

MRN ¹⁵⁰⁰ :	Encounter Date ¹⁵¹⁰ : mm / dd / yyyy	Practice ID ¹⁵²⁰ :	Location ID ¹⁵³⁰ :
Provider NPI ¹⁵⁵⁰ :	Encounter TIN ¹⁵⁵⁵ :	Patient new to the Practice ¹⁵⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes	

A. PATIENT DEMOGRAPHICS

Patient Name (Last, First, MI) ^{2000, 2010, 2020} :	SSN ²⁰³⁰ :	PatientID ²⁰⁴⁰ : (auto)	Patient Zip ²²⁰⁰ :												
Date of Birth ²⁰⁵⁰ : mm / dd / yyyy	Sex ²⁰⁶⁰ : <input type="radio"/> Male <input type="radio"/> Female														
<input type="checkbox"/> Patient Deceased ²⁰⁶⁵ → Date ²⁰⁶⁷ mm / dd / yyyy → If Yes, Primary Cause of Death ²⁰⁶⁸ : <table style="display: inline-table; vertical-align: top; margin-left: 10px;"> <tr> <td><input type="radio"/> Cardiac</td> <td><input type="radio"/> Neurologic</td> <td><input type="radio"/> Renal</td> </tr> <tr> <td><input type="radio"/> Vascular</td> <td><input type="radio"/> Infection</td> <td><input type="radio"/> Valvular</td> </tr> <tr> <td><input type="radio"/> Pulmonary</td> <td><input type="radio"/> Unknown</td> <td><input type="radio"/> Other</td> </tr> </table>				<input type="radio"/> Cardiac	<input type="radio"/> Neurologic	<input type="radio"/> Renal	<input type="radio"/> Vascular	<input type="radio"/> Infection	<input type="radio"/> Valvular	<input type="radio"/> Pulmonary	<input type="radio"/> Unknown	<input type="radio"/> Other			
<input type="radio"/> Cardiac	<input type="radio"/> Neurologic	<input type="radio"/> Renal													
<input type="radio"/> Vascular	<input type="radio"/> Infection	<input type="radio"/> Valvular													
<input type="radio"/> Pulmonary	<input type="radio"/> Unknown	<input type="radio"/> Other													
Race: <input type="checkbox"/> White ²⁰⁷⁰ <input type="checkbox"/> Black/African American ²⁰⁷¹ <input type="checkbox"/> American Indian/Alaskan Native ²⁰⁷³ (Check all that apply) <input type="checkbox"/> Asian ²⁰⁷² → If Yes, <input type="checkbox"/> Asian Indian ²⁰⁸⁰ <input type="checkbox"/> Chinese ²⁰⁸¹ <input type="checkbox"/> Filipino ²⁰⁸² <input type="checkbox"/> Japanese ²⁰⁸³ <input type="checkbox"/> Korean ²⁰⁸⁴ <input type="checkbox"/> Vietnamese ²⁰⁸⁵ <input type="checkbox"/> Other ²⁰⁸⁶ <input type="checkbox"/> Native Hawaiian/Pacific Islander ²⁰⁷⁴ → If Yes, <input type="checkbox"/> Native Hawaiian ²⁰⁹⁰ <input type="checkbox"/> Guamanian or Chamorro ²⁰⁹¹ <input type="checkbox"/> Samoan ²⁰⁹² <input type="checkbox"/> Other Island ²⁰⁹³															
Hispanic or Latino Ethnicity ²⁰⁷⁶ : <input type="radio"/> No <input type="radio"/> Yes															
→ If Yes, Ethnicity Type: <input type="checkbox"/> Mexican, Mexican-American, Chicano ²¹⁰⁰ <input type="checkbox"/> Puerto Rican ²¹⁰¹ <input type="checkbox"/> Cuban ²¹⁰² (Check all that apply) <input type="checkbox"/> Other Hispanic, Latino or Spanish Origin ²¹⁰³															
Insurance Payers: (Check all that apply) <table style="display: inline-table; vertical-align: top; margin-left: 10px;"> <tr> <td><input type="checkbox"/> Medicaid (fee for service)³⁰³⁰</td> <td><input type="checkbox"/> Medicare (fee for service)³⁰²⁸</td> <td><input type="checkbox"/> Private Health Insurance³⁰²⁰</td> <td><input type="checkbox"/> Medicaid (managed care)³⁰³¹</td> </tr> <tr> <td><input type="checkbox"/> Medicare (managed care)³⁰²⁹</td> <td><input type="checkbox"/> Military Health Care³⁰²³</td> <td><input type="checkbox"/> State Specific Plan (non-Medicaid)³⁰²⁴</td> <td><input type="checkbox"/> Indian Health Service³⁰²⁵</td> </tr> <tr> <td><input type="checkbox"/> Non-US Insurance³⁰²⁶</td> <td><input type="checkbox"/> None³⁰²⁷</td> <td colspan="2"></td> </tr> </table>				<input type="checkbox"/> Medicaid (fee for service) ³⁰³⁰	<input type="checkbox"/> Medicare (fee for service) ³⁰²⁸	<input type="checkbox"/> Private Health Insurance ³⁰²⁰	<input type="checkbox"/> Medicaid (managed care) ³⁰³¹	<input type="checkbox"/> Medicare (managed care) ³⁰²⁹	<input type="checkbox"/> Military Health Care ³⁰²³	<input type="checkbox"/> State Specific Plan (non-Medicaid) ³⁰²⁴	<input type="checkbox"/> Indian Health Service ³⁰²⁵	<input type="checkbox"/> Non-US Insurance ³⁰²⁶	<input type="checkbox"/> None ³⁰²⁷		
<input type="checkbox"/> Medicaid (fee for service) ³⁰³⁰	<input type="checkbox"/> Medicare (fee for service) ³⁰²⁸	<input type="checkbox"/> Private Health Insurance ³⁰²⁰	<input type="checkbox"/> Medicaid (managed care) ³⁰³¹												
<input type="checkbox"/> Medicare (managed care) ³⁰²⁹	<input type="checkbox"/> Military Health Care ³⁰²³	<input type="checkbox"/> State Specific Plan (non-Medicaid) ³⁰²⁴	<input type="checkbox"/> Indian Health Service ³⁰²⁵												
<input type="checkbox"/> Non-US Insurance ³⁰²⁶	<input type="checkbox"/> None ³⁰²⁷														
Payer ID ³¹⁰⁰ : _____															

B. DIAGNOSES/CONDITIONS/COMORBIDITIES (CHECK ALL THAT APPLY, AND RECORD THE DATE OF ONSET OR FIRST DOCUMENTED DATE)

DIABETIC	<input type="checkbox"/> Diabetes Mellitus (Any) ⁴¹⁵⁰ → Date ⁴¹⁵² mm / dd / yyyy <input type="checkbox"/> Diabetes Mellitus Type 1 ⁴¹⁶⁰ → Date ⁴¹⁶² mm / dd / yyyy <input type="checkbox"/> Diabetes Mellitus Type 2 ⁴¹⁷⁰ → Date ⁴¹⁷² mm / dd / yyyy <input type="checkbox"/> Prediabetes ⁴¹⁸⁰ → Date ⁴¹⁸² mm / dd / yyyy <input type="checkbox"/> Diabetic Peripheral Neuropathy ⁴¹⁹⁰ → Date ⁴¹⁹² mm / dd / yyyy <input type="checkbox"/> Diabetic Autonomic Neuropathy ⁴²⁰⁰ → Date ⁴²⁰² mm / dd / yyyy <input type="checkbox"/> Diabetic Retinopathy ⁴²¹⁰ → Date ⁴²¹² mm / dd / yyyy <input type="checkbox"/> Gastroparesis ⁴²⁷⁰ → Date ⁴²⁷² mm / dd / yyyy <input type="checkbox"/> Erectile Dysfunction ⁴²⁸⁰ → Date ⁴²⁸² mm / dd / yyyy	PAD	<input type="checkbox"/> Peripheral Artery Disease ⁴⁰⁹⁰ → Date ⁴⁰⁹² mm / dd / yyyy <input type="checkbox"/> PAD – Acute Limb Ischemia ⁴¹⁰⁰ → Date ⁴¹⁰² mm / dd / yyyy <input type="checkbox"/> PAD – Claudication ⁴¹¹⁰ → Date ⁴¹¹² mm / dd / yyyy <input type="checkbox"/> PAD – Critical Limb Ischemia ⁴¹²⁰ → Date ⁴¹²² mm / dd / yyyy <input type="checkbox"/> PAD – Foot/Leg Cellulitis ⁴¹³⁰ → Date ⁴¹³² mm / dd / yyyy <input type="checkbox"/> PAD – Lower Extremity Osteomyelitis (with or without limb ischemia) ⁴¹⁴⁰ → Date ⁴¹⁴² mm / dd / yyyy		
	<input type="checkbox"/> Metabolic Syndrome ⁴²⁶⁰ → Date ⁴²⁶² mm / dd / yyyy <input type="checkbox"/> Chronic Liver Disease ⁴²⁵⁰ → Date ⁴²⁴² mm / dd / yyyy <input type="checkbox"/> Depression ⁴²⁹⁰ → Date ⁴²⁵² mm / dd / yyyy <input type="checkbox"/> Chronic Kidney Disease ⁴²⁴⁰ → Date ⁴²⁹² mm / dd / yyyy → If Chronic Kidney Disease= ‘Yes’, CKD Stage ⁴²⁴⁶ : <input type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Stage 5 <input type="radio"/> Unspecified		CARDIAC	<input type="checkbox"/> Hypertension ⁴⁰³⁰ → Date ⁴⁰³² mm / dd / yyyy <input type="checkbox"/> Coronary Artery Disease ⁴⁰⁰⁰ → Date ⁴⁰⁰² mm / dd / yyyy <input type="checkbox"/> Dyslipidemia ⁴⁰²⁰ → Date ⁴⁰²² mm / dd / yyyy <input type="checkbox"/> Heart Failure ⁴⁰⁴⁰ → Date ⁴⁰⁴² mm / dd / yyyy <input type="checkbox"/> Atrial Fibrillation/Flutter ⁴⁰¹⁰ → Date ⁴⁰¹² mm / dd / yyyy <input type="checkbox"/> Stable Angina ⁴⁰⁶⁰ → Date ⁴⁰⁶² mm / dd / yyyy	
FAMILY HISTORY	FH CONDITION EVALUATED	FH CONDITION PRESENT		FAMILY HISTORY	FH CONDITION EVALUATED
	Atrial Fibrillation ⁴³⁰⁰ Diabetes Mellitus ⁴³⁰² Heart Failure ⁴³⁰⁴ Dyslipidemia ⁴³⁰⁶	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	Hypertension ⁴³⁰⁸ Premature CAD ⁴³¹⁰ Family History of Hypercholesterolemia ⁴³¹²		<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

C. EVENTS (CHECK ALL THAT APPLY OR MOST RECENT DOCUMENTED DATE)		Specify all event(s) and if available, event date(s) that occurred. If month is unknown, use January, and if date is unknown, use the 1 st of the month.			
	Event ⁵¹³⁵	Event Date(s) ⁵¹³⁶	Event ⁵¹³⁵	Event Date(s) ⁵¹³⁶	
DIABETIC	Gestational Diabetes ^{E039}	mm / dd / yyyy	PERIPHERAL	Amputation (Any) ^{E045}	mm / dd / yyyy
	Diabetic Ketoacidosis (DKA) ^{E040}	mm / dd / yyyy		Amputation – Above Foot ^{E046}	mm / dd / yyyy
	Hyperosmolar Hyperglycemic Syndrome ^{E041}	mm / dd / yyyy		Amputation – Foot ^{E047}	mm / dd / yyyy
	Hypoglycemia (severe) ^{E042}	mm / dd / yyyy		Amputation – Toe(s) only ^{E048}	mm / dd / yyyy
CARDIAC	Myocardial Infarction ^{E001}	mm / dd / yyyy	OTHER	PAD – Peripheral Bypass ^{E043}	mm / dd / yyyy
	PCI (Any) ^{E029}	mm / dd / yyyy		PAD – Peripheral Intervention ^{E044}	mm / dd / yyyy
	PCI – Bare Metal Stent Implant ^{E002}	mm / dd / yyyy		Acute Pancreatitis ^{E049}	mm / dd / yyyy
	PCI – Other (non-stent) Intervention ^{E004}	mm / dd / yyyy		Bariatric Surgery (Any) ^{E050}	mm / dd / yyyy
	PCI – Drug Eluting Stent Implant ^{E003}	mm / dd / yyyy		Bariatric Surgery – Adjustable gastric banding ^{E051}	mm / dd / yyyy
	Coronary Artery Bypass Graft ^{E017}	mm / dd / yyyy		Bariatric Surgery – Biliopancreatic diversion with a duodenal switch ^{E052}	mm / dd / yyyy
	CRT-D ^{E024}	mm / dd / yyyy		Bariatric Surgery – Roux-en-Y gastric bypass ^{E053}	mm / dd / yyyy
	ICD Implant ^{E025}	mm / dd / yyyy		Bariatric Surgery – Vertical sleeve gastrectomy ^{E054}	mm / dd / yyyy
CVA	Permanent Pacemaker ^{E027}	mm / dd / yyyy	Foot Ulcer ^{E055}	mm / dd / yyyy	
	Hemorrhage (Any) ^{E031}	mm / dd / yyyy	Gout ^{E056}	mm / dd / yyyy	
	Intracranial Hemorrhage ^{E007}	mm / dd / yyyy	Peritoneal Dialysis ^{E067}	mm / dd / yyyy	
	Non Intracranial Major Hemorrhage (Any) ^{E032}	mm / dd / yyyy	Hemodialysis ^{E057}	mm / dd / yyyy	
	Stroke (Any) ^{E030}	mm / dd / yyyy	Hyperthyroidism ^{E058}	mm / dd / yyyy	
	Stroke – Hemorrhagic ^{E016}	mm / dd / yyyy	Hypothyroidism ^{E059}	mm / dd / yyyy	
	Stroke – Ischemic ^{E015}	mm / dd / yyyy	Infection (Any) ^{E060}	mm / dd / yyyy	
	TIA ^{E014}	mm / dd / yyyy	Infection – Pulmonary ^{E061}	mm / dd / yyyy	
	Carotid Endarterectomy (Any) ^{E033}	mm / dd / yyyy	Infection – Urinary ^{E062}	mm / dd / yyyy	
	Carotid Endarterectomy – Right ^{E034}	mm / dd / yyyy	Non Alcoholic Fatty Liver Disease ^{E063}	mm / dd / yyyy	
	Carotid Endarterectomy – Left ^{E035}	mm / dd / yyyy	Sleep Apnea ^{E064}	mm / dd / yyyy	
	Carotid Artery Stent (Any) ^{E036}	mm / dd / yyyy	Syncope ^{E065}	mm / dd / yyyy	
	Carotid Artery Stent – Right ^{E037}	mm / dd / yyyy	Solid Organ Transplant- Kidney ^{E068}	mm / dd / yyyy	
Carotid Artery Stent – Left ^{E038}	mm / dd / yyyy	Solid Organ Transplant- Pancreas ^{E069}	mm / dd / yyyy		
			Solid Organ Transplant- Heart ^{E070}	mm / dd / yyyy	
			Solid Organ Transplant- Other ^{E071}	mm / dd / yyyy	

D. ENCOUNTER INFORMATION NOTE: COMPLETE ONLY IF ASSESSED DURING TODAY'S ENCOUNTER. IF NOT ASSESSED, LEAVE BLANK.

Height: _____ O in⁶⁰⁰⁰ O cm⁶⁰⁰¹ Blood Pressure^{6010, 6011}: _____ / _____ mmHg

Weight: _____ O lbs⁶⁰²⁰ O kg⁶⁰²¹ Patient unable to be weighed⁶⁰²⁵ Waist Circumference: _____ O in⁶⁰²⁶ O cm⁶⁰²⁷

Tobacco Use⁶⁰³⁰: Never Current Quit within past 12 months Quit more than 12 months ago Screening not performed for medical reasons → If Current or Quit within 12 months, Smoking Cessation Counseling Provided⁶⁰⁴⁰: No Yes

Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco⁶⁰⁴⁵: No Yes

Alcohol Use⁶⁰⁴⁷: None <1 drinks/wk 2-7 drinks/wk 8-14 drinks/wk >= 15 drinks/wk

Advance Care Plan OR Discussion of Advance Care Plan Documented⁶⁰⁵⁰: No – Not documented No – patient reason Yes

Patient screened for evidence of Nephropathy⁶⁰⁵⁵: No Yes → If Yes, Date⁶⁰⁶⁰: mm / dd / yyyy

MRN:	Encounter Date: mm / dd / yyyy	Practice ID:	Location ID:
D. ENCOUNTER INFORMATION (CONT.)			
EDUCATION /COUNSELING	Discussion of Lifestyle Modifications Documented ⁶¹⁰⁰ : <input type="radio"/> No <input type="radio"/> Yes <input type="checkbox"/> Patient enrolled in weight loss program ⁶¹⁰⁵		
	Patient Education (within past 24 months) ⁶¹¹⁰ : <input type="radio"/> No – Patient not Counseled or Educated <input type="radio"/> No Counseling or Education – Medical Reason <input type="radio"/> Yes <input type="checkbox"/> Healthy Diet Counseling ⁶¹²⁰ <input type="checkbox"/> Medication Instruction ⁶¹²¹ <input type="checkbox"/> Physical Activity Counseling ⁶¹²² → If Yes, (check all that apply): <input type="checkbox"/> Symptom Management ⁶¹²³ <input type="checkbox"/> Weight Monitoring ⁶¹²⁴		
FOOT EXAMS/ PROCEDURES	Foot Exam (within past 12 months) ⁶⁶³⁰ : <input type="radio"/> No - Not Documented <input type="radio"/> Yes → If Yes, Date ⁶⁶³² : mm / dd / yyyy		
	Mono Filament Exam ⁶⁶⁴⁰ : <input type="radio"/> No <input type="radio"/> Yes	Pulse Exam ⁶⁶⁵⁰ : <input type="radio"/> No <input type="radio"/> Yes	Ankle Brachial Index Test ⁶⁶⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes
EYE EXAMS/ PROCS	Negative Retinal or Dilated Eye Exam (within past 24 months) ⁶⁶⁷⁰ : <input type="radio"/> No – Not Documented <input type="radio"/> Yes		
	Retinal or Dilated Eye Exam (within past 12 months) ⁶⁶⁸⁰ : <input type="radio"/> No – Not Documented <input type="radio"/> Yes → If Yes, Date ⁶⁶⁸² : mm / dd / yyyy		
DIABETES DEVICES	<input type="checkbox"/> Insulin Pump ⁶⁷⁰⁰ → If Yes, Date ⁶⁷⁰² : mm / dd / yyyy		
	<input type="checkbox"/> Continuous Glucose Monitoring ⁶⁷¹⁰ → If Yes, Date ⁶⁷¹² : mm / dd / yyyy		
CAD	CCS Class ⁶⁴³⁰ : <input type="radio"/> No angina <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV		
	Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months ⁶⁴⁵⁰ : <input type="radio"/> Yes – Referral/Plan Documented <input type="radio"/> No Referral/Plan – Medical Reason <input type="radio"/> No Qualifying Event/Diagnosis <input type="radio"/> No Referral/Plan – System Reason <input type="radio"/> Patient Already Participating in Rehab <small>(Note: Qualifying event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, Heart Failure, CABG, PCI and also new Stable Angina diagnosis.)</small>		
	Referral for Consideration for Coronary Revascularization ⁶⁴⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes		
	Referral for Additional Evaluation/Treatment of Anginal Symptoms ⁶⁴⁷⁰ : <input type="radio"/> No <input type="radio"/> Yes		
HF	NYHA Class ⁶¹³⁰ : <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV	LVEF Assessed Date ⁶⁴⁰⁰ : mm / dd / yyyy	LVEF ⁶⁴¹⁰ : _____ %
	LV Qualitative Assessment ⁶⁴²⁰ : <input type="radio"/> Hyperdynamic: > 70 <input type="radio"/> Normal: 50 – 70 (Note: If a LVEF range is documented, take the average, round up and refer to the LVEF Status ranges (right) to code.) <input type="radio"/> Mildly reduced: 40 – 49 <input type="radio"/> Moderately reduced: 30 – 39 <input type="radio"/> Severely reduced: ≤ 29		

E. LABORATORY RESULTS	<small>NOTE: ENTER MOST RECENT LAB RESULTS AND/OR INDICATE THE LABS ORDERED DURING THIS ENCOUNTER.</small>
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DIABETES/CARDIAC	Lipid Panel Obtained Date ⁷⁰⁰⁰ : mm / dd / yyyy Total Cholesterol ⁷⁰¹⁰ : _____ mg/dL High Density Lipoprotein (HDL) ⁷⁰²⁰ : _____ mg/dL Low Density Lipoprotein (LDL) ⁷⁰³⁰ : _____ mg/dL Direct Low Density Lipoprotein (DLDL) ⁷⁰⁴⁰ : _____ mg/dL Triglycerides ⁷⁰⁵⁰ : _____ mg/dL	Diabetes	Glucose timing ⁷⁰⁶⁰ : <input type="radio"/> Fasting <input type="radio"/> Random Plasma Glucose Results ⁷⁰⁷⁰ : _____ mg/dL → Date ⁷⁰⁷² mm / dd / yyyy C-peptide ⁷⁵⁴² : _____ ng/mL → Date ⁷⁵⁴⁶ mm / dd / yyyy Insulin ⁷⁵⁴⁸ : _____ mIU/L → Date ⁷⁵⁵⁰ mm / dd / yyyy HbA1c ⁷⁰⁸⁰ : _____ % → Date ⁷⁰⁸² mm / dd / yyyy 2 hour Plasma Glucose during Oral Glucose Tolerance Test ⁷⁰⁹⁰ : _____ mg/dL → Date ⁷⁰⁹² mm / dd / yyyy
	Potassium ⁷¹¹⁰ : _____ meq/L → Date ⁷¹¹² mm / dd / yyyy B-type Natiuretic Peptide ⁷¹²⁰ : _____ pg/mL → Date ⁷¹²² mm / dd / yyyy N-terminal pro b-type Natiuretic Peptide ⁷¹²⁵ : _____ pg/mL → Date ⁷¹²⁷ mm / dd / yyyy		
	ALT ⁷³⁰⁰ : _____ U/L → Date ⁷³⁰² mm / dd / yyyy Amylase ⁷³¹⁰ : _____ U/L → Date ⁷³¹² mm / dd / yyyy AST ⁷³²⁰ : _____ U/L → Date ⁷³²² mm / dd / yyyy Bilirubin – Direct ⁷³⁴⁰ : _____ mg/dL → Date ⁷³⁴² mm / dd / yyyy Bilirubin – Total ⁷³⁵⁰ : _____ mg/dL → Date ⁷³⁵² mm / dd / yyyy Blood Urea Nitrogen (BUN) ⁷³⁶⁰ : _____ mg/dL → Date ⁷³⁶² mm / dd / yyyy Creatinine Clearance ⁷²²⁰ : _____ mL/min → Date ⁷²²² mm / dd / yyyy Cystatin-C (Cystatin) ⁷³⁷⁰ : _____ mg/L → Date ⁷³⁷² mm / dd / yyyy		Estimated Glomerular Filtration Rate ⁷²⁰⁰ : _____ mL/min/m ² → Date ⁷²⁰² mm / dd / yyyy hs CRP ⁷³⁸⁰ : _____ mg/L → Date ⁷³⁸² mm / dd / yyyy Lipase ⁷³⁹⁰ : _____ U/L → Date ⁷³⁹² mm / dd / yyyy Serum Creatinine ⁷²³⁰ : _____ mg/dL → Date ⁷²³² mm / dd / yyyy TSH ⁷⁴⁰⁰ : _____ mIU/L → Date ⁷⁴⁰² mm / dd / yyyy Uric Acid ⁷⁴¹⁰ : _____ mg/dL → Date ⁷⁴¹² mm / dd / yyyy 24 Hr Urine Protein ⁷⁴²⁰ : _____ mg/24h → Date ⁷⁴²² mm / dd / yyyy Urine Albumin Creatinine Ratio (UACR) ⁷⁴³⁰ : _____ mg/g for 24h period → Date ⁷⁴³² mm / dd / yyyy
	White Blood Cell Count ⁷⁵⁰⁰ : _____ → Date ⁷⁵⁰² mm / dd / yyyy HgB ⁷⁵¹⁰ : _____ → Date ⁷⁵¹² mm / dd / yyyy		Hematocrit ⁷⁵²⁰ : _____ → Date ⁷⁵²² mm / dd / yyyy Platelet Count ⁷⁵³⁰ : _____ → Date ⁷⁵³² mm / dd / yyyy

F. MEDICATIONS PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.		DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, mL)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ ⁹³⁰⁹	MOST RECENT PRESCRIPTION DATE ⁹³¹⁵	ADMINISTERED ⁹³⁰⁵				
								YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
GLUCOSE LOWERING MEDICATIONS	SHORT/RAPID (MEALTIME, PRANDIAL, NUTRITIONAL)	Aspart						0	0	0	0	
	Lispro							0	0	0	0	
	Glulisine							0	0	0	0	
	Regular Human Insulin							0	0	0	0	
	Inhaled Insulin							0	0	0	0	
	INTERMEDIATE/LONG (BASAL)	Glargine							0	0	0	0
		Detemir							0	0	0	0
		NPH							0	0	0	0
		Degludec ⁺							0	0	0	0
	PRE-MIXED INSULINS	70% Human Insulin Isophane Suspension and 30% Human Insulin Injection (NPH-Regular 70-30 Premix)							0	0	0	0
		70% Insulin Aspart Protamine Suspension and 30% Insulin Aspart Injection (Insulin Aspart 70-30 Premix)							0	0	0	0
		75% Insulin Lispro Protamine Suspension and 25% Insulin Lispro Injection (Insulin Lispro 75-25 Premix)							0	0	0	0
		50% Insulin Lispro Protamine Suspension and 50% Insulin Lispro Injection (Insulin Lispro 50-50 Premix)							0	0	0	0
	Metformin							0	0	0	0	
	SULFONYLUREAS	Glimepiride							0	0	0	0
		Glipizide							0	0	0	0
		Glyburide							0	0	0	0
	GLINDES	Repaglinide							0	0	0	0
		Nateglinide							0	0	0	0
	THIAZOLIDIN E DIONES	Pioglitazone							0	0	0	0
Rosiglitazone								0	0	0	0	
DPP-4 INHIBITORS	Sitagliptin							0	0	0	0	
	Saxagliptin							0	0	0	0	
	Linagliptin							0	0	0	0	
	Alogliptin							0	0	0	0	
ALPHA-GLUCOSIDASE	Acarbose							0	0	0	0	
	Miglitol							0	0	0	0	
BILE ACID SEQUESTRANTS	Colesevelam							0	0	0	0	

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RXNORM 5.SNOMED-CT 6. OTHER

F. MEDICATIONS (CONT.) PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.		DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ ⁹³⁰⁹	MOST RECENT PRESCRIPTION DATE ⁹³¹⁵	ADMINISTERED ⁹³⁰⁵				
								YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
GLUCOSE LOWERING MEDICATIONS	DOPAMINE AGONISTS	Bromocriptine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	AMYLINOMIMETICS	Pramlintide Acetate						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	GLP-1 AGONISTS	Exenatide							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Exenatide QW							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Liraglutide							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Albiglutide							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Dulaglutide ⁺							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Lixisenatide ⁺							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SGLT-2 INHIBITORS	Canagliflozin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Dapagliflozin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Empagliflozin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	COMBINATION PILLS	Pioglitazone & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Pioglitazone & Glimepiride							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Glyburide & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Glipizide & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sitagliptin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Saxagliptin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Linagliptin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Alogliptin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Alogliptin & Pioglitazone							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaglinide & Metformin								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rosiglitazone & Metformin								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rosiglitazone & Glimepiride								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Empagliflozin & Linagliptin								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Empagliflozin & Metformin								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canagliflozin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dapagliflozin & Metformin							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RxNORM 5. SNOMED-CT 6. OTHER

F. MEDICATIONS (CONT.) PLEASE LEAVE BLANK IF THERE IS NO CLINICAL INDICATION FOR A MEDICATION TO BE PRESCRIBED, OR IF NO DOCUMENTATION EXISTS AS TO IF A MEDICATION WAS PRESCRIBED/CONTINUED.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.	DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ ⁹³⁰⁹	MOST RECENT PRESCRIPTION DATE ⁹³¹⁵	ADMINISTERED ⁹³⁰⁵				
							YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
LIPID LOWERING	NON-STATIN	Lipid Lowering Non-Statins (Any)					0	0	0	0	
		Ezetimibe					0	0	0	0	
		Fibrates					0	0	0	0	
		Niacin					0	0	0	0	
		Omega 3 Fatty Acid					0	0	0	0	
	STATIN*	Low Intensity Statin					0	0	0	0	
		Moderate Intensity Statin					0	0	0	0	
		High Intensity Statin					0	0	0	0	
	PCSK9	Alirocumab					0	0	0	0	
		Evolocumab					0	0	0	0	
WEIGHT LOSS MEDICATIONS	Phentermine & Topiramate extended-release						0	0	0	0	
	Bupropion/Naltrexone						0	0	0	0	
	Lorcaserin Hydrochloride						0	0	0	0	
SMOKING CESSATION*	Bupropion						0	0	0	0	
	Nicotine Replacement Therapy						0	0	0	0	
	Varenicline						0	0	0	0	
ANTIPLATELETS	Aspirin	Aspirin					0	0	0	0	
		Aspirin-dipyridamole (Aggrenox)					0	0	0	0	
	P2Y12	Clopidogrel						0	0	0	0
		Ticlopidine						0	0	0	0
		Prasugrel						0	0	0	0
		Ticagrelor						0	0	0	0
ANTICOAGULANTS*	Apixaban						0	0	0	0	
	Dabigatran						0	0	0	0	
	Rivaroxaban						0	0	0	0	
	Warfarin						0	0	0	0	
	Edoxaban ⁺						0	0	0	0	

¹PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RXNORM 5. SNOMED-CT 6. OTHER

F. MEDICATIONS (CONT.) Please leave blank if there is no clinical indication for a medication to be prescribed, or if no documentation exists as to if a medication was prescribed/continued.

MEDICATION ⁹³⁰⁰ * DENOTES THAT THE MEDICATION(S) ARE REQUIRED FOR SPECIFIC PERFORMANCE MEASURES OR PQRS MEASURES + INDICATES A MEDICATION IS NOT YET BEEN APPROVED.	DOSE STRENGTH ⁹³⁰¹	DOSING MEASURE ⁹³⁰² (E.G. MG, ML)	DOSING FREQUENCY ⁹³⁰³	SOURCE MEDICATION CODE ⁹³⁰⁷	SOURCE MEDICATION CODE SYSTEM ¹ ⁹³⁰⁹	MOST RECENT PRESCRIPTION DATE ⁹³¹⁵	ADMINISTERED ⁹³⁰⁵				
							YES (PRESCRIBED)	NO (MEDICAL REASON)	NO (PATIENT REASON)	NO (SYSTEM REASON)	
ANTIHYPERTENSIVE	ACE Inhibitor*						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	ARB*						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Medoxomil/Amlodipine/ Hydrochlorothiazide (Tribenzor)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	CA CHANNEL BLOCKERS	Calcium Channel Blocker (Any)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Dihydropyridine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Non-Dihydropyridine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DIURETICS*	Diuretic (Any)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Loop Diuretic						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Thiazide Diuretic						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Potassium Sparing Diuretic						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BETA BLOCKER*	Beta Blocker (Any)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Atenolol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bisoprolol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Carvedilol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Metoprolol succinate						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Metoprolol tartrate						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Nebivolol						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANTI-ANGINAL	Ranolazine						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

¹ PLEASE PROVIDE SOURCE MEDICATION CODE SYSTEM VALUE: 1. GPI 2. MMSL 3. NDC 4. RXNORM 5. SNOMED-CT 6. OTHER

G. HOSPITALIZATIONS (SINCE PATIENT WAS LAST SEEN)

Hospital Admission Date⁹⁵⁰⁰: mm / dd / yyyy → If Admitted, Primary Reason⁹⁵⁰⁵: _____ Coding Standard⁹⁵¹⁰: ICD-9 ICD-10

Discharge Date⁹⁵⁰²: mm / dd / yyyy Secondary Diagnoses⁹⁵⁰⁷: _____

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