

Bench to Bassinet
Pediatric Cardiac Genomics Consortium: CHD GENES
 Form 107: Medical History/Outcomes Abstraction, Subject <= 1year
 Version: B - 11/01/2010

SECTION A: ADMINISTRATIVE INFORMATION

A1. Study Identification Number:

A2. Study Visit:

A3. Date Form Completed: MM/DD/YYYY

SECTION B: NON-CARDIAC SURGERIES

	Yes	No	Unknown	Source Pending
B1. Non-cardiac Surgery:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Abdominal Surgery: (check all that apply)		<input type="checkbox"/>		
i. Appendectomy	<input type="checkbox"/>			
ii. Bowel Resection	<input type="checkbox"/>			
iii. Duodenal Atresia Repair	<input type="checkbox"/>			
iv. Exploratory Laparotomy	<input type="checkbox"/>			
v. LADS Procedure	<input type="checkbox"/>			
vi. Ostomy Procedure	<input type="checkbox"/>			
vii. Other	<input type="checkbox"/>			
a. Specify:	<input type="text"/>			
b. Adenoidectomy		<input type="checkbox"/>		
c. Bronchoscopy		<input type="checkbox"/>		
d. Dental Surgery		<input type="checkbox"/>		
e. Dermatologic Procedure		<input type="checkbox"/>		
f. Diaphragmatic Plication		<input type="checkbox"/>		
g. Endoscopy		<input type="checkbox"/>		
h. Esophageal Atresia		<input type="checkbox"/>		
i. Esophagoscopy		<input type="checkbox"/>		
j. Eye Surgery		<input type="checkbox"/>		
i. Specify:	<input type="text"/>			
k. Gastrostomy Tube / Jejunostomy Tube Placement		<input type="checkbox"/>		
l. HEENT		<input type="checkbox"/>		
i. Specify:	<input type="text"/>			
m. Hernia / Hydrocele Repair		<input type="checkbox"/>		
n. Liver Surgery: (check all that apply)		<input type="checkbox"/>		
i. Kasai	<input type="checkbox"/>			
ii. Other	<input type="checkbox"/>			
a. Specify:	<input type="text"/>			
o. Myringotomy Tubes		<input type="checkbox"/>		
p. Neuro Surgery		<input type="checkbox"/>		
q. Nissen Fundoplication Procedure		<input type="checkbox"/>		
r. Orchiopexy		<input type="checkbox"/>		
s. Orthopedic Surgery: (check all that apply)		<input type="checkbox"/>		
i. Congenital Anomaly	<input type="checkbox"/>			
ii. Scoliosis	<input type="checkbox"/>			

iii. Other

a. Specify:

t. Palate Procedure

u. Thoracic Non-Cardiac Surgery

v. Tonsillectomy

w. Tracheal Repair / Reconstruction

x. Tracheotomy

y. Urogenital:
(check all that apply)

i. Hypospadias Repair

ii. Undescended Testes
Surgery

iii. Urethral / Bladder

iv. Other

a. Specify:

z. Ventriculoperitoneal Shunt

a. Other

i. Specify:

SECTION C: CARDIAC SURGERIES AND PROCEDURES

Yes No Unknown Source Pending

C1. Cardiac Catheterization Procedures

a. Procedure Code: [View Code List](#)

b. Specify:

c. Procedure Date: MM/DD/YYYY

Yes No Unknown Source Pending

C2. Cardiac Surgeries:

a. Surgical Code: [View Code List](#)

b. Specify:

c. Surgery Date: MM/DD/YYYY

Yes No Unknown Source Pending

C3. Arrhythmia requiring treatment:

- a. Arrhythmia Type:
- Atrial
 - AVB
 - Ventricular
 - Unknown
 - Source Pending

b. Arrhythmia Treatment (check all that apply):

i. Cardioversion

ii. Catheter Ablation

iii. ICD

iv. Pacemaker

v. Pharmacologic

vi. Other

a. Specify:

Yes No Unknown Source Pending

C4. Non-fatal, out of hospital Cardiac Arrest:

a. Date of most recent event: MM/DD/YYYY

Yes No Unknown Source Pending

C5. Extracorporeal Membrane Oxygenation (ECMO) in Intensive Care Unit:

a. Indication: (check all that apply)

- i. Arrest
- ii. Arrhythmia
- iii. Heart Failure
- iv. Unable to wean from bypass
- v. Other

a. Specify:

b. Date of most recent event: MM/DD/YYYY

Yes No Unknown Source Pending

C6. Ventricular Assist Device Placement:

- a. Indication:
- Arrest
 - Arrhythmia
 - Heart Failure
 - Unable to wean from bypass
 - Other
 - Unknown
 - Source Pending

i. Specify:

b. Date: MM/DD/YYYY

Yes No Unknown Source Pending

C7. Pacemaker Placement:

- a. Indication:
- Atrial Tachycardia
 - AV Block
 - Sinus Node Dysfunction
 - Ventricular Dysfunction / dyssynchrony
 - Ventricular Tachycardia
 - Other
 - Unknown
 - Source Pending

i. Specify:

b. Date: MM/DD/YYYY

Yes No Unknown Source Pending

C8. Implantable Cardioverter Defibrillator (ICD) Placement:

- a. Indication:
- Primary Prevention
 - Secondary Prevention
 - Unknown
 - Source Pending

b. Date: MM/DD/YYYY

Yes No Unknown Source Pending

C9. Cardiac Transplant List:

a. Date: MM/DD/YYYY

Yes **No** **Unknown** **Source Pending**

C10. Status Post Cardiac Transplant:

a. Transplant Date: MM/DD/YYYY