American Heart Association®
Get With The Guidelines®
Heart Failure

GWTG-HF Case Record Full Form (CRF) **June 2023**

Patient ID:			
DEMOGRAPHIC DATA			
Sex	○ Male ○ Female ○ Unknown		
Patient Gender Identify	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other. _____ ○ Did not disclose.		
Patient-Identified Sexual Orientation	○ Straight or heterosexual ○ Lesbian or gay ○ Queer, pansexual, and/or questioning ○ Something else; please specify. _____. ○ Don't know ○ Declined to answer		
*+^# Date of Birth	___/___/____ (MM/DD/YYYY)	Patient Postal Code	_____ - _____
Payment Source	❑ Medicare Title 18 ❑ Medicaid Title 19 ❑ Medicare – Private/HMO/PPO/Other ❑ Medicaid– Private/HMO/PPO/Other	❑ Private/HMO/PPO/Other ❑ VA/CHAMPVA/Tricare ❑ Self-pay/No Insurance ❑ Other/Not Documented/UTD	
External Tracking ID	_____		
Race and Ethnicity			
+ Race	❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Asian	❑ Native Hawaiian or Pacific Islander ❑ UTD	
Hispanic Ethnicity	○ Yes	○ No/UTD	
Arrival and Admission Information			
Internal Tracking ID:	_____	Physician/Provider NPI:	_____
+ Arrival Date/Time:	___/___/_____ ___: ___	❑ Unknown Date/UTD	
Admission Date:	___/___/_____		
Point of Origin for Admission or Visit:	❑ Non-Healthcare Facility Point of Origin ❑ Clinic ❑ Transfer From a Hospital (Different Facility) ❑ Transfer From a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) ❑ Transfer From Another Health Care Facility ❑ Emergency Room ❑ Information Not Available ❑ Transfer From a Hospice and is Under a Hospice Plan of Care or is Enrolled in a Hospice Program		
Discharge Date/Time	___/___/_____ ___: ___		
Medical History (Select all that apply):			
❑ Anemia	❑ Heart failure		

- ❑ Atrial Fib (chronic or recurrent)
- ❑ Atrial Flutter (chronic or recurrent)
- ❑ ATTR-CM
  - ❍ Hereditary
  - ❍ Wild-type
- ❑ CAD
- ❑ CardioMEMs (implantable hemodynamic monitor)
- ❑ COPD or Asthma
- ❑ CRT-D (cardiac resynchronization therapy with ICD)
- ❑ CRT-P (cardiac resynchronization therapy-pacing only)
- ❑ CVA/TIA
- ❑ Depression
- ❑ Diabetes
- ❑ Dialysis (chronic)
- ❑ Emerging Infectious Disease
  - ❍ MERS
  - ❍ SARS-COV-1
  - ❍ SARS-COV-2 (COVID-19)
  - ❍ Other infectious respiratory pathogen
- ❑ Familial hypercholesterolemia
- ❑ Heart Transplant
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ ICD only
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Prior CABG
- ❑ Prior MI
- ❑ Prior PCI
- ❑ Renal insufficiency - chronic (SCr>2.0)
- ❑ Sleep-Disordered Breathing
- ❑ TAVR
- ❑ TMVR
- ❑ Tricuspid Valve procedure
- ❑ Valvular Heart Disease
- ❑ Ventricular assist device

❑ No Medical History

History of cigarette smoking? (In the past 12 months)	❍ Yes	❍ No
History of vaping or e-cigarette use in the past 12 months?	❍ Yes	❍ No/ND
Known history of HF prior to this admission?	❍ Yes	❍ No

Diagnosis

Heart Failure Diagnosis	❑ Heart Failure with CAD	❑ Heart Failure, no CAD	❑ Heart Failure, Secondary Diagnosis
Atrial Fibrillation (At presentation or during hospitalization)	❍ Yes	❍ No	
Atrial Flutter (At presentation or during hospitalization)	❍ Yes	❍ No	
New Diagnosis of Diabetes	❍ Yes	❍ No	❍ Not Documented

Active bacterial or viral infection at admission or during hospitalization

- ❑ None
- ❑ Bacterial infection
- ❑ Emerging Infectious Disease
  - ❑ MERS
  - ❑ SARS-COV-1
  - ❑ SARS-COV-2 (COVID-19)
- ❑ Influenza
- ❑ Seasonal Cold
- ❑ Other viral infection

Medications Used Prior to Admission: [Select all that apply]

- ❑ Patient on no meds prior to admission
- ❑ Anti-hyperglycemic medications
- ❑ DPP-4 Inhibitors
- ❑ GLP-1 receptor agonist
- ❑ Insulin
- ❑ Metformin
- ❑ Sulfonylurea
- ❑ Thiazolidinedione
- ❑ Other Oral Agents
- ☐ Mavacamten
- ☐ Mineralocorticoid Receptor Antagonist (MRA)
- ☐ SGLT2
- ☐ Vericiguat

❑ Other injectable/subcutaneous agents					
EXAMS/LABS AT ADMISSION					
Height					
Weight					
Labs (Closest to Admission)	+Serum Creatinine (Admission)	_____	❍ mg/dL	❍ µmol/L	❑ Not Available
	+Potassium (K+) (Admission)	_____	❍ mEq/L	❍ mmol/L	❑ Not Available
	+ EKG QRS Duration (ms)	_____		❑ Not Available	
	+ EKG QRS Morphology	❍ Normal ❍ LBBB	❍ RBBB ❍ NS-IVCD	❍ Paced ❍ Not available	
Clinical Codes					
ICD-10-CM Principal Diagnosis Code					
IN-HOSPITAL CARE					
Procedures					

❑ No Procedures
❑ Cardiac Cath/Coronary Angiography
❑ CardioMEMs (implantable hemodynamic monitor)
❑ Coronary Artery Bypass Graft
❑ CRT-P (cardiac resynchronization therapy-pacing only)
❑ Dialysis or Ultrafiltration unspecified
❑ ICD only
❑ Mechanical Ventilation
❑ PCI
❑ Right Cardiac Catheterization
❑ TMVR
❑ Tricuspid Valve Procedure
❑ Atrial Fibrillation Ablation or Surgery
❑ Cardiac Valve Surgery
❑ Cardioversion
❑ CRT-D (cardiac resynchronization therapy with ICD
❑ Dialysis
❑ ECMO
❑ Intra-aortic Balloon Pump
❑ Left Ventricular Assist Device
❑ Pacemaker
❑ PCI with stent
❑ Stress Testing
❑ TAVR
❑ Transplant (Heart)
❑ Ultrafiltration

*+^ EF – Quantitative	_____ %	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
*+^ EF – Qualitative	❍ Not Applicable ❍ Normal or mild dysfunction ❍ Qualitative moderate/severe dysfunction ❍ Performed/results not available ❍ Planned after discharge ❍ Not performed	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
Documented LVSD?	○ Yes	○ No	
* LVF Assessment?	○ Yes ○ No	○ Not done, Reason Documented	
+ Was the patient ambulating at the end of hospital day 2?		❍ Yes ❍ No	❍ Not Documented
+ Was DVT prophylaxis initiated by the end of hospital day 2?		❍ Yes ❍ No	❍ Contraindicated
+ Influenza Vaccination	○ Influenza vaccine was given during this hospitalization during the current flu season ○ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ○ Documentation of patient's refusal of influenza vaccine ○ Allergy/Sensitivity to influenza or if medically contraindicated ○ Vaccine not available ○ None of the above/Not Documented/UTD		

COVID-19 Vaccination	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/Sensitivity to COVID-19 or if medically contraindicated ○ Vaccine not available ○ None of the above/Not Documented/UTD
COVID-19 Vaccination Date	_____/_____/_____ ❑ Unknown
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND
+ Pneumococcal Vaccination	○ Pneumococcal vaccine was given during this hospitalization ○ Pneumococcal vaccine was received in the past, not during this hospitalization ○ Documentation of patient's refusal of pneumococcal vaccine ○ Allergy/sensitivity or if medically contraindicated to pneumococcal vaccine ○ None of the above/Not Documented/UTD

DISCHARGE INFORMATION			
*+^ What was the patient's discharge disposition on the day of discharge?	1 – Home 2 – Hospice – Home 3 – Hospice – Health Care Facility 4 – Acute Care Facility 5 – Other Health Care Facility		6 – Expired 7 – Left Against Medical Advice/AMA 8 – Not documented or Unable to Determine (UTD)
If other Health Care Facility:	○ Skilled Nursing Facility (SNF) ○ Inpatient Rehabilitation Facility (IRF) ○ Long Term Care Hospital (LTCH)		○ Intermediate Care Facility (ICF) ○ Other
Skilled Nursing Facility	_____		
*+^ When is the earliest physician/APN/PA documentation of comfort measures only?	○ Day 0 or 1 ○ Day 2 or after		○ Timing unclear ○ Not Documented
Labs (Closest to Discharge)	+Serum Creatinine (Discharge)	_____	❍ mg/dL ❍ µmol/L
	+Potassium (K+) (Discharge)	_____	❍ mEq/L ❍ mmol/L

Discharge Medications			
ACE Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ACE Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ACEI:	❑ Contraindicated ❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial		

	❑ Patient Reason ❑ System Reason ❑ Other Reason		
ARB Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARB Medication/ Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ARB:	❑ Contraindicated ❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reasons		
ARNI Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARNI Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	○ Contraindicated ○ ACE inhibitor use within the prior 36 hours ❑ Allergy ❑ Hyperkalemia ❑ Hypotension ❑ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reasons		
Reasons for not switching to ARNI at discharge:	❍ Yes ❍ No	❍ ARNI was prescribed at discharge	
If Yes,	❑ New Onset Heart Failure ❑ Not previously tolerating ACEI/ARB	❑ NYHA Class I ❑ NYHA Class IV	
Beta Blocker Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Beta Blocker Class	❍ Evidence-Based Beta Blocker ❍ Non-Evidence-Based Beta Blocker ❍ Unknown Class		
Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	❑ Contraindicated ❑ Asthma ❑ Fluid Overload ❑ Low Blood Pressure ○ Patient recently treated with an intravenous positive inotropic agent ○ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason		

Beta Blocker Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
SGLT2 Inhibitor Prescribed?	❍ Yes ❍ No ❍ NC Medication: Dosage: Frequency:		
Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:	❑ Contraindicated ❑ Patient currently on dialysis ❑ Ketoacidosis ❑ Known hypersensitivity to the medication ❑ Type I diabetes (not approved for use in patients with Type I diabetes due to increased risk of ketoacidosis) ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reason		
Mineralocorticoid Receptor Antagonist (MRA) Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
MRA Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Was there a dose increase since prior to admission?	❍ Yes ❍ No/ND		
Potassium ordered or planned after discharge?	❍ Yes ❍ No/ND		
Renal function test scheduled	❍ Yes ❍ No/ND		
Contraindications or Other Documented Reason(s) for Not Providing Mineralocorticoid Receptor Antagonist (MRA) at Discharge	❑ Contraindicated ❑ Allergy due to MRA ❑ Hyperkalemia ❑ Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women. ❑ Other contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reason		
Anticoagulation Therapy Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Anticoagulation Therapy Class	❑ Warfarin ❑ Direct Thrombin Inhibitor	❑ Factor Xa Inhibitor ❑ Other	
	Medication:	Dosage:	Frequency:
Anticoagulation Contraindication(s):	❑ Contraindicated ❑ Allergy to or complication r/t anticoagulation therapy (hx or current) ❑ Risk for bleeding or discontinued due to bleeding ❑ Serious side effect to medication ❑ Terminal illness/Comfort Measures Only ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial		

	❑ Patient Reason ❑ System Reason ❑ Other			
Hydralazine Nitrate Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)			
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	❑ Contraindicated ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reasons			
Anti-hyperglycemic Prescribed?	❍ Yes ❍ No ❍ NC			
Antihyperglycemic Class/Medication	Class:		Medication:	
	Class:		Medication:	
	Class:		Medication:	
ASA Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)			
ASA Medication/Dosage/Frequency	Medication:		Dosage:	Frequency:
Other Antiplatelets Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)			
Other Antiplatelets Medication/Dosage/Frequency	Medication:		Dosage:	Frequency:
Clopidogrel Prescribed?	❍ Yes ❍ No ❍ NC			
Clopidogrel Dosage/Frequency	Dosage:		Frequency:	
Ivabradine Prescribed?	❍ Yes ❍ No ❍ NC			
Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:	❑ Contraindicated ❑ Allergy to Ivabradine ❑ Patient 100% atrial or ventricular paced ❑ Other Contraindications ❑ Not Eligible ❑ NYHA class I or IV ❑ Not in sinus rhythm ❑ New Onset of HF ❑ Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated ❑ Not Tolerant		❑ Patient Enrolled in Clinical Trial ❑ Patient Reasons ❑ System Reasons ❑ Other Medical Reasons	
Lipid Lowering Medication Prescribed?	❍ Yes ❍ No ❍ NC			
Lipid Lowering Class/Medication/Dosage/Frequency	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:

Omega-3 Prescribed?	❍ Yes ❍ No ❍ NC

Other Medications

- ❑ Antiarrhythmic (Discharge)
  - ❑ Amiodarone
  - ❑ Dofetilide
  - ❑ Sotalol
  - ❑ Other antiarrhythmics
- ❑ Ca Channel Blocker (Discharge)
- ❑ Digoxin (Discharge)
- ❑ Diuretic (Discharge)
  - ❑ Loop Diuretic
  - ❑ Thiazide Diuretic
- ❑ Finerenone
- ❑ Mavacamten
- ❑ Nitrate (Discharge)
- ❑ Ranolazine
- ❑ Renin Inhibitor (Discharge)
- ❑ Vericiguat
- ❑ Other Anti-Hypertensive
- ❑ Other medications at discharge

Other Therapies

CRT Therapy

+CRT-D Placed or Prescribed?	❍ Yes	❍ No
+CRT-P Placed or Prescribed?	❍ Yes	❍ No
+Reason for not Placing or Prescribing?	❍ Yes	❍ No

+Documented Reason(s) for Not Placing or Prescribing CRT Therapy?	❑ Contraindications ❑ Not receiving optimal medical therapy ❑ Not NYHA functional Class III or ambulatory Class IV ❑ Patient Reason	❑ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF ❑ System Reason

Risk Interventions

Smoking Cessation Counseling Given	❍ Yes	❍ No
Smoking Cessation Therapies Prescribed (select all that apply)	❑ Treatment Not Specified ❑ Counseling Only ❑ Over the Counter Nicotine Replacement Therapy	❑ Prescription Medications ❑ Other

Discharge Instructions

Activity Level	❍ Yes	❍ No	Diet (Salt restricted)	❍ Yes ❍ No
Follow-up	❍ Yes	❍ No	Medications	❍ Yes ❍ No
Symptoms Worsening	❍ Yes	❍ No	Weight Monitoring	❍ Yes ❍ No
Follow-up Visit Scheduled	❍ Yes	❍ No	*+^ Date/Time of first follow-up visit:	___/___/____ ___:___
* Location of first follow-up visit:			❍ Office Visit ❍ Home Health Visit	❍ Telehealth ❍ Not Documented
*+^ Medical or Patient Reason for no follow-up appointment being scheduled?			❍ Yes	❍ No
Follow-up Phone Call Scheduled	❍ Yes	❍ No	Date/Time of first follow-up phone call:	___/___/____ ❍ Unknown
Follow-up appointment scheduled for diabetes management?	❍ Yes	❍ No	Date of diabetes management follow-up visit:	___/___/____ (MM/DD/YYYY) ❍ Unknown

Other Risk Interventions

TLC (Therapeutic Lifestyle Change) Diet	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referred to Outpatient Cardiac Rehab Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referral to Outpatient HF Management Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referral My HF Guide/AHA Heart Failure Interactive Workbook	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable

^ Provision of at least 60 minutes of Heart Failure Education by a qualified educator	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advance Directive Executed	❍ Yes		❍ No	

Post Discharge Transition			
Care Transition Record Transmitted	❍ By the seventh post-discharge day ❍ Exists, but not transmitted by the seventh post-discharge day ❍ No Care Transition Record/UTD		
Care Transition Record Includes	❑ All were included *(Check all yes)*		
	Discharge Medications	❍ Yes	❍ No
	Follow-up Treatment(s) and Service(s) Needed	❍ Yes	❍ No
	Procedures Performed During Hospitalization	❍ Yes	❍ No
	Reason for Hospitalization	❍ Yes	❍ No
	Treatment(s)/Service(s) Provided	❍ Yes	❍ No

Health Related Social Needs Assessment		
During this admission, was a standardized health related social needs form or assessment completed?	❍ Yes	❍ No/ND
If yes, identify the areas of unmet social need. (select all that apply):	❑ None ❑ Education ❑ Employment ❑ Financial Strain ❑ Food ❑ Living Situation/Housing	❑ Mental Health ❑ Personal Safety ❑ Substance Abuse ❑ Transportation Barriers ❑ Utilities

