PEDIATRIC HEART TRANSPLANT STUDY

FORM 09: 2010: **Coronary Revascularization** (PG 1 of 1)

To be filled out post-transplant

ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐ ☐

P	Instituitional Code	Sequential Patient Number	Patient Initials	Tran #

1a. Date of Procedure: ☐☐ ☐☐ ☐☐
(MO | DAY | YR)

1b. Intravascular Ultrasound Performed: ☐ Yes ☐ No
Use separate form for separate procedure, even if on same date
If yes, check vessel(s) studied: ☐ L Main ☐ LAD ☐ LCX ☐ RCA
Stanford Score: __________ Stanford Score, Not Done ☐

* **Percutaneous Procedures Codes**
(write letter code in space for each lesion):
PTCA = Angioplasty
DA = Directional Atherectomy
AA = Angiojet Atherectomy
S = Stent [write brand(s) and size(s) in comments]
RA = Rotational Atherectomy

** **Vessel:**
LM = Left Main (write under comments)
LCx = Left Circumflex
RCA = Right Coronary Artery
PLB1 – PLB3 = Branches 1-3 of the PLSA
LAD = Left Anterior Descending
RI = Ramus Intermedius
PDA = Posterior Descending
PLSA = Posterior Lateral Segmen Artery Aorta
D1-D3 = Diagonals 1-3
M1-M3 = Marginals 1-3

2. ☐ **PTCA/Stent/Atherectomy: (complete one section for each lesion treated, indicate all procedures performed):**

2a. *Procedure Codes:	****Vessel:**			**Location:**	**Lesion Characteristic:**	**Pre Procedure Stenosis:**	**Post Procedure Stenosis:**
______________	☐ LAD	☐ RCA	☐ PDA	☐ Prox	☐ Eccentric	_______ %	_______ %
If other, specify:	☐ D-1	☐ LCx	☐ PLSA	☐ Mid	☐ Concentric		
______________	☐ D-2	☐ M1	☐ PLB1	☐ Distal	☐ Tubular		
	☐ D-3	☐ M2	☐ PLB2				
		☐ M3	☐ PLB3				

Comments on Procedure:
____
____
____
____

2b. *Procedure Codes:	****Vessel:**			**Location:**	**Lesion Characteristic:**	**Pre Procedure Stenosis:**	**Post Procedure Stenosis:**
______________	☐ LAD	☐ RCA	☐ PDA	☐ Prox	☐ Eccentric	_______ %	_______ %
If other, specify:	☐ D-1	☐ LCx	☐ PLSA	☐ Mid	☐ Concentric		
______________	☐ D-2	☐ M1	☐ PLB1	☐ Distal	☐ Tubular		
	☐ D-3	☐ M2	☐ PLB2				
		☐ M3	☐ PLB3				

Comments on Procedure:
____
____
____
____

3. Coronary Artery Bypass Grafting: ☐ **Yes** ☐ **No** (Please attach operative note with any identifiable patient information removed. **Be sure to include PHTS Pt. # and intials.**)

Person completing this form: ______________________________ Date original form mailed (do not send copy) __________

PRINT IN BLACK INK ONLY. USE THIS FORM FOR ALL PATIENTS OR EVENTS AFTER JANUARY 1, 2010