

① 1, 2, 3

This form is to be completed using all information available relating to the patient's death. The top two copies must be sent to the Coordinating Center.

1. Patient ID # <sup>②</sup> 4, 5 <sup>③</sup> 6, 7, 8, 9, 10 <sup>④</sup> 11, 12 <sup>⑤</sup> 2. Acrostic 13, 14, 15, 16, 17, 18

3. Date form completed <sup>⑪</sup> 44, 45 <sup>⑫</sup> 46, 47 <sup>⑬</sup> 48, 49  
Month Day Year

The potential sources of available information listed in Questions 4-8 should be consulted and, where available, copies should be made and sent to the Coordinating Center. On all data sources, the patient's name and hospital identification number should be blacked out and replaced with the BHAT identification number and acrostic.

	Original Exists Copy Enclosed	Original Does Not Exist or Cannot Be Obtained - Specify Reason
	1	2
4. Emergency Room Report	50 <sup>⑫</sup> <input type="checkbox"/>	<input type="checkbox"/>
5. Hospital Inpatient Records		
a) Discharge summary	51 <sup>⑬</sup> <input type="checkbox"/>	<input type="checkbox"/>
b) Discharge diagnosis	52 <input type="checkbox"/>	<input type="checkbox"/>
c) Pertinent ECG's	53 <sup>⑭</sup> <input type="checkbox"/>	<input type="checkbox"/>
d) Reports of cardiovascular-related diagnostic or surgical procedures (e.g., cardiac catheterization, heart surgery)	54 <sup>⑮</sup> <input type="checkbox"/>	<input type="checkbox"/>
6. Coroner's or Medical Examiner's Report	55 <sup>⑯</sup> <input type="checkbox"/>	<input type="checkbox"/>
7. Copy of Death Certificate enclosed?	56 <input type="checkbox"/> YES	<sup>⑱</sup> <input type="checkbox"/> NO
If copy of Death Certificate is not obtained and enclosed, state reason:		<sup>⑲</sup> P / 1 57

8. Autopsy performed? <sup>⑳</sup> 1  Yes 2  No <sup>58</sup>

<sup>㉑</sup> 1.  Copy of final report attached (final report includes microscopic report) <sup>59</sup>

<sup>㉒</sup> 2.  Final autopsy report not yet available; summary of preliminary gross findings attached <sup>⑩</sup>

<sup>⑥</sup> Edit Status 19-20  
<sup>⑦</sup> Batch Number 21-28  
<sup>⑧</sup> Date Received 29-34  
<sup>⑨</sup> Update Number 35-57  
<sup>⑩</sup> Date Last Processed 38-4

If final report of autopsy is not yet available, send preliminary report to the Coordinating Center as soon as possible and then forward final copy as soon as it is obtained.

9. a. Was patient hospitalized since the most recent BHAT visit? <sup>㉒</sup> 1  Yes 2  No <sup>60</sup>

**SKIP to Item 10**

The term "most recent BHAT visit" refers to either scheduled or unscheduled visits.

b. Number of hospitalizations <sup>㉓</sup> 61, 62

If death occurs during a hospitalization this should be counted as a hospitalization "since the most recent BHAT visit." If the patient is dead on arrival (D.O.A.) at a hospital emergency room, this should also be counted as a hospitalization. Submit a hospitalization form for each hospital admission if not already submitted.

c. Date of most recent admission to hospital: <sup>㉔</sup> 63, 64 <sup>⑬</sup> 65, 66 <sup>⑭</sup> 67, 68  
Month Day Year

See note for 9. b. regarding hospitalization

10. Was patient taking BHAT medication or beta-blockers since most recent BHAT visit?

(25) 1  Yes 2  No 3  Unknown

If not already submitted, complete Follow-up Drug Section (BH31-F) giving information on all medication changes since the most recent BHAT visit. For date of interview on BH31-F, use the date on which the Death Notification (BH16) is completed. If the patient took medication until death, make an entry for that date on BH31-F indicating medication was stopped. Use 044 (death) as reason for stopping drug. If applicable, code any other symptoms which occurred.

11. Date and time of death:

a. What was the official date and time of pronouncement of death as cited on the death certificate?

Code 9's if exact date unknown

(26) Date: 70, 71 72, 73 74, 75  
Month Day Year

Code 9's if exact time unknown

(27) Time: 76, 77 78, 79 1  a.m. (28)  
2  p.m.  
Hour Minute 80

b. What was the date and time of clinical death?

A BHAT Clinical death is defined as that point: (1) at which there was spontaneous cessation of respiration and blood circulation with loss of consciousness (patient became comatose) and (2) from which there was no recovery, i.e., clinical death progressed to biological death with no intervening recovery of respiration, circulation and consciousness. In many instances the date and time of biological death will be identical to the official date and time of death. Enter time of death to the nearest hour and minute known. Indicate whether the time is known definitely (within 5 minutes of actual death) or is estimated. If no information is available regarding time of death, code 99 for hour and for minute, and leave blank the boxes beside and below hour and minute. For estimates of time of death, include in the Physician's Summary a statement about the accuracy of the estimate.

Code 9's if exact date unknown

(29) Date: 81, 82 83, 84 85, 86  
Month Day Year

Code 9's if exact time unknown

(30) Time: 87, 88 89, 90 1  a.m. (31)  
2  p.m.  
Hour Minute 91

(32) 1  Known definitely (± 5 minute)  
2  Estimated 92

12. At the time of clinical death the patient was:

Check one answer only.

- 1  At home 2  At work, other than home 3  At a public place, other than at work 4  En route to hospital  
 (33) 93 5  In hospital emergency room 6  Hospitalized, not in emergency room 7  Unknown  
 8  Other, specify (34) 0/1 94

13. Was the death most likely a result of arteriosclerotic heart disease (e.g., death associated with cardiovascular surgery related to coronary heart disease, sudden unexpected death, MI, or CHF)?

1  Yes (35) 95 SKIP to Item 16  
 2  No Proceed to Item 14a

14. a. Was death most likely the result of a cardiovascular disease other than arteriosclerotic heart disease?

1  Yes (36) 96  
 b. If yes, death was due to:  
 2  No → Skip to Item 15

Check only one box for main cause. You may check as many contributing causes as appropriate. Check Neither if not Main or Contributing cause.

	Main 1	Contributing 2	Neither 3
Cardiomyopathy (non-ischemic)	97 <input type="checkbox"/>	(37) <input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular surgery unrelated to coronary heart disease	98 <input type="checkbox"/>	<input type="checkbox"/> (38)	<input type="checkbox"/>
Cerebrovascular disease	99 <input type="checkbox"/>	(39) <input type="checkbox"/>	<input type="checkbox"/>
Infective endocarditis	100 <input type="checkbox"/>	<input type="checkbox"/> (40)	<input type="checkbox"/>
Pulmonary embolism	101 <input type="checkbox"/>	(41) <input type="checkbox"/>	<input type="checkbox"/>
Valvular heart disease	102 <input type="checkbox"/>	<input type="checkbox"/> (42)	<input type="checkbox"/>
Other cardiovascular events (Specify):	(44) 0/1 104		
(43) 103 <input type="checkbox"/> Main	(46) 0/1 106		
(45) 105 <input type="checkbox"/> Contributing			

After completion of Item 14b., SKIP to Item 24.

15. Death was due to the following non-cardiovascular cause:

Check only one box for main cause. You may check as many contributing causes as appropriate. Check Neither if not Main or Contributing cause.

	Main 1	Contributing 2	Neither 3
Accident	107 <input type="checkbox"/>	(47) <input type="checkbox"/>	<input type="checkbox"/>
Blood dyscrasia	108 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	109 <input type="checkbox"/>	(49) <input type="checkbox"/>	<input type="checkbox"/>
Homicide	110 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyper- or auto-immune disease	111 <input type="checkbox"/>	(51) <input type="checkbox"/>	<input type="checkbox"/>
Infection	112 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	113 <input type="checkbox"/>	(53) <input type="checkbox"/>	<input type="checkbox"/>
Malignant neoplasia	114 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease other than liver disease	115 <input type="checkbox"/>	(55) <input type="checkbox"/>	<input type="checkbox"/>
Pulmonary disease other than pulmonary embolism	116 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal disease	117 <input type="checkbox"/>	(57) <input type="checkbox"/>	<input type="checkbox"/>
Suicide	118 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	119 <input type="checkbox"/>	(59) <input type="checkbox"/>	<input type="checkbox"/>
Other non-cardiovascular (Specify):			

120 (60)  Main \_\_\_\_\_ (61) ♂ 0/1 121  
 122 (62)  Contributing \_\_\_\_\_ (63) ♂ 0/1 123

After completion of Item 15, SKIP to Item 24.

16. a. Was the clinical death directly observed?

Directly observed refers to direct visual contact.

1  Yes (64) 124      2  No

Proceed to Item 17

Proceed to Item 16. b.

b. If death was not directly observed, what is the estimated time between when the patient was last known to be alive and death?

1  less than 1 minute      2  1-5 minutes      3  6-30 minutes      4  31-60 minutes  
 5  more than 60 minutes to 24 hours      6  more than 24 hours

SKIP to Item 20

(65) 125

17. Did the patient experience a sudden, unexpected loss of consciousness or collapse (without immediately preceding signs/symptoms) that terminated in death?

1  Yes      2  No      3  Unknown

(66) 126      SKIP to Item 20

18. Indicate the time and date of sudden collapse or loss of consciousness:

(67) Date: 127, 128      129, 130      131, 132  
 Month      Day      Year

(68) Time: 133, 134      135, 136      1  a.m. (69)  
 Hour      Minute      2  p.m. 137

(70) 1  Known definitely (±5 minutes)  
 2  Estimated 138

Enter time of sudden collapse or loss of consciousness to the nearest hour and minute known. Indicate whether the time is known definitely (within five minutes before or after actual death) or is estimated. If no information is available regarding the time of the sudden collapse or loss of consciousness, code 99 for hour and for minute and leave blank the boxes beside and below hour and minute. For estimates of time, include in the Physician's Summary a statement about the accuracy of the estimate.

19. From the following list, what was the maximum activity that the patient was doing within the 30 minutes prior to the collapse or sudden loss of consciousness?

- 1  Asleep  
2  Awake but sedentary (includes resting in bed or chair)  
3  Engaged in light physical activity (such as light housework or raking leaves)  
4  Engaged in moderate physical activity (such as climbing stairs)  
5  Engaged in heavy physical activity (such as heavy lifting or fast, competitive sports)  
6  Unknown

20. Please complete the following table:

*Completion of the following Table may involve some value judgement. Please explain all signs/symptoms in the physician summary. In column 2, the definition of new relates to the de novo development of signs/symptoms which initiated a clinical syndrome. The sign or symptom might have been present in the preceeding month (column 1) but had ended. If syndrome initiated by a sign/symptom marked yes in column 1 continued into the 1-24 hours preceeding death, persistent should be checked in column 2.*

NOTE: in fields 74,78,82,86,90,94, and 98: New punched as 1  
 Persistent punched as 2 3

	1	2	3
Sign/symptom	Had the patient experienced this sign/symptom at any time in the past month but more than 24 hours before clinical death?	Did this sign/symptom occur from 24th hour to 60 minutes prior to clinical death?	Did this sign/symptom newly occur or worsen within the 60 minutes prior to clinical death?
a. Chest pain	(72) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 140 Uncertain	(73) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> New (74) <input type="checkbox"/> Persistent 142 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 141 Uncertain	(75) 1 <input type="checkbox"/> Yes 143 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
b. Indigestion	(76) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 144 Uncertain	(77) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (78) <input type="checkbox"/> 146 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 145 Uncertain	(79) 1 <input type="checkbox"/> Yes 147 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
c. Shortness of breath or dyspnea	(80) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 148 Uncertain	(81) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (82) <input type="checkbox"/> 150 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 149 Uncertain	(83) 1 <input type="checkbox"/> Yes 151 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
Cold, clammy (moist) skin	(84) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 152 Uncertain	(85) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (86) <input type="checkbox"/> 154 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 153 Uncertain	(87) 1 <input type="checkbox"/> Yes 155 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
e. Evidence of congestive heart failure	(88) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 156 Uncertain	(89) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (90) <input type="checkbox"/> 158 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 157 Uncertain	(91) 1 <input type="checkbox"/> Yes 159 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
f. Syncope	(92) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 160 Uncertain	(93) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (94) <input type="checkbox"/> 162 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or 161 Uncertain	(95) 1 <input type="checkbox"/> Yes 163 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown or Uncertain 4 <input type="checkbox"/> Not Applicable
g. Documented Cardiac arrhythmia	(96) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 164	(97) 1 <input type="checkbox"/> Yes → <input type="checkbox"/> (98) <input type="checkbox"/> 166 2 <input type="checkbox"/> No 165	(99) 1 <input type="checkbox"/> Yes 167 2 <input type="checkbox"/> No
If answer to g. is "yes", specify all documented arrhythmias	(100) P %1 168	(101) P %1 169	(102) P %1 170

If any "yes" is checked for Items 20 a-g, columns 2 or 3, proceed to Item 21. Otherwise skip to Item 23.

21. a. What was the earliest sign/symptom checked in column 2 or 3 of Item 20? Check only one.

103 1  a. 171 2  b. 3  c. 4  d. 5  e. 6  f. 7  g.

b. What was the duration of the time period from the onset of the earliest-occurring sign/symptom in column 2 or 3 of Item 20 to clinical death? ... 104

172, 173 174, 175

Hours Minutes

Code 9999 if time unknown

22. From Item 21 what was the maximum activity that the patient was doing during the 30 minutes prior to the earliest sign/symptom?

Check one box only

105

176

- 1  Asleep 2  Awake but sedentary (includes resting in bed or chair) 3  Engaged in light physical activity  
4  Engaged in moderate physical activity 5  Engaged in heavy physical activity  
6  In coma or under anesthesia 7  Unknown

23. Were emergency cardiopulmonary resuscitation measures initiated during the acute sequence of events terminating in death?

106

- 1  Yes 2  No

177

24. PHYSICIAN'S SUMMARY

*This section must be completed by a BHAT physician and typed.*

*Please describe events surrounding the death. Specific information must be included to permit classification of the death as due to arteriosclerotic coronary heart disease, other cardiovascular disease, or non-cardiovascular disease. If death most likely due to arteriosclerotic coronary heart disease, provide information relating to suddenness of death, existence of signs and symptoms prior to death, occurrence of surgery, occurrence of heart failure, and occurrence of cardiac arrhythmia(s). Physician is expected to review the entire form for accuracy and consistency. Be sure to discuss the accuracy of time estimates that may occur within the form (see Items 11, 18 and 20). Explain the events occurring between clinical death and official pronouncement.*

107

178

0/1

!

5. Physician completing summary \_\_\_\_\_

108

179, 180

BHAT Code

26. Person completing form \_\_\_\_\_

109

181, 182

BHAT Code