veradigm

PINNACLE Registry® Data Collection Form
Version 1.6

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]: O No O 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]: O Male O Female	☐ Patient Deceased[2065] → Date[2067] mm / dd / yyyy	

Race: (Check all that apply)
☐ White[2070] ☐ Black/African American[2071] ☐ American Indian/Alaskan Native[2073]
☐ Asian[2072] → If Yes, ☐ Asian Indian[2080] ☐ Chinese[2081] ☐ Filipino[2082] ☐ Japanese[2083] ☐ Korean[2084] ☐ Vietnamese[2085] ☐ Other[2086]
☐ Native Hawaiian/Pacific Islander[2074] → If Yes, ☐ Native Hawaiian[2090] ☐ Guamanian or Chamorro[2091] ☐ Samoan[2092] ☐ Other Island[2093]

Hispanic or Latino Ethnicity[2076]: O No O Yes → If Yes, **Ethnicity Type:** (Check all that apply)
☐ Mexican, Mexican-American, Chicano[2100] ☐ Puerto Rican[2101] ☐ Cuban[2102] ☐ Other Hispanic, Latino or Spanish Origin[2103]

Insurance Payers: (Check all that apply)
☐ Medicaid (fee for service)[3030] ☐ Medicare (fee for service)[3028]
☐ Private Health Insurance[3020] ☐ Medicaid (managed care)[3031] ☐ Medicare (managed care)[3029]
☐ Military Health Care[3023] ☐ State Specific Plan (non-Medicaid)[3024] ☐ Indian Health Service[3025] ☐ Non-US Insurance[3026] ☐ None[3027]

Payer ID[3100]: _____

B. Diagnoses/Conditions/Co-Morbidities (Check all that apply)

Note: Indicate if the patient has a history of any of the following.

☐ **Coronary Artery Disease**[4000] → **Date**[4002] mm / dd / yyyy
☐ **Atrial Fibrillation/Flutter**[4010] → **Date**[4012] mm / dd / yyyy
☐ **Dyslipidemia**[4020] → **Date**[4022] mm / dd / yyyy
☐ **Diabetes Mellitus (Any)**[4150] → **Date**[4152] mm / dd / yyyy
☐ **Hypertension**[4030] → **Date**[4032] mm / dd / yyyy
☐ **Peripheral Vascular Disease**[4230] → **Date**[4232] mm / dd / yyyy
☐ **Peripheral Arterial Disease**[4090] → **Date**[4092] mm / dd / yyyy
☐ **PAD – Acute Limb Ischemia**[4100] → **Date**[4102] mm / dd / yyyy
☐ **PAD – Claudication**[4110] → **Date**[4112] mm / dd / yyyy
☐ **PAD – Critical Limb Ischemia**[4120] → **Date**[4122] mm / dd / yyyy
☐ **PAD – Foot/Leg cellulitis**[4130] → **Date**[4132] mm / dd / yyyy
☐ **PAD – Lower Extremity Osteomyelitis** (with or without limb ischemia)[4140] → **Date**[4142] mm / dd / yyyy

☐ **Heart Failure**[4040] → **Date**[4042] mm / dd / yyyy
→ If Yes, ☐ **New diagnosis**[4050] (within 12 months)
→ If Yes, **Etiology**[4052]
O Ischemic O Hypertensive O Valvular O Congenital
O Idiopathic/dilated O Peripartum O Chemotherapy induced
O Substance related O Tachycardia

☐ **CAD - Unstable Angina**[4080] → **Date**[4082] mm / dd / yyyy
☐ **CAD - Stable Angina**[4060] → **Date**[4062] mm / dd / yyyy
→ If Yes, ☐ **New diagnosis**[4070] (within 12 months)
☐ **Ischemic Vascular Disease**[4220] → **Date**[4222] mm / dd / yyyy
☐ **Chronic Kidney Disease**[4240] → **Date**[4242] mm / dd / yyyy
☐ **Chronic Liver Disease**[4250] → **Date**[4252] mm / dd / yyyy

C. Cardiac Events

Note: Indicate if the patient has a history of any of the following.

Specify all Event(s) and if available, Event Date(s) that occurred.

Event[5135]	Event Date(s)[5136]	Event[5135]	Event Date(s)[5136]
CAD – Myocardial Infarction[E001]	mm / dd / yyyy	**Minor Hemorrhage**[E006]	mm / dd / yyyy
PCI (Any)[E029]	mm / dd / yyyy	**Intracranial Hemorrhage**[E007]	mm / dd / yyyy
PCI – Bare Metal Stent Implant[E002]	mm / dd / yyyy	**Non Intracranial Major Hemorrhage** (Any)[E032]	mm / dd / yyyy
PCI – Drug Eluting Stent Implant[E003]	mm / dd / yyyy	**Non Intracranial Major Hemorrhage Location – Intra-articular (Atraumatic)**[E009]	mm / dd / yyyy
PCI – Other (non-stent) Intervention[E004]	mm / dd / yyyy	**Non Intracranial Major Hemorrhage Location – Intra-ocular**[E010]	mm / dd / yyyy
Coronary Artery Bypass Graft[E017]	mm / dd / yyyy	**Non Intracranial Major Hemorrhage Location – Intra-spinal**[E011]	mm / dd / yyyy
Systemic Embolism[E005]	mm / dd / yyyy		
Hemorrhage (Any)[E031]	mm / dd / yyyy		

MRN:	Encounter Date: mm / dd / yyyy	Practice ID:	Location ID:

C. Cardiac Events (Cont.)

Note: Indicate if the patient has a history of any of the following.

Specify all Event(s) and if available, Event Date(s) that occurred.

Event[5135]	Event Date(s)[5136]	Event[5135]	Event Date(s)[5136]
Non Intracranial Major Hemorrhage Location – Pericardial[E012]	mm / dd / yyyy	**ICD Implant**[E025]	mm / dd / yyyy
		Permanent Pacemaker[E027]	mm / dd / yyyy
Non Intracranial Major Hemorrhage Location – Retroperitoneal/Abdominal[E013]	mm / dd / yyyy	**Carotid Endarterectomy** (Any)[E033]	mm / dd / yyyy
TIA[E014]	mm / dd / yyyy	**Carotid Endarterectomy – Right**[E034]	mm / dd / yyyy
Stroke (Any)[E030]	mm / dd / yyyy	**Carotid Endarterectomy – Left**[E035]	mm / dd / yyyy
Stroke – Ischemic[E015]	mm / dd / yyyy	**Carotid Artery Stent** (Any)[E036]	mm / dd / yyyy
Stroke – Hemorrhagic[E016]	mm / dd / yyyy	**Carotid Artery Stent – Right**[E037]	mm / dd / yyyy
Cardiac Valve Surgery[E018]	mm / dd / yyyy	**Carotid Artery Stent – Left**[E038]	mm / dd / yyyy
Heart Transplantation[E019]	mm / dd / yyyy	**PAD – Peripheral Bypass**[E043]	mm / dd / yyyy
Cardioversion[E021]	mm / dd / yyyy	**PAD – Peripheral Intervention**[E044]	mm / dd / yyyy
LVAD[E022]	mm / dd / yyyy	**Syncope**[E065]	mm / dd / yyyy
CRT[E023]	mm / dd / yyyy	**Left Bundle Branch Block**[E066]	mm / dd / yyyy
CRT-D[E024]	mm / dd / yyyy		

D. Encounter Information

Note: Complete only if assessed during today's encounter. If not assessed, leave blank.

Height: _____ O in[6000] O cm[6001] | **Blood Pressure**[6010, 6011]: _____ / _____ mmHg | **Heart Rate**[6015]: _____ bpm

Weight: _____ O lbs[6020] O kg[6021] ☐ **Patient unable to be weighed**[6025] | **QRS Duration (Non-Ventricular Paced Complex)**[6028]: _____ ms

Tobacco Use[6030]: O Never O Current O Quit within past 12 months O Quit more than 12 months ago
O Screening not performed for medical reasons

→ **If** Current or Quit within 12 months, **Tobacco Type:** (check all that apply) ☐ Cigarettes[6035] ☐ Cigars[6036] ☐ Pipe[6037] ☐ Smokeless[6038]

→ **If** Current or Quit within 12 months, **Smoking Cessation Counseling Provided**[6040]: O No O Yes

Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco[6045]: O No O Yes

Alcohol Use[6047]: O None O <1 drinks/wk O 2-7 drinks/wk O 8-14 drinks/wk O >= 15 drinks/wk

Advance Care Plan OR Discussion of Advance Care Plan Documented[6050]: O No – Not documented O No – patient reason O Yes

Angina Symptoms and Activity Assessment(s)

Note: Complete at least one to meet measure.

CAD

CCS Class[6430]: O No angina O I O II O III O IV ☐ **Other Tool/Method to Assess Angina Symptoms and Activity Completed**[6440]

☐ **Seattle Angina Questionnaire Completed**[6435]

Heart Failure Activity Assessment(s)

Note: Complete NYHA to meet measure.

HF

Stage of Heart Failure[6128]: O A O B O C O D

NYHA Class[6130]: O I O II O III O IV

☐ **Kansas City Cardiomyopathy Questionnaire Completed**[6135] → **If** Yes, _____ score (0-100)[6136]

☐ **Other Tool/Method to Assess Heart Failure Activity Completed**[6155]

Heart Failure Symptoms Assessment(s)

Note: Complete at least one to meet measure.

HF

Dyspnea Present[6200]: O No O Yes | **Orthopnea Present**[6210]: O No O Yes

Heart Failure Physical Assessment(s)

Note: Complete at least one to meet measure.

HF

Rales Present[6220]: O No O Yes | **Peripheral Edema Present**[6230]: O No O Yes | **S_3 Gallop Present**[6240]: O No O Yes

Ascites Present[6250]: O No O Yes | **Hepatomegaly Present**[6260]: O No O Yes | **S_4 Gallop Present**[6270]: O No O Yes

Jugular Venous Distention Present[6275]: O No O Yes

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PLAN OF CARE

BMI

☐ **Body Mass Index Screen Performed**[6900] →**Date**[6902] mm / dd / yyyy ☐ **BMI Management Plan**[6910]

CAD

Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months[6450]:
O Yes – Referral/Plan Documented
O No Qualifying Event/Diagnosis
O Patient Already Participating in Rehab
O No Referral/Plan – Medical Reason
O No Referral/Plan – System Reason

(**Note:** Cardiac event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, CABG, PCI or new Stable Angina diagnosis.)

Referral for Consideration for Coronary Revascularization[6460]: O No O Yes

Referral for Additional Evaluation/Treatment of Anginal Symptoms[6470]: O No O Yes

Discussion of Lifestyle Modifications Documented[6100]: O No O Yes

EF

LVEF Assessed Date[6400]: mm / dd / yyyy

LVEF[6410]: _____ %

(**Note**: If a LVEF range is documented, take the average, round up and refer to the **LVEF Status** ranges (right) to code.)

LV Qualitative Assessment[6420]: →
O Hyperdynamic: > 70
O Mildly reduced: 40 – 49
O Severely reduced: ≤ 29
O Normal: 50 – 70
O Moderately reduced: 30 – 39

HF

HF Education Completed/Documented: (Check all that apply)

☐ All of the following[6280] ☐ Weight Monitoring[6281] ☐ Diet (Sodium Restriction)[6282] ☐ Symptom Management[6283]
☐ Physical Activity[6284] ☐ Smoking Cessation[6285] ☐ Medication Instruction[6286] ☐ Prognosis/end-of-life Issues[6287]
☐ Minimizing or Avoiding use of NSAIDs[6288] ☐ Referral for visiting nurse or specific educational or management programs[6289]

ICD Counseling[6300]: O Yes – Patient Counseled O No – Patient Not Counseled O No Counseling – Medical Reason

HF Plan of Care[6310]: O No O Yes

ATRIAL FIBRILLATION/FLUTTER ASSESSMENT AND TREATMENT

AFIB

AFib/Flutter Duration[6500]: O First diagnosed O Paroxysmal O Persistent O Long-standing Persistent O Permanent

AFib/Flutter Type[6510]: O Non-Valvular O Valvular

☐ **Afib/Flutter Etiology – Transient/Reversible Cause**[6520] (e.g., pneumonia, hyperthyroidism, pregnancy, post-surgery)

INR Value[6530]: _____ →**Date**[6532] mm / dd / yyyy

☐ **EP Study**[6540] →**Date**[6542] mm / dd / yyyy

☐ **Atrial Ablation**[6550] →**Date**[6552] mm / dd / yyyy

☐ **Atrial Fibrillation Recurrence**[6560] →**Date**[6562] mm / dd / yyyy

Atrial Fibrillation Symptom Frequency[6570]: (every) _____ days

Atrial Fibrillation Symptom Duration[6580]:

O < 48 hours O >= 48 hours – 7 days O >7 days – 3 months O > 3 months

☐ **Rate Control Therapy**[6590] ☐ **Rhythm Control Therapy**[6595]

TE RISK FACTORS

$CHADS_2$ Score[6600]: _____ **CHA_2DS_2-VASc Score**[6610]: _____ **HAS-BLED Score**[6620]: _____

E. LABORATORY RESULTS

NOTE: ENTER **ALL** LAB RESULTS AND/OR INDICATE THE LABS ORDERED DATES.

CAD

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]: O Fasting O Random

Plasma Glucose Results[7070]: _____ mg/dL →**Date**[7072] mm / dd / yyyy

HbA1c[7080]: _____ % →**Date**[7082] mm / dd / yyyy

HgB[7510]: _____ g/dL →**Date**[7512] mm / dd / yyyy

HF

Potassium[7110]: _____ mEq/L →**Date**[7112] mm / dd / yyyy

Sodium[7115]: _____ mEq/L →**Date**[7117] 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

RENAL

Estimated Glomerular Filtration Rate[7200]: _____ mL/min →**Date**[7202] mm / dd / yyyy

Creatinine Clearance[7220]: _____ →**Date**[7222] mm / dd / yyyy

Serum Creatinine[7230]: _____ mg/dL →**Date**[7232] mm / dd / yyyy

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** **Location ID:**

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)
ANTIANGINAL	Nitroglycerin							O	O	O	O
	Ranolazine							O	O	O	O
ANTIARRYTHMIC	Antiarrhythmic (Any)							O	O	O	O
	Amiodarone							O	O	O	O
	Dronedarone							O	O	O	O
ANTICOAGULANTS*	Apixaban							O	O	O	O
	Dabigatran							O	O	O	O
	Edoxaban							O	O	O	O
	Rivaroxaban							O	O	O	O
	Warfarin							O	O	O	O
ANGIOTENSION RECEPTOR-NEPRILYSIN INHIBITOR	Sacubitril/Valsartan							O	O	O	O
ANTIHYPERTENSIVE	ACE Inhibitor*							O	O	O	O
	ARB*							O	O	O	O
	Combination Antihypertensive							O	O	O	O
CA CHANNEL BLOCKERS	Calcium Channel Blocker (any)							O	O	O	O
	Dihydropyridine							O	O	O	O
	Non-Dihydropyridine							O	O	O	O
DIURETICS*	Diuretic (Any)							O	O	O	O
	Loop Diuretic							O	O	O	O
	Thiazide Diuretic							O	O	O	O
	Potassium Sparing Diuretic							O	O	O	O
ANTIPLATELETS	Aspirin							O	O	O	O
	Aspirin-dipyridamole (Aggrenox)							O	O	O	O
P2Y12 INHIBITOR	Clopidogrel							O	O	O	O
	Ticlopidine							O	O	O	O
	Prasugrel							O	O	O	O
	Ticagrelor							O	O	O	O
THROMBIN RECEPTOR ANTAGONIST	Vorapaxar (Zontivity)							O	O	O	O

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

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** **Location ID:**

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)
BETA BLOCKER	Beta Blocker (Any)							O	O	O	O
	Atenolol							O	O	O	O
	Metoprolol Tartrate							O	O	O	O
	Sustained release metoprolol succinate							O	O	O	O
	Bisoprolol							O	O	O	O
	Carvedilol							O	O	O	O
	Nebivolol							O	O	O	O
HEART RATE LOWERING	Ivabradine							O	O	O	O
GLUCOSE LOWERING	Insulin							O	O	O	O
	Metformin							O	O	O	O
	Pioglitazone							O	O	O	O
	Rosiglitazone							O	O	O	O
SGLT-2 INHIBITORS	Canaglifozin							O	O	O	O
	Dapagliflozin							O	O	O	O
	Empagliflozin							O	O	O	O
DPP-4 INHIBITORS	Sitagliptin							O	O	O	O
	Saxagliptin							O	O	O	O
	Linagliptin							O	O	O	O
	Alogliptin							O	O	O	O
ALPHA-GLUOSIDASE	Acarbose							O	O	O	O
	Miglitol							O	O	O	O
LIPID LOWERING	Lipid Lowering Non-Statin							O	O	O	O
	Ezetimibe							O	O	O	O
STATIN	Lipid Lowering Statin (Any)							O	O	O	O
	Atorvastatin							O	O	O	O
	Rosuvastatin							O	O	O	O
	Simvastatin							O	O	O	O
	Low Intensity Statin							O	O	O	O
	Moderate Intensity Statin							O	O	O	O
	High Intensity Statin							O	O	O	O
PCKSK9 INHIBITORS	Alirocumab							O	O	O	O
	Evolocumab							O	O	O	O

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

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** **Location ID:**

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)
Smoking Cessation	Bupropion							O	O	O	O
	Nicotine Replacement Therapy							O	O	O	O
	Varenicline							O	O	O	O
Combination Pills	Hydralazine and Isosorbide Dinitrate							O	O	O	O
Other	Corticosteroids							O	O	O	O
	Digoxin (Any)							O	O	O	O
	NSAID							O	O	O	O
	Proton Pump Inhibitor							O	O	O	O
	SSRI							O	O	O	O

[1]Please provide Source Medication Code System value: 1. GPI 2. MMSL 3. NDC 4. RxNorm 5. SNOMED-CT 6. Other

G. Hospitalizations

Hospital Admission Date[9500]**:** mm / dd / yyyy → If Admitted, **Primary Reason**[9505]**:** _____ **Coding Standard**[9510]**:** O ICD-9 O ICD-10

Discharge Date[9502]**:** mm / dd / yyyy **Secondary Diagnosis**[9507]**:** _____