

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

OPTIONAL: Local Event ID:		
Did pt. receive chest compressions and/or defibrillation during this event?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented (Does NOT meet inclusion criteria)
Where did the event occur?	<input type="radio"/> Out of Hospital	<input type="radio"/> In-Hospital
Did patient have subsequent cardiac arrest event(s) during the course of this hospitalization?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time the need for chest compressions (or defibrillation when initial rhythm was VF or Pulseless VT) was FIRST recognized:	___/___/___ :__ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
System Entry Date:	___/___/___ :__ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented

PCAC 2.1 PRE-EXISTING CONDITIONS Pre-Event Tab

Pre-existing Conditions at Time of Event (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Hepatic Insufficiency
<input type="checkbox"/> Acute Stroke	<input type="checkbox"/> Hypotension/hypoperfusion
<input type="checkbox"/> Acute CNS non-stroke event	<input type="checkbox"/> Major Trauma
<input type="checkbox"/> Baseline depression in CNS function	<input type="checkbox"/> Metabolic/Electrolyte Abnormality
<input type="checkbox"/> Cardiac malformation/abnormality - cyanotic (pediatric and newborn/neonate only)	<input type="checkbox"/> Myocardial ischemia/infarction (this admission)
<input type="checkbox"/> Cardiac malformation/abnormality - acyanotic (pediatric and newborn/neonate only)	<input type="checkbox"/> Myocardial ischemia/infarction (prior to this admit)
<input type="checkbox"/> Congenital malformation/abnormality (Non-Cardiac) (pediatric and newborn/neonate only)	<input type="checkbox"/> Metastatic or hematologic malignancy
<input type="checkbox"/> Congestive heart failure (this admission)	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Congestive heart failure (prior to this admission)	<input type="checkbox"/> Renal Insufficiency
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Respiratory insufficiency
	<input type="checkbox"/> Sepsis
	<input type="checkbox"/> Prior CPR Event

PCAC 3.1 CARDIAC ARREST EVENT Event Tab

Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unknown
Date/Time of Birth:	___/___/___ :__ (MM/DD/YYYY HH:MM)		
Age at Event (in yrs., months, weeks, days, hrs., or minutes):	___ <input type="radio"/> Years <input type="radio"/> Months	<input type="radio"/> Weeks <input type="radio"/> Days	<input type="radio"/> Hours <input type="radio"/> Minutes <input type="checkbox"/> Estimated <input type="checkbox"/> Age Unknown / Not Documented
Event Witnessed?	<input type="radio"/> Yes		<input type="radio"/> No/Not Documented
Did patient receive chest compressions (includes open cardiac massage)?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	<input type="radio"/> No, Per Advance Directive
Date/Time compressions started:	___/___/___ :__ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented
Was out of Hospital CPR performed?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
If yes, out of hospital CPR performed first by:	<input type="radio"/> Healthcare provider/ EMS	<input type="radio"/> Layperson	<input type="radio"/> Not Documented
Condition that best describes this event:	<input type="radio"/> Patient was PULSELESS when need for chest compressions and/or need for defibrillation of initial rhythm VF/Pulseless VT was first identified <input type="radio"/> Patient had a pulse (poor perfusion) requiring chest compressions PRIOR to becoming pulseless <input type="radio"/> Patient had a pulse (poor perfusion) requiring chest compressions, but did NOT become pulseless at any time during this event		
If pulseless at ANY time during event: Date/Time pulselessness was first identified:	___/___/___ :__ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

First documented pulseless rhythm:	<input type="radio"/> Asystole <input type="radio"/> Pulseless Electrical Activity (PEA) <input type="radio"/> Pulseless Ventricular Tachycardia	<input type="radio"/> Ventricular Fibrillation (VF) <input type="radio"/> Unknown/Not Documented
Total time patient without a pulse prior to CPR (in minutes):	_____	<input type="checkbox"/> Not Documented
Duration of CPR (in minutes):	_____	<input type="checkbox"/> Not Documented
Sustained Return of Spontaneous Circulation (ROSC) achieved?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
For out-of-hospital events, ROSC attained?	<input type="radio"/> At scene <input type="radio"/> En-route	<input type="radio"/> After arrival to hospital <input type="radio"/> Not Documented
Date/Time sustained ROSC began (lasting > 20 min) OR resuscitation efforts were terminated (End of event):	____/____/____ ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Time Estimated

PCAC 4.1 ARRIVAL INFORMATION

Arrival Tab

Arrival Date/Time	____/____/____ ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
Was patient transferred from another hospital?	<input type="radio"/> Yes	<input type="checkbox"/> No
Neurological assessment performed within 1-hr of ROSC?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented	<input type="radio"/> Neurological Assessment obtained at transferring facility
Date/Time initial neurological assessment:	____/____/____ ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Time Estimated
Neurological Assessment Findings:		
Pupils equal?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Are pupils fixed and dilated?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Right pupil reaction?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Left pupil reaction?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Follows commands at time of initial assessment?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented

Glasgow Coma Scale (GCS) within 1-hr of ROSC:

	<input type="checkbox"/> Unknown/Not Documented	<input type="checkbox"/> Intubated
Motor:	_____ <input type="checkbox"/> Sedation/Paralytic	<input type="checkbox"/> Unknown/Not Documented
Eye:	_____ <input type="checkbox"/> Sedation/Paralytic	<input type="checkbox"/> Unknown/Not Documented
Verbal:	_____ <input type="checkbox"/> Sedation/Paralytic	<input type="checkbox"/> Unknown/Not Documented
Total GCS:	_____ <input type="checkbox"/> Sedation/Paralytic	<input type="checkbox"/> Unknown/Not Documented

PCAC 4.2 TARGETED TEMPERATURE MANAGEMENT

Arrival Tab

Did you utilize targeted temperature management?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown/Not Documented
If yes, what was the targeted temperature (choose one)?	<input type="radio"/> <= 38.0 degrees Celsius <input type="radio"/> <= 37.0 degrees Celsius <input type="radio"/> <= 36.0 degrees Celsius <input type="radio"/> <= 35.0 degrees Celsius	<input type="radio"/> <= 34.0 degrees Celsius <input type="radio"/> <= 33.0 degrees Celsius <input type="radio"/> <= 32.0 degrees Celsius <input type="radio"/> <= 31.0 degrees Celsius
Temperature control method (select all that apply):	<input type="checkbox"/> Surface Cooling <input type="checkbox"/> Intravascular device or catheter (continuous)	<input type="checkbox"/> Cold IV Saline Bolus <input type="checkbox"/> Intranasal <input type="checkbox"/> Other

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

	<input type="checkbox"/> Antipyretics	<input type="checkbox"/> None
Where was targeted temperature management initiated?	<input type="checkbox"/> In-hospital (either at another hospital prior to transfer or in my hospital)	<input type="checkbox"/> Pre-hospital (by EMS) <input type="checkbox"/> Unknown/Undocumented
Date/Time targeted temperature management initiated:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented

If targeted temperature was <= 36.0 degrees Celsius:

Was goal temperature met?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
If yes, Date/Time goal temperature met:	____/____/____ : ____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
Date/Time re-warming started?	____/____/____ : ____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
Date/Time re-warming completed?	____/____/____ : ____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
Was there a documented temperature of <= 31.0 degrees Celsius 6 hours after the initiation of the temperature-controlled period?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Did patient receive a paralytic drug during induction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Documented

For patients that are not treated with targeted temperature management:

Clinical rationale documented by medical team why targeted temperature management was not initiated (check all that apply):	<input type="checkbox"/> DNAR with limitation on technologic support <input type="checkbox"/> Awake, alert, following commands <input type="checkbox"/> Increased risk of bleeding <input type="checkbox"/> Pregnancy <input type="checkbox"/> Hemodynamic instability <input type="checkbox"/> Limited life expectancy	<input type="checkbox"/> Poor functional status pre-arrest (including dementia) <input type="checkbox"/> Facility does not routinely treat patients with targeted temperature management <input type="checkbox"/> Clinician preference <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> If other, specify: _____
---	--	--

For All Patients:

Was there ever a documented temperature of >= 38 degrees Celsius?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, when was a temperature of >= 38 degrees Celsius documented? (check all that apply)	<input type="checkbox"/> Day 1 - Was patient following commands at time of fever?	<input type="radio"/> Yes <input type="radio"/> No
	<input type="checkbox"/> Day 2 - Was patient following commands at time of fever?	<input type="radio"/> Yes <input type="radio"/> No
	<input type="checkbox"/> Day 3 - Was patient following commands at time of fever?	<input type="radio"/> Yes <input type="radio"/> No
Documented Adverse Events (check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Bleeding requiring blood product transfusion <input type="checkbox"/> Hemodynamically significant bradycardia, heart block, and/or pacemaker requirement	<input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Other If other, specify: _____ <input type="checkbox"/> Not Documented

PCAC 5.1 MEASUREMENTS AND MEDICATIONS

Measurements & Medications Tab

If patient was transferred to your hospital, vital signs prior to transfer?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, Date/Time of vital signs prior to transfer:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	
Vital signs prior to transfer:	Temperature	____ °C ○ F
	Site:	<input type="radio"/> Axillary <input type="radio"/> Rectal

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

		<input type="radio"/> Bladder <input type="radio"/> Blood <input type="radio"/> Brain <input type="radio"/> Oral	<input type="radio"/> Surface (skin, temporal) <input type="radio"/> Tympanic <input type="radio"/> Other <input type="radio"/> Unknown/Not Documented
	Heart Rate	_____ bpm	<input type="checkbox"/> Not Documented
	Systolic BP	_____ mmHg	<input type="checkbox"/> Not Documented
	Diastolic BP	_____ mmHg	<input type="checkbox"/> Not Documented
	Respiratory Rate	_____ breaths/min	<input type="checkbox"/> Not Documented
	Intubated or on mechanical ventilator?	<input type="radio"/> Yes	<input type="radio"/> No
	Pulse Oximetry Saturation (SpO2):	_____ %	<input type="checkbox"/> Not Documented
Initial Measurements – Initial Vital Signs	Date/Time of initial vital sign measurements:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
	Temperature	_____ °C °F	<input type="checkbox"/> Not Documented
	Site:	<input type="radio"/> Axillary <input type="radio"/> Bladder <input type="radio"/> Blood <input type="radio"/> Brain	<input type="radio"/> Oral <input type="radio"/> Rectal <input type="radio"/> Surface (skin, temporal) <input type="radio"/> Tympanic <input type="radio"/> Other <input type="radio"/> Unknown/Not Documented
	Heart Rate	_____ bpm	<input type="checkbox"/> Not Documented
	Systolic BP	_____ mmHg	<input type="checkbox"/> Not Documented
	Diastolic BP	_____ mmHg	<input type="checkbox"/> Not Documented
	MAP	_____ mmHg	<input type="checkbox"/> Not Documented
	Respiratory Rate	_____ breaths/min	<input type="checkbox"/> Not Documented
	Intubated or on mechanical ventilator?	<input type="radio"/> Yes	<input type="radio"/> No
	Pulse Oximetry Saturation (SpO2):	_____ %	<input type="checkbox"/> Not Documented
	FiO2 at time SpO2 assessed:	_____ %	<input type="checkbox"/> Not Documented
Initial Electrolytes (Post ROSC)			
	Date/Time of initial electrolyte & lab measurements:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
	Serum Creatinine:	_____ mg/dL micromol/L	<input type="checkbox"/> Not Documented
	Bicarbonate/CO2:	_____ mmol/L mEq/L	<input type="checkbox"/> Not Documented
	Glucose:	_____ mg/dL	<input type="checkbox"/> Not Documented
	Date/Time of initial Lactate:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
	Lactate:	_____ mmol/L mg/dL	<input type="checkbox"/> Not Documented
	Date/Time of initial Troponin:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
	Troponin:	_____ ng/dL _____ mcg/L	<input type="radio"/> T <input type="radio"/> I <input type="checkbox"/> Not Documented
	Date/Time of initial Blood Gas measurements:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Unknown/Not Documented
	pH:	_____	<input type="checkbox"/> Not Documented
	pCO2:	_____ mmHg	<input type="checkbox"/> Not Documented
	Was there a PaO2 in the first 24 hours of >300 mmHg?	<input type="radio"/> Yes	<input type="radio"/> No
	If yes, FiO2 at time PaO2 assessed:	_____ %	<input type="radio"/> Not Documented
	Was there a PaO2 in the first 24 hours of <60 mmHg?	<input type="radio"/> Yes	<input type="radio"/> No

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

If yes, FiO2 at time PaO2 assessed: _____ %	
Is there documentation that Central Venous Saturation (ScvO2) or mixed venous saturation was tracked within the first 24 hours?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented
Serial Measurements:	
6hr post ROSC: Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Patient did not survive 6hr post ROSC <input type="checkbox"/> Not Documented (6hr post ROSC measurements Not Documented)
Lactate: _____ mmol/L _____ mg/dL	<input type="checkbox"/> Not Documented
Glucose: _____ mg/dL	<input type="checkbox"/> Not Documented
Did patient receive any sedatives in the 0-6-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any paralytics in the 0-6-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
24hr post ROSC: Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Patient did not survive 6hr post ROSC <input type="checkbox"/> Not Documented (6hr post ROSC measurements Not Documented)
Lactate: _____ mmol/L _____ mg/dL	<input type="checkbox"/> Not Documented
Glucose: _____ mg/dL	<input type="checkbox"/> Not Documented
Did patient receive any sedatives in the 6-24-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any paralytics in the 6-24-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any sedatives in the 24-48-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any paralytics in the 24-48-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any sedatives in the 48-72-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Did patient receive any paralytics in the 48-72-hour time period post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No <input type="radio"/> None-Contraindicated
Serial Blood Pressure Measurements	
Enter lowest Systolic BP for each of the following time periods:	
Hours 0-6 post ROSC: Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)	Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)
Systolic BP: _____ mmHg	<input type="checkbox"/> Patient did not survive 6hr post ROSC <input type="checkbox"/> Not Documented
Were there at least two consecutive systolic blood pressure readings of <90mmHg separated by at least one hour in the first 0-6 hours post ROSC?	<input type="radio"/> Yes <input type="radio"/> Not Documented <input type="radio"/> No
MAP: _____ mmHg	<input type="checkbox"/> Not Documented
Select all vasopressors/inotropes patient was on during the first 0-6 hours post ROSC:	<input type="checkbox"/> None <input type="checkbox"/> Isoproterenol (Isuprel) <input type="checkbox"/> Vasopressin (Pitressin) <input type="checkbox"/> Dobutamine (Dobutrex) <input type="checkbox"/> Milrinone (Primacor) <input type="checkbox"/> Dopamine <input type="checkbox"/> Noradrenaline (norepinephrine (Levophed)) <input type="checkbox"/> Adrenaline (epinephrine) <input type="checkbox"/> Phenylephrine (NeoSynephrine)
Hours 6-24 post ROSC: Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)	Date/Time: _____ : _____ (MM/DD/YYYY HH:MM)
Systolic BP: _____ mmHg	<input type="checkbox"/> Patient did not survive 24hr post ROSC <input type="checkbox"/> Not Documented

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

Were there at least two consecutive systolic blood pressure readings of <90mmHg separated by at least one hour in the 6-24 hours post ROSC?		<input type="radio"/> Yes	<input type="radio"/> Not Documented
MAP: _____ mmHg		<input type="checkbox"/> Not Documented	
Select all vasopressors/inotropes patient was on during hours 6-24 post ROSC:	<input type="checkbox"/> None <input type="checkbox"/> Isoproterenol (Isuprel) <input type="checkbox"/> Vasopressin (Pitressin) <input type="checkbox"/> Dobutamine (Dobutrex) <input type="checkbox"/> Milrinone (Primacor)	<input type="checkbox"/> Dopamine <input type="checkbox"/> Noradrenaline (norepinephrine (Levophed)) <input type="checkbox"/> Adrenaline (epinephrine) <input type="checkbox"/> Phenylephrine (NeoSynephrine)	
Hours 24-48 post ROSC:	____/____/____ : ____:____	Date/Time: (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Patient did not survive 48hr post ROSC
Systolic BP: _____ mmHg		<input type="checkbox"/> Not Documented	
Select all vasopressors/inotropes patient was on during hours 24-48 post ROSC:	<input type="checkbox"/> None <input type="checkbox"/> Isoproterenol (Isuprel) <input type="checkbox"/> Vasopressin (Pitressin) <input type="checkbox"/> Dobutamine (Dobutrex) <input type="checkbox"/> Milrinone (Primacor)	<input type="checkbox"/> Dopamine <input type="checkbox"/> Noradrenaline (norepinephrine (Levophed)) <input type="checkbox"/> Adrenaline (epinephrine) <input type="checkbox"/> Phenylephrine (NeoSynephrine)	
Hours 48-72 post ROSC:	____/____/____ : ____:____	Date/Time: (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Patient did not survive 72hr post ROSC
Systolic BP: _____ mmHg		<input type="checkbox"/> Not Documented	
Select all vasopressors/inotropes patient was on during hours 48-72 post ROSC:	<input type="checkbox"/> None <input type="checkbox"/> Isoproterenol (Isuprel) <input type="checkbox"/> Vasopressin (Pitressin) <input type="checkbox"/> Dobutamine (Dobutrex) <input type="checkbox"/> Milrinone (Primacor)	<input type="checkbox"/> Dopamine <input type="checkbox"/> Noradrenaline (norepinephrine (Levophed)) <input type="checkbox"/> Adrenaline (epinephrine) <input type="checkbox"/> Phenylephrine (NeoSynephrine)	
Did patient receive any anticonvulsants in the 0-72-hour time period post ROSC?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
PCAC 5.2 CLINICAL STUDY DATA		Clinical Study Data Tab	
Was a 12-lead ECG performed?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
ECG Interpretation:	<input type="checkbox"/> STEMI <input type="checkbox"/> Ischemic changes (not a STEMI) <input type="checkbox"/> Other	<input type="checkbox"/> New Left Bundle Branch Block (BBB) <input type="checkbox"/> Unknown/Not Documented If Other, Specify: _____	
Did patient go to the Cath lab at any time during this admission?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
Date/Time at Cath lab:	____/____/____ : ____:____	<input type="checkbox"/> Time Not Documented	
Reason went to Cath lab:	<input type="checkbox"/> ST Elevation <input type="checkbox"/> Elevated cardiac enzymes <input type="checkbox"/> Cardiogenic Shock <input type="checkbox"/> Routine Cath post-arrest <input type="checkbox"/> VF arrest <input type="checkbox"/> New BBB	<input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> Abnormal ECG (not including STEMI) <input type="checkbox"/> Focal wall motion abnormality on echocardiogram <input type="checkbox"/> Other If Other, Specify: _____	
Cath Lab Interventions:	<input type="radio"/> Stent/PCI <input type="radio"/> Balloon Pump <input type="radio"/> LVAD	<input type="radio"/> No Intervention <input type="radio"/> Unknown/Not Documented	
Date/Time of Cath lab intervention:	____/____/____ : ____:____	<input type="checkbox"/> Time Not Documented	
ICD placed during this admission?	<input type="radio"/> Yes	<input type="radio"/> No	

Post Cardiac Arrest Care (PCAC) Event

NOT FOR USE WITHOUT PERMISSION. ©2021 American Heart Association.

Was an Echo performed?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time of FIRST Echo:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
FIRST Echo Findings:	LVEF: _____	<input type="checkbox"/> LVEF Not Documented
Head CT performed?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time of initial head CT:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
Head CT Findings:	<input type="checkbox"/> Normal <input type="checkbox"/> Cerebral edema <input type="checkbox"/> Intracranial hemorrhage <input type="checkbox"/> Herniation	<input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> Other If Other, Specify: _____
Cerebral MRI performed?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time of initial MRI:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
EEG performed within the first 24 hours post ROSC?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
If EEG performed, was there evidence of any seizure activity?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
If evidence of seizure activity, was there evidence of Status Epilepticus (sustained seizures)?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
If yes, was an anticonvulsant administered?	<input type="radio"/> Yes	<input type="radio"/> No

PCAC 6.1 OUTCOME DATA Outcome Data Tab

Did patient survive to hospital discharge?	<input type="radio"/> Yes, patient lived	<input type="radio"/> No, patient died
Date/Time of discharge from ICU:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented <input type="checkbox"/> Patient was not discharged from ICU
Did patient ever follow commands?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Date/Time of first documented following of commands:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
Discharge Modified Rankin Scale:	_____	<input type="checkbox"/> Not Documented
Discharge Modified Rankin Scale:	<input type="radio"/> 0 - No symptoms at all <input type="radio"/> 1 - No significant disability despite symptoms: ability to carry out all usual activities <input type="radio"/> 2 - Slight disability <input type="radio"/> 3 - Moderate disability: Requiring some help but able to walk without assistance <input type="radio"/> 4 - Moderate to severe disability: Unable to walk without assistance and unable to attend to own bodily needs without assistance <input type="radio"/> 5 - Severe disability: Bedridden, incontinent and requiring constant nursing care and attention <input type="radio"/> 6 - Death	

NOTE: Please do not enter any patient identifiable information in these optional fields.

Comments:			
PCAC Optional 1		PCAC Optional 2	
PCAC Optional 3		PCAC Optional 4	
PCAC Optional 5		PCAC Optional 6	
PCAC Optional 7		PCAC Optional 8	
PCAC Optional 9		PCAC Optional 10	

END OF PCAC FORM