

This Worksheet is to be used at the Screening Visit.

Was Echocardiogram/CT performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Complete protocol deviation form)</i>
Are the required images for this visit available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Complete protocol deviation form)</i>
Were images uploaded into the Imaging Module?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date echocardiogram/CT completed	___ / ___ / ___ (DD/MMM/YYYY)
Imaging Type	<input type="checkbox"/> TTE – Transthoracic echocardiogram <input type="checkbox"/> TEE – Transesophageal echocardiogram <input type="checkbox"/> Cardiac CT <input type="checkbox"/> Cardiac MRI <input type="checkbox"/> Brain CT <input type="checkbox"/> MRI
Left atrial appendage visible	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available

If available, confirm if the following was noted on echo/CT:

Dense spontaneous echo contrast consistent with thrombus?	<input type="checkbox"/> Yes <i>(Review for I&E!)</i> <input type="checkbox"/> No <input type="checkbox"/> Not Available		
Intra-cardiac thrombus	<input type="checkbox"/> Yes <i>(Review for I&E!)</i> <input type="checkbox"/> No <input type="checkbox"/> Not available	If yes, confirm location	<input type="checkbox"/> Left atrium <input type="checkbox"/> Left atrial appendage <input type="checkbox"/> Left ventricle <input type="checkbox"/> Right atrium <input type="checkbox"/> Right ventricle <input type="checkbox"/> Other, specify: _____
Intra-cardiac vegetation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available	If yes, confirm location	<input type="checkbox"/> Left atrium <input type="checkbox"/> Left atrial appendage <input type="checkbox"/> Left ventricle <input type="checkbox"/> Right atrium <input type="checkbox"/> Right ventricle <input type="checkbox"/> Other, specify: _____

Patent foramen ovale warranting closure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available	If yes, is this a high risk PFO?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No
Atrial septal defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available	If yes, specify	<input type="checkbox"/> Right to left shunt present <input type="checkbox"/> Left to right shunt present <input type="checkbox"/> Bidirectional shunt present <input type="checkbox"/> Unable to determine
		If yes, does defect warrant closure?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No
Pericardial effusion present?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available	If yes, select type	<input type="checkbox"/> Circumferential <input type="checkbox"/> Loculated
		If yes, select size	<input type="checkbox"/> Trivial <input type="checkbox"/> Small (<1 cm) <input type="checkbox"/> Moderate (1-2 cm) <input type="checkbox"/> Large (>2 cm and <5cm) <input type="checkbox"/> Large (> 5 cm) (<i>Review for I&E!</i>)
		If yes, Do any of the following apply? Check all that apply (<i>Review for I&E!</i>)	<input type="checkbox"/> Symptomatic <input type="checkbox"/> Sign or symptom of acute or chronic pericarditis <input type="checkbox"/> Evidence of tamponade physiology

Site Personnel Signature

____/____/_____
Date (DD/MMM/YYYY)