

PERFUSION DOWNUNDER COLLABORATION FORM



DATA SET

Basic procedural data will be entered on all cases performed at centre
(this is necessary to allow us to clearly define a denominator for future work)

Affix Patient
Sticker Here

Clinical Definitions	
Clinical Procedure Data	
Eligible PDU	Isolated CABG/MVR/AVR or CABG + MVR/AVR
Urgency	Urgency of operation. Elective-could be deferred without risk, Urgent-medical reason for operating this admission, Emergency-Unscheduled surgery required in next available theatre on same day due to cardiac compromise, Salvage-CPR en route to OR
Critical Preoperative State	Critical preoperative state Ventricular Tachycardia / Ventricular Fibrillation or aborted sudden death, preoperative cardiac massage, preoperative ventilation before anaesthetic room, preoperative inotropes or IABP, preoperative Acute Renal Failure
Previous Cardiac Surgery	Previous surgical replacement and/or repair of a cardiac valve by any approach, and/or CABG either with or without CPB or other: Any other previous cardiac surgery, including operation on the ascending aorta and/or aortic arch, including pericardiectomy.
Clinical General Data	
Family History	Whether any direct blood relatives (parents, siblings, children) have had any of the following at age <55 - a: Angina, b: Myocardial infarction (MI), c: Sudden cardiac death presumed to be from ischaemic heart disease because of no other obvious cause, d: Coronary intervention.
Current Smoker	Patients having smoked cigarettes within one month of surgery are considered to be current smokers.
Smoking History	A history confirming any form of tobacco use in the past.
Diabetes	A history of diabetes, regardless of type, duration of disease or need for anti-diabetic agents.
Diabetes Control Method	Method of diabetic control, at time of intervention. The most aggressive therapy should be indicated as per the following order: insulin > oral > diet. Section requirement one choice only - None: No treatment for diabetes, Diet: Diet treatment only, Oral: Oral agent treatment, Insulin: Insulin treatment (includes any combination of above with insulin).
Hypercholesterolemia	Whether the patient has a history of hypercholesterolemia diagnosed and/or treated by a physician, and/or Cholesterol > 5.0 mmol.
Hypertension	Does the patient have a diagnosis of hypertension documented by one of the following - a: Documented history of hypertension diagnosed and treated with medication, diet and/or exercise, b: Blood pressure >140 systolic or >90 diastolic on at least 2 occasions, c: Currently on antihypertensive medication.
Pulmonary Hypertension	History of pulmonary hypertension, or measured systolic pulmonary artery pressure >60mmHg
Chronic Pulmonary Disease	Whether the patient has chronic lung disease; including emphysema, chronic bronchitis, asthma (treated with medication) or bronchiectasis.
Extracardiac Arteriopathy	Extracardiac arteriopathy One or more of claudication, carotid occlusion or >50% stenosis, previous or planned intervention on the abdominal aorta, limb arteries or carotids
Renal Dialysis	Renal dialysis preoperatively
History of Stroke	History of previous stroke at any time preoperatively
Carotid Bruits	Diagnosis of carotid bruits preoperatively
Neurological Dysfunction	Neurological dysfunction Disease severely affecting ambulation or day-to-day functioning
Cerebrovascular Disease	Whether the patient has had Cerebrovascular Disease, documented by any one of the following - a: Unresponsive coma >24 hrs. b: CVA (symptoms >72 hrs after onset). c: RIND (recovery within 72 hrs). d: TIA (recovery with 24 hrs). e: Non-invasive carotid test with >75% stenosis.
CVD Type	What type of Cerebrovascular Disease does the patient have? Please select the most severe type of cerebrovascular disease experienced by the patient. Severity is in the order: Coma>CVA>RIND/TIA>Carotid. Choose one of the following -Coma: Unresponsive coma >24 hrs. CVA: CVA (symptoms >72 hrs after onset). RIND: RIND (recovery within 72 hrs). TIA: TIA (recovery with 24 hrs). Carotid>75%: Non-invasive carotid test with >75% occlusion.
CVD When	Those events occurring within two weeks of the surgical procedure are considered recent, while all others are considered remote.
Clinical Cardiac Data	
Angina (Classification)	Canadian Cardiovascular Society Classification. The highest class leading to episode of hospitalisation and/or intervention - 0: No angina symptoms. 1: Ordinary physical activity, such as walking or climbing the stairs does not cause angina. Angina may occur with strenuous, rapid or prolonged exertion at work or recreation. 2: There is slight limitation of ordinary activity. Angina may occur with moderate activity such as walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals or in the cold, in the wind or under emotional stress, or walking more than two blocks on the level, and climbing more than one flight of stairs at normal pace under normal conditions. 3: There is marked limitation of ordinary physical activity. Angina may occur after walking one or two blocks on the level or climbing one flight of stairs under normal conditions at a normal pace. 4: There is inability to carry on any physical activity without discomfort; angina may be present at rest.
Unstable Angina	Rest angina requiring i.v. nitrates until arrival in anaesthetic room
Ejection Fraction (%)	The percentage of the blood emptied from the left ventricle at the end of the contraction. Use the most recent determination prior to intervention. Enter a percentage in the range of 5 - 90.
Estimated LV Function	If scan, echo or angiogram did not yield a digital EF%, provide an estimate from reviewing the study. Choose ONE of: Normal (LV-EF >60%), Mild Impairment (EF 40-60%), Moderate (EF 30-40%), Severe (EF <30%)
Previous MI	Patient hospitalised at any time for a Myocardial Infarction documented in the medical record. Two of the following four criteria are necessary - a: Prolonged (>20min) typical chest pain not relieved by rest and/or nitrates. b: Enzyme level elevation: either (1) CK-MB>5% of total CK; (2) troponin > 2.0 micrograms/L. c: New wall motion abnormalities. d: Serial ECG (at least two) showing Q waves in at least two (2) leads.
Recent MI	Myocardial infarction within 90 days
Post infarct septal rupture	Recent post infarct septal rupture preoperatively
Active endocarditis	Patient still on antibiotic treatment for endocarditis at time of surgery
Infective endocarditis	A patient presenting with valvular disease of infectious aetiology with positive blood culture, or post-operative pathology confirmation.

Demography	
1. Procedure Number (local site):	
2. Surname:	
3. Procedure Type: <input type="checkbox"/> Isolated CABG <input type="checkbox"/> Isolated MVR <input type="checkbox"/> Isolated AVR <input type="checkbox"/> AVR + CABG <input type="checkbox"/> MVR + CABG <input type="checkbox"/> Other	
4. Eligible for Inclusion in Data Set: <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Method of Data Collection: <input type="checkbox"/> Electronic <input type="checkbox"/> Manual
6. Height:	7. Weight:
8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	9. D.O.B:

Clinical

Clinical Procedure Data
10. Urgency: <input type="checkbox"/> Elective <input type="checkbox"/> Urgent <input type="checkbox"/> Emergency <input type="checkbox"/> Salvage
11. Critical Postoperative State: <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Previous Cardiac Surgery: <input type="checkbox"/> CABG <input type="checkbox"/> OPCABG <input type="checkbox"/> Valve Repair/Replacement <input type="checkbox"/> Valve/CABG <input type="checkbox"/> Other <input type="checkbox"/> No

Clinical General Data	
13. Family History: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	22. Extracardiac arteriopathy: <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Current Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Renal Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Smoking History: <input type="checkbox"/> Yes <input type="checkbox"/> No	24. History of Stroke: <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Carotid Bruits: <input type="checkbox"/> Yes <input type="checkbox"/> No
17. If yes, Diabetes Control: <input type="checkbox"/> Diet <input type="checkbox"/> Oral <input type="checkbox"/> Insulin <input type="checkbox"/> None	26. Neurological Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Hypercholesterolemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Cerebrovascular Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If yes: CVD Type: <input type="checkbox"/> Coma >24hrs <input type="checkbox"/> CVA Symptoms >72hrs
20. Pulmonary Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RIND or TIA >72hrs <input type="checkbox"/> Carotid Test >75% <input type="checkbox"/> None
21. Chronic Pulmonary Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	29. CVD When: <input type="checkbox"/> Recent <=2/52 <input type="checkbox"/> Remote >2/52 <input type="checkbox"/> None

Clinical Cardiac Data	
30. Angina (classification): <input type="checkbox"/> Not Classified <input type="checkbox"/> I	34. Previous MI: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV	35. Recent MI: <input type="checkbox"/> Yes <input type="checkbox"/> No
31. Unstable Angina: <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Post infarct septal rupture: <input type="checkbox"/> Yes <input type="checkbox"/> No
32. Ejection Fraction (%):	37. Infective Endocarditis: <input type="checkbox"/> Yes <input type="checkbox"/> No
33. Estimated LV Function: <input type="checkbox"/> Normal <input type="checkbox"/> Mild	38. Active Endocarditis: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Moderate <input type="checkbox"/> Severe	

Perfusion Data Definitions

Perfusion Circuit Data	
Date of Admission	Date Patient admitted/transferred to hospital where surgery performed.
Date of Surgery	Date on which the first surgical incision was made for the current Cardiac Surgical Procedure.
Arterial Filter	What type of arterial filter was used?
Reservoir	What type of venous reservoir was used?
Arterial Pump	What was the arterial pump type?
Coating	Partial = some components coated, some components uncoated, Total = all components of bypass circuit coated (excluding cannulas), None = no components of the bypass circuit are coated.
Coating Type	CPB circuit coating type
Hemofilter	Was a Hemofilter used, and when was it set up?
Perfusion Monitoring Data	
Arterial Blood Gas	Was a continuous online blood gas analyser used?
Venous Saturation	Was a venous saturation monitor used?
rCRM02	Was a cerebral saturation monitor used?
BIS	Was a bi-spectral index monitor used?
Other cerebral monitor	Description of other cerebral monitor
Cannulation Sites	
Aorta	Site of Aortic cannulation
Femoral Artery	Was femoral arterial cannulation used?
Axillary Artery	Was axillary artery cannulation used?
Right Atrium	Type of right atrial cannulation
Other Venous	Method of venous cannulation other than via right atrium

Perfusion Data

39. Date of Admission: _____ **40. Date of Surgery:** _____

Perfusion Circuit Data

41. Arterial Filter: 38 – 40um 20um Other No

42. Reservoir: Open Closed

43. Arterial Pump: Roller Centrifugal

44. Coating: No Total Partial

45. Coating Type: Carmeda Trillium Smart Physio X Coating Other

46. Hemofilter: None Set up pre CPB Set up during CPB

Perfusion Monitoring Data

47. Arterial Blood Gas: Continuous Intermittent

48. Venous Saturation: Yes No

49. rCRM02: Yes No

50. BIS: Yes No

51. Other cerebral monitor: _____

Cannulation Sites

Arterial:	Venous:
<p>52. Aorta: <input type="checkbox"/> No <input type="checkbox"/> Ascending</p> <p style="padding-left: 100px;"><input type="checkbox"/> Transverse <input type="checkbox"/> Descending</p>	<p>55. Right Atrium: <input type="checkbox"/> No <input type="checkbox"/> Single Stage</p> <p style="padding-left: 100px;"><input type="checkbox"/> Multiple Stage <input type="checkbox"/> Bicaval</p>
<p>53. Femoral Artery: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>56. Other Venous: <input type="checkbox"/> No <input type="checkbox"/> IVC Direct</p> <p style="padding-left: 100px;"><input type="checkbox"/> IVC + SVC Direct <input type="checkbox"/> SVC Direct</p> <p style="padding-left: 100px;"><input type="checkbox"/> Femoral <input type="checkbox"/> Other</p>
<p>54. Axillary Artery: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Perfusion Data Definitions Continued

Perfusion General Data	
Bypass Time	Total number of minutes on cardiopulmonary bypass. Enter zero if no cardiopulmonary bypass was used. 0 - 999 minutes.
X-Clamp Time	Total number of minutes the aorta is completely cross-clamped and the heart was ischaemic during bypass. Enter zero if no cross clamp was used. 0 - 600 minutes.
Myocardial Protection Strategy	Type of cardioplegia solution and delivery method
Cardioplegia Induction Temperature	Temperature of induction dose of cardioplegia
Maintenance Temperature	Temperature of cardioplegia maintenance doses (doses subsequent to induction)
Hot Shot	Was a hot shot used?
pH strategy	Blood gas(pH) management strategy
Perfusion Biochemistry	
Preoperative Haemoglobin (g/dl)	Most recent preoperative haemoglobin concentration (g/dl)
Minimum Haemoglobin on bypass (g/dl)	Minimum haemoglobin concentration during CPB (g/dl)
Maximum Haemoglobin on bypass (g/dl)	Maximum haemoglobin concentration during CPB (g/dl)
Preoperative creatinine (mmol/L)	Most recent preoperative creatinine (mmol/L) preoperatively
Preoperative glucose	Most recent preoperative glucose concentration (g/dl)
Minimum Glucose on bypass	Minimum glucose during CPB (g/dl)
Maximum glucose on bypass	Maximum glucose during CPB (g/dl)
Glucose management strategy	Management strategy for glycemic control during CPB
Perfusion Temperature/Pressure/Flow Data	
Average MAP Pressure	Average pressure for the duration of bypass from bypass on to bypass off. For electronic data calculate from all data points collected. For manual data average mean arterial pressure from hand reported record
Maximum MAP on bypass	Maximum mean arterial pressure during CPB, from hand reported record
Minimum MAP on bypass	Minimum mean arterial pressure during CPB, from hand reported record
Minimum flow on bypass (LPM)	Minimum average flow recorded during bypass, from hand reported record
Maximum flow on bypass (LPM)	Maximum arterial flow recorded during CPB, from hand reported record
Average bypass flow (LPM)	Average flow for the duration of bypass from bypass on to bypass off. For electronic data calculate from all data points collected. For manual data average mean arterial pressure from hand reported record
Duration of rewarming arterial outlet to 36	Time from minimum temperature to 36C
Duration of rewarming nasopharyngeal to 36	Time from start of rewarming to reach a nasopharyngeal temperature of 36.

Perfusion Data Definitions Continued

Anticoagulation Data	
Anticoagulant type	Type of anticoagulant used for CPB
Anticoagulant other	Specify name of anticoagulant used if not heparin or bivalirudin
Pre CPB anticoagulant dose	Bolus anticoagulant dose pre-bypass including CPB prime (units: heparin = iu, bivalirudin = mg)
CPB anticoagulant bolus dose	Bolus anticoagulant dose during CPB (units: heparin = iu, bivalirudin = mg)
Protamine Dose	Protamine dose in mg
Antifibrinolytic type	Name of antifibrinolytic drug used
Antifibrinolytic dose	Dose regimen - Hammersmith or 1/2 Hammersmith for aprotinin (or bolus), bolus or infusion for tranexamic acid
Other coagulant drugs	List other drugs used to promote hemostasis and dose, separated by a comma (eg DDAVP 20ug, etc.)
1 st ACT after anticoagulation	1st ACT after initial anticoagulant dose
Minimum ACT during CPB	Minimum ACT during CPB
Maximum ACT during CPB	Maximum ACT during CPB
ACT measurement type	Type of ACT activator (celite or kaolin)
ACT device type	Model of ACT machine
Intraoperative Transfusion Data	
Pericardial suction blood	Pericardial suction blood usage
Number of units RCC CPB prime	Number of units of donor blood in the cardiopulmonary bypass prime
Number of units RCC during CPB	Number of units of donor blood given during cardiopulmonary bypass (not in prime)
Number of units RCC anaesthesia	Number of units of donor blood given by the anaesthetist
Number of FFP units	Number of units of FFP given by the anaesthetist

Perfusion Data Continued

Anticoagulation Data

88. Anticoagulant type: <input type="checkbox"/> Heparin <input type="checkbox"/> Bivalirudin <input type="checkbox"/> Other	98. Baseline ACT:
89. Anticoagulant other:	99. 1 st ACT after anticoagulation:
90. CPB Prime Anticoagulant dose:	100. Minimum ACT during CPB:
91. Pre CPB Anticoagulant dose:	101. Maximum ACT during CPB:
92. CPB Anticoagulant bolus dose:	102. Final ACT:
93. Anticoagulant infusion dose:	103. ACT measurement type: <input type="checkbox"/> Celite <input type="checkbox"/> Kaolin <input type="checkbox"/> Other
94. Protamine Dose:	104. ACT device type: <input type="checkbox"/> Hemochron <input type="checkbox"/> ACT Plus
95. Other coagulant drugs:	<input type="checkbox"/> i-stat <input type="checkbox"/> ACT II <input type="checkbox"/> Other
96. Antifibrinolytic type <input type="checkbox"/> None <input type="checkbox"/> Trasylol <input type="checkbox"/> Tranexamic Acid <input type="checkbox"/> Other	
97. Antifibrinolytic dose <input type="checkbox"/> None <input type="checkbox"/> Hammersmith <input type="checkbox"/> ½ Hammersmith <input type="checkbox"/> Bolus <input type="checkbox"/> Infusion	

Intraoperative Transfusion Data

Number of Transfusions (Perfusion)	Number of Transfusions (Anaesthesia)
105. Blood units CPB prime:	107. Blood units Pre CPB:
106. Blood units during CPB:	108. Blood units Post CPB:
	109. FFP units:
	110. Platelet units:
111. Pericardial Suction Blood: <input type="checkbox"/> All PSB reinfused unprocessed <input type="checkbox"/> Reinfused Processed <input type="checkbox"/> Some PSB reinfused unprocessed <input type="checkbox"/> No reinfused	

Procedure Data Definitions	
Procedure Type	Database eligible procedures include isolated CABG, Isolated mitral valve repair or replacement, isolated aortic valve replacement, or CABG combined with aortic or mitral valve replacement.
CABG Anastomosis Data	
Left internal mammary graft	Was a Left Internal Mammary Artery Used for Coronary Bypass?
Number left internal mammary distal anastomoses	Number of LIMA distal anastomosis
Right internal mammary graft	Was a Right Internal Mammary Artery Used for Coronary Bypass?
Number right internal mammary distal anastomoses	Number of RIMA distal anastomosis
Number of vein grafts conduits	Number of saphenous vein conduits used
Number of distal anastomoses (vein grafts)	Number of saphenous vein distal anastomosis
Radial artery graft	Was a Radial Artery Used for Coronary Bypass?
Number radial artery distal anastomoses	Number of Radial artery distal anastomosis
Gastroeploic artery graft	Was a Gastroeploic Artery Used for Coronary Bypass?
Number gastroeploic artery distal anastomoses	Number of Gastroeploic artery distal anastomosis
Valve Data	
Aortic valve prosthesis	Was the aortic valve replaced and type of implant
Mitral valve prosthesis	Was the aortic valve replaced and type of implant
Mitral valve repair	Was the mitral valve repaired or converted to replacement?
Aortic Occlusion	
Method of Occlusion	Type of Manipulation
Number of X Clamp applications	Number of times cross clamp applied
Number of side biter applications	Number of times side biter applied

Procedure Data			
112. Procedure Type:	<input type="checkbox"/> Isolated CABG	<input type="checkbox"/> Isolated MV surgery	<input type="checkbox"/> Isolated AV surgery
	<input type="checkbox"/> AVR + CABG	<input type="checkbox"/> MVR + CABG	<input type="checkbox"/> Other

CABG Anastomosis Data		<input type="checkbox"/> No CABG	
113. Left Internal Mammary graft:	<input type="checkbox"/> Yes <input type="checkbox"/> No	119. Radial artery graft:	<input type="checkbox"/> Yes <input type="checkbox"/> No
114. Number Left Internal Mammary Distal Anastomoses:		120. Number of Radial Distal Anastomoses:	
115. Right Internal Mammary graft:	<input type="checkbox"/> Yes <input type="checkbox"/> No	121. Gastroeploic artery graft:	<input type="checkbox"/> Yes <input type="checkbox"/> No
116. Number Right Internal Mammary Distal Anastomoses:		122. Number of Radial Gastroeploic Anastomoses:	
117. Number of Vein Grafts Conduits:			
118. Number of distal anastomoses (vein grafts):			

Valve Surgical/Implant Data		<input type="checkbox"/> No Valve	
123. Aortic valve prosthesis:	<input type="checkbox"/> No <input type="checkbox"/> Mechanical Prosthesis	<input type="checkbox"/> Bioprosthetic Prosthesis	
124. Mitral valve prosthesis:	<input type="checkbox"/> No <input type="checkbox"/> Mechanical Prosthesis	<input type="checkbox"/> Bioprosthetic Prosthesis	
125. Mitral valve repair:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Converted to Replacement	

Aortic Occlusion					
126. Method of aortic occlusion:	<input type="checkbox"/> X Clamp only	<input type="checkbox"/> Side Biter only	<input type="checkbox"/> X Clamp and Side Biter	<input type="checkbox"/> Balloon Occlusion	<input type="checkbox"/> No X clamp
127. Number of X Clamp Applications:					
128. Number of Side Biter Applications:					

Outcome Variables Definitions	
Ventilation Time (hrs)	Indicate the number of hours post operation for which the patient was ventilated. Calculate from the date and time of exit from theatre to that of extubation. Round to the nearest hour eg 6 hours 25 minutes is rounded down to 6 hours, and 6 hours 35 minutes is rounded up to 7 hours. In the unlikely event that the time is exactly 30 minutes then round up. Use zero if the patient was extubated on the operating table. Do not count delayed re-intubation time.
ICU stay duration (hrs)	Number of hours spent by the patient in the ICU prior to transfer to the HDU or General Ward (does not include readmission to ICU). Round to the nearest hour eg 6 hours 25 minutes is rounded down to 6 hours, and 6 hours 35 minutes is rounded up to 7 hours. In the unlikely event that the time is exactly 30 minutes between the hour then round up.
Length of hospital stay (d)	Number of total days spent by the patient in hospital
Length of postoperative stay (d)	Number of days spent by the patient in hospital postoperatively
Date of Discharge	Date Patient discharged from being an inpatient at the hospital where the procedure was performed. Discharged to Hospital in the Home, rehabilitation hospital or unit or to a local referring hospital is considered as discharge from hospital.
Discharge Status	Where the patient was discharged
Insertion of IABP	When IABP initially inserted
Return to theatre	Reason for return to theatre
Stroke	A new central neurologic deficit persisting for > 72 hours.
Encephalopathy in hospital	Incidence of postoperative encephalopathy (cognitive dysfunction including confusion, psychosis, memory loss)
New Coma	New post-operative coma that persists for at least 24 hours.
New Renal Failure	Acute post-operative renal insufficiency resulting in two or more of the following - a: Increased serum creatinine to >0.2mmol/l (>200mmol/l), b: A doubling or greater increase in creatinine over baseline per-operative value, c: A new requirement for dialysis/hemofiltration.
Max postoperative creatinine	Maximum post-operative creatinine (mmol/L)
ICU 4hr blood loss (ml)	Indicate the blood loss in mls from the chest drains in the first 4 hrs postoperatively.
ICU blood transfusions	Number of units of donor blood transfused in the intensive care unit
ICU blood Platelet transfusions	Number of units of platelets transfused in the intensive care unit (or ml / 50 rounded up)
ICU FFP transfusions	Number of units of FFP transfused in the intensive care unit
Death	Specify whether the patient was alive or dead at discharge from the hospital following the admission during which the surgery occurred (Discharged to Hospital in the Home is considered discharge from hospital)
Death within 30 days	Specify whether the patient was alive or dead 30 days after the procedure was performed. (Data of surgery counts as day 0).
Date of death	What was the date of death?
Location of death	Specify the patient location at time of death. Operating Room (OR), Hospital (Other than operating room), Home (Including hospital in the home) Other Care Facility.

Outcomes Data

129. Ventilation Time (hrs):
130. ICU Stay Duration (hrs):
131. Length of Hospital Stay (d):
132. Length of Postoperative Stay (d):
133. Date of Discharge:
134. Discharge Status: <input type="checkbox"/> Home <input type="checkbox"/> Hospital in the Home <input type="checkbox"/> Rehabilitation Unit/Hospital <input type="checkbox"/> Local/Referring Hospital

Complications

135. Insertion of IAPB: <input type="checkbox"/> No <input type="checkbox"/> Pre op <input type="checkbox"/> CPB <input type="checkbox"/> Post CPB <input type="checkbox"/> Post op	142. ICU 4 hr blood loss (ml):
	143. ICU Blood Transfusions:
136. Return to Theatre: <input type="checkbox"/> No <input type="checkbox"/> Valve Dysfunction <input type="checkbox"/> Bleeding <input type="checkbox"/> Deep Sternal Infection <input type="checkbox"/> Graft Occlusion <input type="checkbox"/> Other Cardiac <input type="checkbox"/> Other Non-cardiac	144. ICU Platelet Transfusions:
	145. ICU FFP Transfusions:
	146. Death: <input type="checkbox"/> Yes <input type="checkbox"/> No
	147. Death within 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No
137. Stroke: <input type="checkbox"/> Yes <input type="checkbox"/> No	148. Date of Death:
138. Encephalopathy in Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No	149. Location of Death: <input type="checkbox"/> OR <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other facility
139. New Coma: <input type="checkbox"/> Yes <input type="checkbox"/> No	
140. New Renal Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	
141. Max Postoperative Creatinine:	