

TTE is required to surveil for pericardial effusion. The study must be performed a minimum of 4 hours after discharge from cardiac catheterization laboratory.

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>		
Was imaging uploaded into the Imaging Module?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date echocardiogram/CT completed	___ / ___ / ___ (DD/MMM/YYYY)		
What time was pre-discharge TTE performed?	_____ : _____		
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		
If available, confirm if the following was noted on echo/CT:			
Left atrial appendage visible	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available		
Dense spontaneous echo contrast consistent with thrombus?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available		
Intra-cardiac thrombus	<input type="checkbox"/> Yes <i>(Complete AE form)</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: _____

<p>Intra-cardiac vegetation</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>	<p>If yes, confirm location</p>	<p><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: _____</p>
<p>Patent foramen ovale warranting closure?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available</p>	<p>If yes, is this a high risk PFO?</p>	<p><input type="checkbox"/> Yes (<i>Complete AE Form</i>) <input type="checkbox"/> No</p>
<p>Atrial septal defect?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>	<p>If yes, specify</p>	<p><input type="checkbox"/> Right to left shunt present <input type="checkbox"/> Left to right shunt present <input type="checkbox"/> Bidirectional shunt <input type="checkbox"/> Unable to determine</p> <p>If yes, does defect warrant closure? <input type="checkbox"/> Yes (<i>Complete AE form</i>) <input type="checkbox"/> No</p>
<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>			
<p>Pericardial effusion present?</p>		<p>If yes, select type</p>	<p><input type="checkbox"/> Circumferential <input type="checkbox"/> Loculated</p>
<p>Pericardial effusion present?</p>		<p>If yes, select size: <i>(Pericardial effusion deemed as trivial or small does not meet adverse event reporting criteria)</i></p>	<p><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) (Review for I&E!)</p>
		<p>If yes, Do any of the following apply? <i>(Check all that apply)</i></p>	<p><input type="checkbox"/> Symptomatic <input type="checkbox"/> Sign or symptom of acute or chronic pericarditis <input type="checkbox"/> Evidence of tamponade physiology</p>

Site Personnel Signature

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