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| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age \_\_\_\_ Occupation **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Social Hx:** □ lives with spouse / partner □ lives alone □ lives in retirement home □ NFA  |
| **Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ no FP Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PMH : check all that apply** □ previous cardioversion ------------------------------- date □previous ablation ---------------------- date□ HTN □ CAD □ MI □ cardiac surgery □ HF □ valvular heart disease (MS, AS) □ diabetes □ thyroid disease □ dyslipidemia □ asthma on puffers □ COPD □ OSA □ confirmed by sleep study □ on CPAP□ pulmonary HTN □ P. emboli □ GI bleed confirmed by □colonoscopy ­­­­­­----------------date □ OGD----------------------date **Social Hx:** smoker □never □ current\_\_\_\_\_\_(pack per day x years) □ never □ Ex quit \_\_\_\_\_\_\_\_ Alcohol □ never □ rarely □ drinks per day \_\_\_\_\_\_\_ □ drinks per week \_\_\_\_\_\_\_ Caffeine □ none □ avg/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other Significant PMH: ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------ Family History:** -----------------------------------------------------------------------------------------------------------------------------**Chief Complaint:** (reason for ED visit **------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------** **------------------------------------------------------------------------------------------------ Severity AF Functional Class****------------------------------------------------------------------------------------------------** Class 0 –no symptoms ---------------------------------------------------------------------------------------------------------------------- Class 1 – minimal & infrequent episodes-------------------------------------------------------------------------------------------------------------------- Class 2- mild awareness, rare episodes--------------------------------------------------------------------------------------------------------------------- Class 3- moderate, more common episodes-------------------------------------------------------------------------------------------------------------------- Class 4 – severe, unpleasant symptoms with syncope heart failure**Exercise Tolerance/ Functional Capacity: ----------------------------------------------------------------------------------------------****-----------------------------------------------------------------------------------------------------------------------------------------------------****HPI**: presented to the ED on\_\_\_\_\_\_\_\_\_\_\_\_date)□ AF confirmed □ unclear □ new onset □ persistent □ permanent**------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------****------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**ECG at time of discharge from ED **----------------------------** ECG today --------------**Medications:** □ NKDA□allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(reaction) See medication reconciliation □BB □CCB □ Digoxin □ antiarrhythmic □ anticoagulation □ diuretic □ ACE |

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| **CV Physical Exam Findings: Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_Kg *or*  \_\_\_\_\_\_Lb****JVP \_\_\_\_\_\_\_\_\_ HJR** □ negative □ positive **Carotid bruit** 🞎 N 🞎 Y Enlarged thyroid 🞎 N 🞎 Y  **HR** radial pulse \_\_\_\_\_bpm 🞎 regular 🞎 irregular B/P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Heart Sounds** □normal S1 🞎 normal S2 🞎 e**xtra heart sounds** □ N □ Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Murmur** □ N □ Y \_\_\_\_\_\_\_\_\_\_\_\_\_**RV Heave** □ N □ Y **Apex** □ normal □ displaced **Chest sounds** □clear 🞎 rales / crackles 🞎 wheezes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Hepatomegaly** 🞎 N 🞎Y **Peripheral edema** 🞎 N 🞎 Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Laboratory: date of results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Troponin □ negative □ positive Electrolytes: Creatinine: eGFR: Coagulation: TSH/dateLipids/date: |  **CHADS₂ Score**□ **CHF 1**□ **HTN (or treated HTN) 1**□ **Age ≥ 75 1** □ **Diabetes 1**□ **Stroke** **/ previous emboli 2**  **Score \_\_\_** **Score 0:**□ no antithrombotic **(no other risk factors)**□ vascular disease **= ASA (prior MI, CAD, PVD, claudication)**□age ≥ 65 ***=* OAC****CHADS₂ = 1+ = OAC** **HAS-BLED** □ \*Hypertension (SBP> 160 mmHg) **1**  □ Abnormal renal function **1**□ Abnormal liver function **1** □ Stroke (past history) **1** □ \*Bleeding history/ predisposition **1**□ \*Labile INR (low, high, not therapeutic) **1**□ Elderly age > 65 **1**□ \*Drugs (ASA,NSAIDs) **1**□ \*ETOH abuse **1** \*consider improving modifiable risk factors |
|  **Investigations ordered:** □ ECHO □ Holter monitor x \_\_\_\_\_ hoursAssessment: (type of AFib /FL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Etiology AF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CHADS ₂ \_\_\_\_\_\_\_ CHA₂DS₂ VASC \_\_\_\_\_\_\_\_\_\_\_\_\_\_Issues: Plan : □ no OAC □ Aspirin 81 mg □ Warfarin □ Dabigatran 150 mg BID □ Dabigatran 110 mg BID (rationale)□ Apixaban 5 mg BID □ Rivaroxaban 20 mg daily (rationale)  |