedure. Note(s): If an event occurred more than once, specify each Intra/Post Procedure Event ID (7301) with its corresponding date. Target Value: The value between start of procedure and discharge</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 7302
	424	ce_eventid	Intra or Post Procedure Event ID <i>Indicate all adverse events, interventions or surgical procedures that occurred intra or post procedure. Note(s): If an event occurred more than once, specify each event with its corresponding Intra/Post Procedure Event Date (Seq Number 7302). Target Value: The value between start of procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 7301
	425	ce_eventname	Intra or Post Procedure Event Name	text
	426	hospital_event_complete	Section Header: <i>Form Status</i> Complete?	dropdown 0 Incomplete 1 Unverified 2 Complete
Instrument: Discharge (discharge) ^ Collapse				
	427	dc_rbc	RBC/Whole Blood Transfusion <i>Indicate if there was a transfusion of either whole blood or packed red blood cells. Target Value: Any occurrence between start of the procedure and discharge</i>	radio 0 No 1 Yes Field Annotation: v2.1 SeqNo 9011
	428	dc_rbcunit	RBC/Whole Blood Transfusion Units Transfused <i>Indicate the total number of units transfused of either whole blood and/or packed red blood cells. Note(s): Do not include autologous, cell-saver or chest tube recirculated blood. Target Value: The total between start of the procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 9012
	429	icuhours	Number of Hours in ICU <i>Indicate the total number of hours spent in the intensive care unit. Do not include hours spent in a telemetry or step-down unit. Target Value: The total between end of the procedure and discharge</i>	text Field Annotation: v2.1 SeqNo 9040
	430	dcdate_deid	Discharge Date (Deid) <i>Indicate the date on which the patient was discharged from your facility. Note(s): If the deceased is an organ donor, code the Discharge Date as the date of the final organ harvest. Target Value: The value on discharge</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 9045
	431	dcstatus	Discharge Status <i>Indicate whether the patient was alive or deceased at discharge. Target Value: The value on discharge</i>	radio 1 Alive 2 Deceased Field Annotation: v2.1 SeqNo 9050

432	dclocation	Discharge Location <i>Indicate the location to where the patient was discharged. Target Value: The value on discharge</i>	radio <table border="1"> <tr><td>1</td><td>Home</td></tr> <tr><td>2</td><td>Extended care/TCU/rehab</td></tr> <tr><td>3</td><td>Other acute care hospital</td></tr> <tr><td>4</td><td>Nursing home</td></tr> <tr><td>5</td><td>Hospice</td></tr> <tr><td>6</td><td>Other</td></tr> <tr><td>7</td><td>Left against medical advice</td></tr> </table> Field Annotation: v2.1 SeqNo 9055	1	Home	2	Extended care/TCU/rehab	3	Other acute care hospital	4	Nursing home	5	Hospice	6	Other	7	Left against medical advice				
1	Home																				
2	Extended care/TCU/rehab																				
3	Other acute care hospital																				
4	Nursing home																				
5	Hospice																				
6	Other																				
7	Left against medical advice																				
433	deathdate_deid	Death Date (Deid)	text																		
434	deathlocation	Death in Lab/OR <i>If the patient expired during this hospitalization, indicate if the patient expired in the cath lab, operating room or hybrid suite. Target Value: The value on discharge</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 9060	0	No	1	Yes														
0	No																				
1	Yes																				
435	deathcause	Primary Cause of Death <i>Select the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death. Target Value: The value on discharge</i>	dropdown <table border="1"> <tr><td>1</td><td>Cardiac</td></tr> <tr><td>2</td><td>Neurologic</td></tr> <tr><td>3</td><td>Renal</td></tr> <tr><td>4</td><td>Vascular</td></tr> <tr><td>5</td><td>Infection</td></tr> <tr><td>6</td><td>Valvular</td></tr> <tr><td>7</td><td>Pulmonary</td></tr> <tr><td>8</td><td>Unknown</td></tr> <tr><td>9</td><td>Other</td></tr> </table> Field Annotation: v2.1 SeqNo 9065	1	Cardiac	2	Neurologic	3	Renal	4	Vascular	5	Infection	6	Valvular	7	Pulmonary	8	Unknown	9	Other
1	Cardiac																				
2	Neurologic																				
3	Renal																				
4	Vascular																				
5	Infection																				
6	Valvular																				
7	Pulmonary																				
8	Unknown																				
9	Other																				
436	dc_acei_any	Section Header: <i>Medications</i> ACE Inhibitor (any)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded										
0	No																				
1	Yes																				
2	Contraindicated																				
3	Blinded																				
437	dc_arb_any	ARB (any)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded										
0	No																				
1	Yes																				
2	Contraindicated																				
3	Blinded																				
438	dc_asa_any	Aspirin (any)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded										
0	No																				
1	Yes																				
2	Contraindicated																				
3	Blinded																				
439	dc_betablocker	Beta Blocker (any)	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded										
0	No																				
1	Yes																				
2	Contraindicated																				
3	Blinded																				

440	dc_antiarrhyth_any	Antiarrhythmic (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
441	dc_warfarin	Warfarin	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
442	dc_dabigatran	Dabigatran	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
443	dc_p2y12_any	P2Y12 (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
444	dc_factor_xa	Factor Xa inhibitor	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
445	dc_acei_arb	ACE-I or ARB (Any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
446	dc_aldo	Aldosterone Antagonists	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
447	dc_loop_diur	Loop diuretic	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
448	dc_thiazides	Thiazides	radio 0 No 1 Yes 2 Contraindicated 3 Blinded

449	dc_diur_other	Diuretics (Other)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
450	dc_anticoag_any	Anticoagulants (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
451	dc_asa_alone	Aspirin (alone)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
452	dc_asa_dual	Aspirin (dual antiplatelet therapy)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
453	meddose_discharge	Loop diuretic Dose (mg) at discharge	text Field Annotation: v2.1 SeqNo 9110
454	discharge_complete	Section Header: <i>Form Status</i> Complete?	dropdown 0 Incomplete 1 Unverified 2 Complete
Instrument: Adjudication Event (adjudication_event)			^ Collapse
455	aj_adjudevent	Adjudication Event <i>Indicate the event being adjudicated. Target Value: N/A</i>	dropdown 11 Ischemic Stroke (In-hospital) 12 Hemorrhagic Stroke (In-hospital) 13 Undetermined Stroke (In-hospital) 10 TIA (In-hospital) 30 Aortic Valve Re-intervention (In-hospital) 53 Mitral Valve Re-intervention (In-hospital) 110 TIA (F-U) 111 Ischemic Stroke (F-U) 112 Hemorrhagic Stroke (F-U) 113 Undetermined Stroke (F-U) 130 Aortic Valve Re-intervention (F-U) 153 Mitral Valve Re-intervention (F-U) 155 Readmission - Hear Failure (F-U) 300 To Be Updated in TVT 1.3 Field Annotation: v2.1 SeqNo 12000
456	aj_eventdate_deid	Event Date (Deid) <i>Indicate the clinical event date that occurred during any procedures or during any follow-ups Target Value: N/A</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 12005

457	aj_status	Adjudication Status <i>Indicate whether the patient was alive or deceased on the date the adjudication was performed. Target Value: N/A</i>	radio <table border="1"> <tr><td>1</td><td>Alive</td></tr> <tr><td>2</td><td>Deceased</td></tr> </table> Field Annotation: v2.1 SeqNo 12010	1	Alive	2	Deceased						
1	Alive												
2	Deceased												
458	aj_sxonset_deid	Date of Symptom Onset (Deid) <i>Indicate the date of symptom onset of the neurologic deficit. Target Value: N/A</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 12015										
459	aj_neurodef	Neurologic Deficit with Rapid Onset <i>Indicate if the patient had a sudden onset of a focal or global neurologic deficit (regardless of the duration of symptoms) with at least one of the following present: change in level of consciousness, hemiplegia, hemiparesis, numbness or sensory loss affecting one side of the body, dysphasia or aphasia, hemianopia, amaurosis fugax, other neurological signs or symptoms consistent with a stroke. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12020	0	No	1	Yes						
0	No												
1	Yes												
460	aj_neuroclinpresent	Neurologic Deficit Clinical Presentation <i>Indicate the clinical presentation of the neurologic deficit. Target Value: N/A</i>	radio <table border="1"> <tr><td>1</td><td>Stroke/TIA</td></tr> <tr><td>2</td><td>Non-Stroke</td></tr> </table> Field Annotation: v2.1 SeqNo 12025	1	Stroke/TIA	2	Non-Stroke						
1	Stroke/TIA												
2	Non-Stroke												
461	aj_neuroxduration	Neurologic Symptom Duration >= 24 hours <i>Indicate if the duration of the neurologic symptoms lasted >= 24 hours. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12030	0	No	1	Yes						
0	No												
1	Yes												
462	aj_neuroimag	Neuroimaging Performed <i>Indicate if neuroimaging such as CT, MRI, cerebral angiography was performed. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12040	0	No	1	Yes						
0	No												
1	Yes												
463	aj_neurodeficitytype	Neuroimaging Deficit Type <i>Indicate the type of deficit found as a result of the neuroimaging study. Target Value: N/A</i>	radio <table border="1"> <tr><td>1</td><td>No deficit</td></tr> <tr><td>2</td><td>Infarction</td></tr> <tr><td>3</td><td>Hemorrhage</td></tr> <tr><td>4</td><td>Both</td></tr> <tr><td>5</td><td>Subarachnoid Hemorrhage</td></tr> </table> Field Annotation: v2.1 SeqNo 12045	1	No deficit	2	Infarction	3	Hemorrhage	4	Both	5	Subarachnoid Hemorrhage
1	No deficit												
2	Infarction												
3	Hemorrhage												
4	Both												
5	Subarachnoid Hemorrhage												
464	aj_neurodiag	Neurologist/Neurosurgeon Confirmation of Diagnosis <i>Indicate if the diagnosis of stroke was confirmed on formal consultation by a neurologist or neurosurgeon. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12055	0	No	1	Yes						
0	No												
1	Yes												
465	aj_socrecimpair	Social/Recreational Activities Impaired <i>Indicate if the neurologic deficit led to an impairment in the ability to carry out social and or recreational activities (as compared to prior to the event). For example, the patient can no longer play bridge with friends or cannot drive. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12056	0	No	1	Yes						
0	No												
1	Yes												
466	aj_neurocogimpair	Neurocognitive Functions Essential to Patient Impaired <i>Indicate if the neurologic deficit led to an impairment of neurocognitive functions that are essential to the patient and/or their livelihood (as compared to prior to the event). Examples include a pianist who cannot play the piano, accountant who cannot perform mental math, or an individual who now needs help paying bills. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 12057	0	No	1	Yes						
0	No												
1	Yes												

467	aj_newaidsrequired	New Aids or Assistance Required <i>Indicate if the patient required new aids or assistance as a result of the new neurologic event. For example, the patient now needs to use a cane, brace or walker or they need assistance with activities of daily living. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes										
0	No																
1	Yes																
			Field Annotation: v2.1 SeqNo 12058														
468	aj_neurodeath	Death as a Result of Neurologic Deficit <i>Indicate if the neurologic event resulted in death of the patient. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table>	0	No	1	Yes										
0	No																
1	Yes																
			Field Annotation: v2.1 SeqNo 12060														
469	aj_commentsstroketa	Stroke TIA Clinical Comments <i>Provide information and details that may assist in assessing this stroke or TIA outcome. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 12065														
470	aj_reinttype	Aortic Valve Re-intervention Type <i>Indicate the type of aortic valve re-intervention. Target Value: N/A</i>	radio <table border="1"> <tr><td>1</td><td>Surgical AV Repair/Replacement</td></tr> <tr><td>2</td><td>Balloon Valvuloplasty</td></tr> <tr><td>3</td><td>Transcatheter AVR</td></tr> <tr><td>4</td><td>Other Transcatheter Intervention</td></tr> </table>	1	Surgical AV Repair/Replacement	2	Balloon Valvuloplasty	3	Transcatheter AVR	4	Other Transcatheter Intervention						
1	Surgical AV Repair/Replacement																
2	Balloon Valvuloplasty																
3	Transcatheter AVR																
4	Other Transcatheter Intervention																
			Field Annotation: v2.1 SeqNo 12105														
471	aj_traninttype	Transcatheter Intervention Type <i>Indicate the type of 'other' aortic transcatheter intervention. (Such as a procedure that deploys an occluder or plug for aortic regurgitation.) This does not include surgical aortic valve repair/replacements, transcatheter AV replacements or AV balloon valvuloplasties. Target Value: N/A</i>	text Field Annotation: v2.1 SeqNo 12110														
472	aj_primaryind	Section Header: Aortic Valve Re-intervention Aortic Valve Re-intervention Primary Indication <i>Indicate the primary indication for the re-intervention. If more than one indication is present, code the indication the operator feels has the highest significance. Target Value: N/A</i>	dropdown <table border="1"> <tr><td>1</td><td>Aortic insufficiency</td></tr> <tr><td>2</td><td>Aortic stenosis</td></tr> <tr><td>3</td><td>Device migration</td></tr> <tr><td>4</td><td>Device fracture</td></tr> <tr><td>5</td><td>Endocarditis</td></tr> <tr><td>6</td><td>Valve thrombosis</td></tr> <tr><td>7</td><td>Other</td></tr> </table>	1	Aortic insufficiency	2	Aortic stenosis	3	Device migration	4	Device fracture	5	Endocarditis	6	Valve thrombosis	7	Other
1	Aortic insufficiency																
2	Aortic stenosis																
3	Device migration																
4	Device fracture																
5	Endocarditis																
6	Valve thrombosis																
7	Other																
			Field Annotation: v2.1 SeqNo 12115														
473	aj_aisev	Aortic Valve Re-intervention Aortic Regurgitation Severity <i>Indicate the highest level of aortic regurgitation prior to the aortic valve re-intervention. Note(s): Mild-to-moderate should be coded as moderate; moderate to severe should be coded as severe. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe				
0	None																
1	Trace/Trivial																
2	Mild																
3	Moderate																
4	Severe																
			Field Annotation: v2.1 SeqNo 12120														
474	aj_pvsev	Aortic Valve Re-intervention Aortic Regurgitation Perivalvular Severity <i>Indicate the highest severity of paravalvular leak prior to the aortic valve re-intervention. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
2	Mild																
3	Moderate																
4	Severe																
5	Not Documented																
			Field Annotation: v2.1 SeqNo 12125														

475	aj_censev	<p>Aortic Valve Re-intervention Aortic Regurgitation Valvular Severity <i>Indicate the highest severity of central leak prior to the aortic valve re-intervention. Target Value: N/A</i></p>	<table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12130</p>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented								
0	None																				
2	Mild																				
3	Moderate																				
4	Severe																				
5	Not Documented																				
476	aj_assev	<p>Aortic Valve Re-intervention Aortic Stenosis Severity <i>Indicate the highest severity of aortic stenosis prior to the aortic valve re-intervention. Target Value: N/A</i></p>	<table border="1"> <tr><td>1</td><td>Possible stenosis</td></tr> <tr><td>2</td><td>Significant stenosis</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12135</p>	1	Possible stenosis	2	Significant stenosis														
1	Possible stenosis																				
2	Significant stenosis																				
477	aj_otherind	<p>Aortic Valve Re-intervention Other Indication <i>Specify the other indication for the aortic valve re-intervention. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 12140</p>																		
478	aj_commentsreint	<p>Aortic Valve Re-intervention Clinical Comments <i>Provide information and details that may assist in assessing this repeat intervention. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 12145</p>																		
479	aj_mvreinttype	<p>Section Header: <i>Mitral Valve Re-intervention</i> Mitral Valve Re-intervention Type <i>Indicate the type of mitral valve re-intervention. Target Value: N/A Surgical mitral valve repair Surgical mitral valve replacement Transcatheter mitral valve repair Transcatheter mitral valve replacement Leaflet clip procedure Other transcatheter intervention</i></p>	<table border="1"> <tr><td>1</td><td>Surgical mitral valve repair</td></tr> <tr><td>2</td><td>Surgical mitral valve replacement</td></tr> <tr><td>3</td><td>Transcatheter mitral valve repair</td></tr> <tr><td>4</td><td>Transcatheter mitral valve replacement</td></tr> <tr><td>5</td><td>Leaflet clip procedure</td></tr> <tr><td>6</td><td>Other transcatheter intervention</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12200</p>	1	Surgical mitral valve repair	2	Surgical mitral valve replacement	3	Transcatheter mitral valve repair	4	Transcatheter mitral valve replacement	5	Leaflet clip procedure	6	Other transcatheter intervention						
1	Surgical mitral valve repair																				
2	Surgical mitral valve replacement																				
3	Transcatheter mitral valve repair																				
4	Transcatheter mitral valve replacement																				
5	Leaflet clip procedure																				
6	Other transcatheter intervention																				
480	aj_mvothertype	<p>Other Type <i>Indicate the type of 'other' transcatheter mitral valve intervention. This does not include surgical mitral valve repair/replacements, transcatheter MV replacements or MV balloon valvuloplasties. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 12205</p>																		
481	aj_mvind	<p>Mitral Valve Re-intervention Indication <i>Indicate the primary indication for the re-intervention. If more than one indication is present, code the indication the operator feels has the highest significance. Target Value: N/A</i></p>	<table border="1"> <tr><td>1</td><td>Mitral regurgitation</td></tr> <tr><td>2</td><td>Mitral stenosis</td></tr> <tr><td>3</td><td>Mitral valve injury</td></tr> <tr><td>4</td><td>Device migration</td></tr> <tr><td>5</td><td>Device embolization</td></tr> <tr><td>6</td><td>Device fracture</td></tr> <tr><td>7</td><td>Endocarditis</td></tr> <tr><td>8</td><td>Device thrombosis</td></tr> <tr><td>9</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12210</p>	1	Mitral regurgitation	2	Mitral stenosis	3	Mitral valve injury	4	Device migration	5	Device embolization	6	Device fracture	7	Endocarditis	8	Device thrombosis	9	Other
1	Mitral regurgitation																				
2	Mitral stenosis																				
3	Mitral valve injury																				
4	Device migration																				
5	Device embolization																				
6	Device fracture																				
7	Endocarditis																				
8	Device thrombosis																				
9	Other																				
482	aj_mvotherind	<p>Mitral Valve Re-intervention Other Indication <i>Specify the other indication for the mitral valve re-intervention. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 12215</p>																		
483	aj_mvcommentsreint	<p>Mitral Valve Re-intervention Clinical Comments <i>Provide information and details that may assist in assessing this repeat intervention. Target Value: N/A</i></p>	<p>text Field Annotation: v2.1 SeqNo 12220</p>																		
484	aj_hospitalization	<p>Hospitalization>=24 Hours <i>Indicate if the heart failure readmission required the patient to be hospitalized with treatment in any inpatient unit or ward in the hospital for at least 24 hours, including emergency department stay. Target Value: N/A</i></p>	<table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>3</td><td>Information not available</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12225</p>	0	No	1	Yes	3	Information not available												
0	No																				
1	Yes																				
3	Information not available																				

485	aj_sshf	<p>Clinical Signs or Sx of Heart Failure <i>Indicate if the patient had clinical signs and/or symptoms of heart failure, including new or worsening dyspnea, orthopnea, paroxysmal nocturnal dyspnea, increasing fatigue, worsening functional capacity or activity intolerance, or signs and/or symptoms of volume overload. Target Value: N/A</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>3</td><td>Information not available</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12230</p>	0	No	1	Yes	3	Information not available
0	No								
1	Yes								
3	Information not available								
486	aj_hftreatment	<p>IV or Invasive Treatment Required <i>Indicate if the patient had signs and symptoms that resulted in intravenous (e.g. diuretic or vasoactive therapy) or invasive (e.g., ultrafiltration, IABP, mechanical assistance) treatment for heart failure. Target Value: N/A No Yes Information not available</i></p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>3</td><td>Information not available</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 12335</p>	0	No	1	Yes	3	Information not available
0	No								
1	Yes								
3	Information not available								
487	adjudication_event_complete	<p>Section Header: <i>Form Status</i> Complete?</p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Incomplete</td></tr> <tr><td>1</td><td>Unverified</td></tr> <tr><td>2</td><td>Complete</td></tr> </table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete								
1	Unverified								
2	Complete								

Instrument: **Follow Up** (follow_up) [^ Collapse](#)

488	f_assessmentdate_deid	<p>Follow-up Assessment Date (Deid) <i>Indicate the date the follow-up assessment was performed. Target Value: The value on follow-up</i></p>	<p>text (date_mdy) Field Annotation: v2.1 SeqNo 10000</p>												
489	f_assessmentmethod	<p>Follow-up Assessment Method <i>Indicate the primary method to determine patient status at follow-up. Target Value: Any occurrence on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Clinic</td></tr> <tr><td>2</td><td>Medical record</td></tr> <tr><td>3</td><td>Letter from medical provider</td></tr> <tr><td>4</td><td>Phone call to patient/family</td></tr> <tr><td>5</td><td>Social Security Death master File</td></tr> <tr><td>6</td><td>Other</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10005</p>	1	Clinic	2	Medical record	3	Letter from medical provider	4	Phone call to patient/family	5	Social Security Death master File	6	Other
1	Clinic														
2	Medical record														
3	Letter from medical provider														
4	Phone call to patient/family														
5	Social Security Death master File														
6	Other														
490	f_residence	<p>Follow-up Residence <i>Indicate the primary residence of the patient during the follow-up period. If the primary residence is not available, code not documented. Target Value: The value on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Home with no health-aid</td></tr> <tr><td>2</td><td>Home with health aid</td></tr> <tr><td>3</td><td>Long term care</td></tr> <tr><td>4</td><td>Other</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10008</p>	1	Home with no health-aid	2	Home with health aid	3	Long term care	4	Other	5	Not Documented		
1	Home with no health-aid														
2	Home with health aid														
3	Long term care														
4	Other														
5	Not Documented														
491	f_status	<p>Follow-up Status <i>Indicate whether the patient was alive or deceased at the date the follow-up was performed. Target Value: Any occurrence on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Alive</td></tr> <tr><td>2</td><td>Deceased</td></tr> <tr><td>3</td><td>Lost to follow-up</td></tr> <tr><td>4</td><td>Withdrawn</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10010</p>	1	Alive	2	Deceased	3	Lost to follow-up	4	Withdrawn				
1	Alive														
2	Deceased														
3	Lost to follow-up														
4	Withdrawn														

492	f_deathcause	<p>Follow-up Primary Cause of Death <i>Indicate the PRIMARY cause of death (i.e. the first significant event which ultimately led to death).</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Cardiac</td></tr> <tr><td>2</td><td>Neurologic</td></tr> <tr><td>3</td><td>Renal</td></tr> <tr><td>4</td><td>Vascular</td></tr> <tr><td>5</td><td>Infection</td></tr> <tr><td>6</td><td>Valvular</td></tr> <tr><td>7</td><td>Pulmonary</td></tr> <tr><td>8</td><td>Unknown</td></tr> <tr><td>9</td><td>Other</td></tr> </table> <p>Field Annotation: Seq. #: 10015</p>	1	Cardiac	2	Neurologic	3	Renal	4	Vascular	5	Infection	6	Valvular	7	Pulmonary	8	Unknown	9	Other
1	Cardiac																				
2	Neurologic																				
3	Renal																				
4	Vascular																				
5	Infection																				
6	Valvular																				
7	Pulmonary																				
8	Unknown																				
9	Other																				
493	f_hgbnd	<p>Section Header: <i>Follow-up Labs and Assessments</i></p> <p>Follow-up Hemoglobin Not Drawn <i>Indicate if a hemoglobin level was not drawn during the follow-up period. Target Value: N/A No</i></p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10086</p>	0	No	1	Yes														
0	No																				
1	Yes																				
494	f_hgb	<p>Follow-up Hemoglobin <i>Indicate the hemoglobin value in g/dL collected at follow-up. A hemoglobin level should be collected on all patients to assess for bleeding events as a result of the procedure. Target Value: The last value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10085</p>																		
495	f_crnd	<p>Follow-up Creatinine Not Drawn <i>Indicate if a creatinine level was not drawn during the follow-up period. Target Value: N/A</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10091</p>	0	No	1	Yes														
0	No																				
1	Yes																				
496	f_cr	<p>Follow-up Creatinine <i>Indicate the creatinine level collected at follow-up, in mg/dL. A creatinine level should be collected on all patients to determine kidney injury as a result of the procedure. Target Value: The last value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10090</p>																		
497	f_nyha	<p>Follow-up NYHA Classification <i>Indicate the patient's functional class, coded as the New York Heart Association (NYHA) classification at follow-up. Target Value: The highest value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Class I</td></tr> <tr><td>2</td><td>Class II</td></tr> <tr><td>3</td><td>Class III</td></tr> <tr><td>4</td><td>Class IV</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10100</p>	1	Class I	2	Class II	3	Class III	4	Class IV										
1	Class I																				
2	Class II																				
3	Class III																				
4	Class IV																				
498	f_fivemwalktest	<p>Follow-up Five Meter Walk Test Performed <i>Indicate whether the five meter walk test was performed during the follow-up period. Target Value: Any occurrence on follow-up Not performed</i></p>	<p>dropdown</p> <table border="1"> <tr><td>0</td><td>Not performed</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Unable to walk</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10135</p>	0	Not performed	1	Yes	2	Unable to walk												
0	Not performed																				
1	Yes																				
2	Unable to walk																				
499	f_fivemwalk1	<p>Follow-up Five Meter Walk Test Time 1 <i>Indicate the time in seconds it takes the patient to walk 5 meters for the first of three tests. Target Value: The value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10140</p>																		
500	f_fivemwalk2	<p>Follow-up Five Meter Walk Test Time 2 <i>Indicate the time in seconds it takes the patient to walk 5 meters for the second of three tests. Target Value: The value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10145</p>																		
501	f_fivemwalk3	<p>Follow-up Five Meter Walk Test Time 3 <i>Indicate the time in seconds it takes the patient to walk 5 meters for the third of three tests. Target Value: The value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10150</p>																		

502	f_sixminwalkperf	Follow-Up Six Minute Walk Test Performed <i>Indicate whether the six minute walk test was performed at follow-up. Target Value: Any occurrence on follow-up</i>	dropdown <table border="1"> <tr><td>1</td><td>Performed</td></tr> <tr><td>2</td><td>Not performed -unable to walk</td></tr> <tr><td>3</td><td>Not performed -cardiac reason (SOB)</td></tr> <tr><td>4</td><td>Not performed -patient not willing to walk</td></tr> <tr><td>5</td><td>Not performed by site</td></tr> </table> Field Annotation: v2.1 SeqNo 10380	1	Performed	2	Not performed -unable to walk	3	Not performed -cardiac reason (SOB)	4	Not performed -patient not willing to walk	5	Not performed by site
1	Performed												
2	Not performed -unable to walk												
3	Not performed -cardiac reason (SOB)												
4	Not performed -patient not willing to walk												
5	Not performed by site												
503	f_sixminwalkdate_deid	Follow-Up Six Minute Walk Test Date (Deid) <i>Indicate the date the six minute walk test was performed at follow-up. Target Value: The value on follow-up</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 10385										
504	f_sixminwalkdist	Follow-Up Total Distance <i>Indicate the total distance, in feet, the patient walked at follow-up. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10390										
505	f_12leadekg	Follow-up 12-Lead ECG Findings <i>Indicate the 12 lead ECG findings during the follow-up period. Target Value: Any occurrence on follow-up</i>	radio <table border="1"> <tr><td>1</td><td>Not performed</td></tr> <tr><td>2</td><td>No significant changes</td></tr> <tr><td>3</td><td>New changes noted</td></tr> </table> Field Annotation: v2.1 SeqNo 10155	1	Not performed	2	No significant changes	3	New changes noted				
1	Not performed												
2	No significant changes												
3	New changes noted												
506	f_ekgchange	Follow-up 12-Lead ECG Changes Noted <i>Indicate the ECG changes noted on the follow-up ECG. Target Value: Any occurrence on follow-up</i>	radio <table border="1"> <tr><td>1</td><td>Pathological Q-wave or LBBB</td></tr> <tr><td>2</td><td>Arrhythmia</td></tr> <tr><td>3</td><td>Both</td></tr> </table> Field Annotation: v2.1 SeqNo 10160	1	Pathological Q-wave or LBBB	2	Arrhythmia	3	Both				
1	Pathological Q-wave or LBBB												
2	Arrhythmia												
3	Both												
507	f_popttech	Section Header: <i>Follow-up Echo</i> Follow-up Echocardiogram <i>Indicate if an echocardiogram has been performed. Target Value: Any occurrence on follow-up</i>	radio <table border="1"> <tr><td>1</td><td>Not Performed</td></tr> <tr><td>2</td><td>Yes - TTE</td></tr> <tr><td>3</td><td>Yes - TEE</td></tr> </table> Field Annotation: v2.1 SeqNo 10206	1	Not Performed	2	Yes - TTE	3	Yes - TEE				
1	Not Performed												
2	Yes - TTE												
3	Yes - TEE												
508	f_popttechdate_deid	Follow-up Echo Date (Deid) <i>Indicate the date the echocardiogram was performed. If more than one echocardiogram has been performed since discharge or the last follow-up period, code the date of the most recent echo. Target Value: The last value on follow-up</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 10207										
509	f_lvefna	Follow-up LVEF Not Assessed <i>Indicate whether the left ventricular ejection fraction was not assessed. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 10211	0	No	1	Yes						
0	No												
1	Yes												
510	f_lvef	Follow-up LVEF <i>Indicate the left ventricular ejection fraction (LVEF), or the percentage of the blood emptied from the left ventricle at the end of the contraction. Use the most recent echocardiogram documented. Enter a percentage in the range of 1 - 99. If a percentage range is reported, report a whole number using the 'mean' (i.e., 50-55%, is reported as 53%). If only a descriptive value is reported, (i.e., normal), enter the corresponding percentage value from the list below: Normal = 60% Good function = 50% Mildly reduced = 45% Fair function = 40% Moderately reduced = 30% Poor function = 25% Severely reduced = 20% Target Value: The last value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10210										
511	f_post_avmeangradient	Follow-up Aortic Valve Mean Gradient <i>Indicate the aortic valve mean gradient in mmHg captured on echocardiogram since discharge or the last follow-up period. Target Value: The last value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10215										

512	f_popttar	<p>Follow-up Aortic Regurgitation Severity <i>Indicate the highest level of aortic regurgitation found on echo since discharge or the last follow-up period. Note(s): Code mild-moderate as mild and moderate-severe as moderate. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 107 1198 310"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10220</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe				
0	None																
1	Trace/Trivial																
2	Mild																
3	Moderate																
4	Severe																
513	f_post_aiperiseverity	<p>Follow-up Aortic Regurgitation Paravalvular Severity <i>Indicate the highest severity of perivalvular leak found on echo since discharge or the last follow-up period. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 405 1247 604"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10225</p>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
2	Mild																
3	Moderate																
4	Severe																
5	Not Documented																
514	f_post_aicentralseverity	<p>Follow-up Aortic Regurgitation Central Severity <i>Indicate the highest severity of central leak found on echo since discharge or the last follow-up period. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 699 1247 898"> <tr><td>0</td><td>None</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> <tr><td>5</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10227</p>	0	None	2	Mild	3	Moderate	4	Severe	5	Not Documented				
0	None																
2	Mild																
3	Moderate																
4	Severe																
5	Not Documented																
515	f_post_mr	<p>Follow-up Mitral Regurgitation <i>Indicate the level of mitral regurgitation found on echocardiogram in the last follow-up period. Note(s): Code mild-moderate as mild. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 993 1271 1276"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>1+/Mild</td></tr> <tr><td>3</td><td>2+/Moderate</td></tr> <tr><td>5</td><td>3+/Moderate-Severe</td></tr> <tr><td>6</td><td>4+/Severe</td></tr> <tr><td>4</td><td>Severe (retired)</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10300</p>	0	None	1	Trace/Trivial	2	1+/Mild	3	2+/Moderate	5	3+/Moderate-Severe	6	4+/Severe	4	Severe (retired)
0	None																
1	Trace/Trivial																
2	1+/Mild																
3	2+/Moderate																
5	3+/Moderate-Severe																
6	4+/Severe																
4	Severe (retired)																
516	f_post_mrpara	<p>Follow-up Paravalvular Severity <i>Indicate the highest severity of paravalvular mitral regurgitation. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 1371 1247 1570"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Mild</td></tr> <tr><td>2</td><td>Moderate</td></tr> <tr><td>3</td><td>Severe</td></tr> <tr><td>4</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10305</p>	0	None	1	Mild	2	Moderate	3	Severe	4	Not Documented				
0	None																
1	Mild																
2	Moderate																
3	Severe																
4	Not Documented																
517	f_post_mrvalv	<p>Follow-up Valvular Severity <i>Indicate the highest severity of valvular mitral regurgitation. Target Value: The highest value on follow-up</i></p>	<p>radio</p> <table border="1" data-bbox="1044 1665 1247 1864"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Mild</td></tr> <tr><td>2</td><td>Moderate</td></tr> <tr><td>3</td><td>Severe</td></tr> <tr><td>4</td><td>Not Documented</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10310</p>	0	None	1	Mild	2	Moderate	3	Severe	4	Not Documented				
0	None																
1	Mild																
2	Moderate																
3	Severe																
4	Not Documented																
518	f_post_mvaoa	<p>Follow-up Effective Orifice Area (EOA) <i>Indicate the effective orifice area (EOA), in cm2. Target Value: The highest value on follow-up</i></p>	<p>text Field Annotation: v2.1 SeqNo 10315</p>														

519	f_post_mvveamethod	Follow-up Effective Orifice Area Method of Assessment <i>Indicate the method used to measure the effective orifice area. Target Value: The highest value on follow-up</i>	radio <table border="1"> <tr><td>1</td><td>3D planimetry</td></tr> <tr><td>2</td><td>PISA</td></tr> <tr><td>3</td><td>Quantitative doppler</td></tr> <tr><td>4</td><td>Other</td></tr> </table> Field Annotation: v2.1 SeqNo 10320	1	3D planimetry	2	PISA	3	Quantitative doppler	4	Other
1	3D planimetry										
2	PISA										
3	Quantitative doppler										
4	Other										
520	f_post_mvarea	Follow-up Mitral Valve Area <i>Indicate the smallest mitral valve area in cm2. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10325								
521	f_post_mvmeangrad	Follow-up Mean Mitral Gradient <i>Indicate the mean gradient (in mm Hg) across the mitral valve. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10330								
522	f_post_lavol	Follow-up Left Atrial Volume <i>Indicate the left atrial volume in ml, documented by echocardiogram. If the left atrial volume index is documented, leave this field blank. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10335								
523	f_post_lavolindex	Follow-up Left Atrial Volume Index <i>Indicate the left atrial volume index in mL/m2, documented by echocardiogram. If the left atrial volume is documented, leave this field blank. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10340								
524	f_post_lvvisdnm	Follow-up Left Ventricular Internal Systolic Dimension Not Measured <i>Indicate if the left ventricular internal systolic dimension in cm was not measured at follow-up. Target Value: N/A No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 10346	0	No	1	Yes				
0	No										
1	Yes										
525	f_post_lvvisd	Follow-up Left Ventricular Internal Systolic Dimension <i>Indicate the left ventricular internal systolic dimension in cm. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10345								
526	f_post_lviddnm	Follow-up Left Ventricular Internal Diastolic Dimension Not Measured <i>Indicate if the left ventricular internal diastolic dimension in cm was not measured at follow-up. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 10351	0	No	1	Yes				
0	No										
1	Yes										
527	f_post_lvidd	Follow-up Left Ventricular Internal Diastolic Dimension <i>Indicate the left ventricular internal diastolic dimension in cm at follow-up. If more than one LV internal diastolic diameter is available, code the value determined by echocardiography. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10350								
528	f_post_lvesvnm	Follow-up Left Ventricular End Systolic Volume Not Measured <i>Indicate if the left ventricular end systolic volume in ml was not measured at follow-up. Target Value: N/A No Yes</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 10356	0	No	1	Yes				
0	No										
1	Yes										
529	f_post_lvesv	Follow-up Left Ventricular End Systolic Volume <i>Indicate the left ventricular end systolic volume in ml, documented by echocardiogram at follow-up. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10355								
530	f_post_lvedvnm	Follow-up Left Ventricular End Diastolic Volume Not Measured <i>Indicate the left ventricular end diastolic volume in ml, documented by echocardiogram was not measured at follow-up. Target Value: N/A</i>	radio <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> Field Annotation: v2.1 SeqNo 10361	0	No	1	Yes				
0	No										
1	Yes										
531	f_post_lvedv	Follow-up Left Ventricular End Diastolic Volume <i>Indicate the left ventricular end diastolic volume in ml, documented by echocardiogram at follow-up. Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10360								

532	f_post_tr	<p>Follow-up Tricuspid Regurgitation <i>Indicate whether there is evidence of tricuspid valve regurgitation. Enter level of valve function associated with highest risk (i.e., worst performance). Target Value: The value on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Trace/Trivial</td></tr> <tr><td>2</td><td>Mild</td></tr> <tr><td>3</td><td>Moderate</td></tr> <tr><td>4</td><td>Severe</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10365</p>	0	None	1	Trace/Trivial	2	Mild	3	Moderate	4	Severe		
0	None														
1	Trace/Trivial														
2	Mild														
3	Moderate														
4	Severe														
533	f_post_lvot	<p>Left Ventricular Outflow Tract Gradient (Peak) <i>Indicate the peak gradient of the left ventricular outflow tract at follow-up. Target Value: The value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10370</p>												
534	f_post_sam	<p>Systolic Anterior Motion Present <i>Indicate if systolic anterior motion was present at follow-up. Target Value: The value on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10375</p>	0	No	1	Yes								
0	No														
1	Yes														
535	f_kccq12_performed	<p>Section Header: <i>KCCQ</i></p> <p>Follow-Up KCCQ-12 Patient Questionnaire Performed <i>Indicate if the follow-up Kansas City Cardiomyopathy Questionnaire (KCCQ-12) was performed. Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: Any occurrence on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10230</p>	0	No	1	Yes								
0	No														
1	Yes														
536	f_kccq12_1a	<p>Follow-Up KCCQ-12 Question 1a <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1a. Heart Failure Limitation - Showering/bathing Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10231</p>	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity
1	Extremely limited														
2	Quite a bit limited														
3	Moderately limited														
4	Slightly limited														
5	Not at all limited														
6	Limited for other reasons or did not do the activity														
537	f_kccq12_1b	<p>Follow-Up KCCQ-12 Question 1b <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1b. Heart Failure Limitation - Walking 1 block on level ground Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10232</p>	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity
1	Extremely limited														
2	Quite a bit limited														
3	Moderately limited														
4	Slightly limited														
5	Not at all limited														
6	Limited for other reasons or did not do the activity														
538	f_kccq12_1c	<p>Follow-Up KCCQ-12 Question 1c <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 1c. Heart Failure Limitation - Hurrying or jogging Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up Extremely limited Quite a bit limited Moderately limited Slightly limited Not at all limited Limited for other reasons or did not do the activity</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Extremely limited</td></tr> <tr><td>2</td><td>Quite a bit limited</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Not at all limited</td></tr> <tr><td>6</td><td>Limited for other reasons or did not do the activity</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10233</p>	1	Extremely limited	2	Quite a bit limited	3	Moderately limited	4	Slightly limited	5	Not at all limited	6	Limited for other reasons or did not do the activity
1	Extremely limited														
2	Quite a bit limited														
3	Moderately limited														
4	Slightly limited														
5	Not at all limited														
6	Limited for other reasons or did not do the activity														

539	f_kccq12_2	<p>Follow-Up KCCQ-12 Question 2 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 2. Symptom Frequency - Swelling in legs Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Every morning</td></tr> <tr><td>2</td><td>3 or more times per week but not every day</td></tr> <tr><td>3</td><td>1-2 times per week</td></tr> <tr><td>4</td><td>Less than once a week</td></tr> <tr><td>5</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10234</p>	1	Every morning	2	3 or more times per week but not every day	3	1-2 times per week	4	Less than once a week	5	Never over the past 2 weeks				
1	Every morning																
2	3 or more times per week but not every day																
3	1-2 times per week																
4	Less than once a week																
5	Never over the past 2 weeks																
540	f_kccq12_3	<p>Follow-Up KCCQ-12 Question 3 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 3. Symptom Frequency - Fatigue Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>All of the time</td></tr> <tr><td>2</td><td>Several times per day</td></tr> <tr><td>3</td><td>At least once a day</td></tr> <tr><td>4</td><td>3 or more times per week but not every day</td></tr> <tr><td>5</td><td>1-2 times per week</td></tr> <tr><td>6</td><td>Less than once a week</td></tr> <tr><td>7</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10235</p>	1	All of the time	2	Several times per day	3	At least once a day	4	3 or more times per week but not every day	5	1-2 times per week	6	Less than once a week	7	Never over the past 2 weeks
1	All of the time																
2	Several times per day																
3	At least once a day																
4	3 or more times per week but not every day																
5	1-2 times per week																
6	Less than once a week																
7	Never over the past 2 weeks																
541	f_kccq12_4	<p>Follow-Up KCCQ-12 Question 4 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 4. Symptom Frequency - shortness of breath Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>All of the time</td></tr> <tr><td>2</td><td>Several times per day</td></tr> <tr><td>3</td><td>At least once a day</td></tr> <tr><td>4</td><td>3 or more times per week but not every day</td></tr> <tr><td>5</td><td>1-2 times per week</td></tr> <tr><td>6</td><td>Less than once a week</td></tr> <tr><td>7</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10236</p>	1	All of the time	2	Several times per day	3	At least once a day	4	3 or more times per week but not every day	5	1-2 times per week	6	Less than once a week	7	Never over the past 2 weeks
1	All of the time																
2	Several times per day																
3	At least once a day																
4	3 or more times per week but not every day																
5	1-2 times per week																
6	Less than once a week																
7	Never over the past 2 weeks																
542	f_kccq12_5	<p>Follow-Up KCCQ-12 Question 5 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 5. Symptom Frequency - sleep sitting up due to shortness of breath Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up Every night 3 or more times per week but not every day 1-2 times per week Less than once a week Never over the past 2 weeks</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Every night</td></tr> <tr><td>2</td><td>3 or more times per week but not every day</td></tr> <tr><td>3</td><td>1-2 times per week</td></tr> <tr><td>4</td><td>Less than once a week</td></tr> <tr><td>5</td><td>Never over the past 2 weeks</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10237</p>	1	Every night	2	3 or more times per week but not every day	3	1-2 times per week	4	Less than once a week	5	Never over the past 2 weeks				
1	Every night																
2	3 or more times per week but not every day																
3	1-2 times per week																
4	Less than once a week																
5	Never over the past 2 weeks																
543	f_kccq12_6	<p>Follow-Up KCCQ-12 Question 6 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 6. Quality of Life - effect on enjoyment of life due to heart failure Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>It has extremely limited my enjoyment of life</td></tr> <tr><td>2</td><td>It has limited my enjoyment of life quite a bit</td></tr> <tr><td>3</td><td>It has moderately limited my enjoyment of life</td></tr> <tr><td>4</td><td>It has slightly limited my enjoyment of life</td></tr> <tr><td>5</td><td>It has not limited my enjoyment of life at all</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10238</p>	1	It has extremely limited my enjoyment of life	2	It has limited my enjoyment of life quite a bit	3	It has moderately limited my enjoyment of life	4	It has slightly limited my enjoyment of life	5	It has not limited my enjoyment of life at all				
1	It has extremely limited my enjoyment of life																
2	It has limited my enjoyment of life quite a bit																
3	It has moderately limited my enjoyment of life																
4	It has slightly limited my enjoyment of life																
5	It has not limited my enjoyment of life at all																
544	f_kccq12_7	<p>Follow-Up KCCQ-12 Question 7 <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 7. Quality of life - remaining life with heart failure Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>radio</p> <table border="1"> <tr><td>1</td><td>Not at all satisfied</td></tr> <tr><td>2</td><td>Mostly dissatisfied</td></tr> <tr><td>3</td><td>Somewhat satisfied</td></tr> <tr><td>4</td><td>Mostly satisfied</td></tr> <tr><td>5</td><td>Completely satisfied</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10239</p>	1	Not at all satisfied	2	Mostly dissatisfied	3	Somewhat satisfied	4	Mostly satisfied	5	Completely satisfied				
1	Not at all satisfied																
2	Mostly dissatisfied																
3	Somewhat satisfied																
4	Mostly satisfied																
5	Completely satisfied																

545	f_kccq12_8a	<p>Follow-Up KCCQ-12 Question 8a <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8a. Social limitation - hobbies, recreational activities Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10240</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														
546	f_kccq12_8b	<p>Follow-Up KCCQ-12 Question 8b <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8b. Social limitation - working or doing household chores Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up Severely limited Limited quite a bit Moderately limited Slightly limited Did not limit at all Does not apply or did not do for other reasons</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10241</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														
547	f_kccq12_8c	<p>Follow-Up KCCQ-12 Question 8c <i>Indicate the patient's response to the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Question 8c. Social limitation - visiting family or friends Note(s): Please refer to the separate KCCQ-12 questionnaire for patient instructions. For additional information on scoring, please refer to Seq Num 10243, Follow-Up KCCQ-12 Overall Summary Score. Target Value: The value on follow-up</i></p>	<p>dropdown</p> <table border="1"> <tr><td>1</td><td>Severely limited</td></tr> <tr><td>2</td><td>Limited quite a bit</td></tr> <tr><td>3</td><td>Moderately limited</td></tr> <tr><td>4</td><td>Slightly limited</td></tr> <tr><td>5</td><td>Did not limit at all</td></tr> <tr><td>6</td><td>Does not apply or did not do for other reasons</td></tr> </table> <p>Field Annotation: v2.1 SeqNo 10242</p>	1	Severely limited	2	Limited quite a bit	3	Moderately limited	4	Slightly limited	5	Did not limit at all	6	Does not apply or did not do for other reasons
1	Severely limited														
2	Limited quite a bit														
3	Moderately limited														
4	Slightly limited														
5	Did not limit at all														
6	Does not apply or did not do for other reasons														
548	f_kccq12_overall	<p>Follow-Up KCCQ Overall Summary Score <i>(Auto Calculated) This field is auto-populated by your application. Kansas City Cardiomyopathy Questionnaire (KCCQ-12) Overall Summary Score. Note(s): The 12 patient responses are reduced into four summary scores (Physical Limitation Score, Symptom Frequency Score, Quality of Life Score, Social Limitation Score). The four summary scores are used to calculate the Overall Summary Score. For more information, please refer to the KCCQ-12 Scoring Instructions document provided by the STS/ACC TVT Registry. Target Value: The value on follow-up</i></p>	<p>text</p> <p>Field Annotation: v2.1 SeqNo 10243</p>												
549	f_acei_any	<p>Section Header: Medications ACE Inhibitor (any)</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded				
0	No														
1	Yes														
2	Contraindicated														
3	Blinded														
550	f_arb_any	<p>ARB (any)</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded				
0	No														
1	Yes														
2	Contraindicated														
3	Blinded														
551	f_asa_any	<p>Aspirin (any)</p>	<p>radio</p> <table border="1"> <tr><td>0</td><td>No</td></tr> <tr><td>1</td><td>Yes</td></tr> <tr><td>2</td><td>Contraindicated</td></tr> <tr><td>3</td><td>Blinded</td></tr> </table>	0	No	1	Yes	2	Contraindicated	3	Blinded				
0	No														
1	Yes														
2	Contraindicated														
3	Blinded														

552	f_betablock	Beta Blocker (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
553	f_antiarrhyth	Antiarrhythmic (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
554	f_warfarin	Warfarin	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
555	f_dabigatran	Dabigatran	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
556	f_p2y12_any	P2Y12 (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
557	f_factor_xa	Factor Xa inhibitor	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
558	f_acei_arb	ACE-I or ARB (Any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
559	f_aldo	Aldosterone Antagonists	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
560	f_loop_diur	Loop diuretic	radio 0 No 1 Yes 2 Contraindicated 3 Blinded

561	f_thiazides	Thiazides	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
562	f_diur_other	Diuretics (Other)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
563	f_anticoag_any	Anticoagulants (any)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
564	f_asa_alone	Aspirin (alone)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
565	f_asa_dual	Aspirin (dual antiplatelet therapy)	radio 0 No 1 Yes 2 Contraindicated 3 Blinded
566	f_meddose_discharge	Loop diuretic Dose (mg) at discharge	text Field Annotation: v2.1 SeqNo 9110
567	follow_up_complete	Section Header: <i>Form Status</i> Complete?	dropdown 0 Incomplete 1 Unverified 2 Complete
Instrument: Follow Up Event (follow_up_event)			^ Collapse
568	f_eventoccurred	Section Header: <i>Follow-up Event</i> Follow-Up Event Occurred <i>Indicate if any adverse event, intervention, or surgical procedures occurred between discharge and follow-up, or between follow-up assessment periods. Target Value: Any occurrence on follow-up</i>	radio 0 No 1 Yes Field Annotation: v2.1 SeqNo 10245
569	f_eventdate_deid	Follow-Up Event Date (Deid) <i>Indicate the date of any adverse events, interventions, or surgical procedures that occurred between discharge and 30-day follow-up, or between follow-up assessment periods. Note(s): If an event occurred more than once, specify each Follow-Up Event ID (10246) with its corresponding date. If month or day are unknown, enter 01 Target Value: The value on follow-up</i>	text (date_mdy) Field Annotation: v2.1 SeqNo 10247
570	f_eventid	Follow-Up Event ID <i>Indicate all adverse events, interventions or surgical procedures that occurred between discharge and 30-day follow-up, or between follow-up assessment periods. Note(s): If an event occurred more than once, specify each event with its corresponding Follow-Up Event Date (Seq Number 10247). Target Value: The value on follow-up</i>	text Field Annotation: v2.1 SeqNo 10246
571	f_eventname	Follow-Up Event Name	text Field Annotation: v2.1 SeqNo 10247

	572	follow_up_event_complete	Section Header: <i>Form Status</i> Complete?	dropdown <table border="1"><tr><td>0</td><td>Incomplete</td></tr><tr><td>1</td><td>Unverified</td></tr><tr><td>2</td><td>Complete</td></tr></table>	0	Incomplete	1	Unverified	2	Complete
0	Incomplete									
1	Unverified									
2	Complete									