SCREENING FORM

Demographics

Complete Questions 1-4 for all patients who are screened.

1. Gender:	☐ Male ☐ Female
2. Age in years:	_____ years
3. Ethnicity:	☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown
4. Race: Select ALL that apply.	NOTE: If the race(s) cannot be obtained from the patient, the patient's family, or from a source document, select **"not reported".**
A. American Indian or Alaskan Native	☐
B. Asian	☐
C. White	☐
D. Black or African Native	☐
E. Native Hawaiian or Pacific Islander	☐
F. Not reported	☐

Inclusion/Exclusion Criteria

To be completed on all patients who are screened.

1. Please select yes or no to indicate whether patient meets the following inclusion criteria?	
1) Participant must have at least five minutes of chest pain or equivalent (chest tightness; pain radiating to left, right, or both arms or shoulders, back, neck, epigastrium, jaw/throat; or unexplained shortness of breath, syncope/presyncope, generalized weakness, nausea, or vomiting thought to be of cardiac origin) at rest or during exercise within 24 hours of ED presentation, warranting further risk stratification, as determined by an ED attending.	☐ Yes ☐ No
2) Participant is able to provide written Informed Consent	☐ Yes ☐ No
3) Participant is <75 years of age, but ≥40 years of age	☐ Yes ☐ No
4) Participant is able to perform a breath hold of at least 10 seconds	☐ Yes ☐ No
5) Participant is in sinus rhythm	☐ Yes ☐ No
2. Please select yes or no to indicate whether patient meets the following exclusion criteria	
1) New diagnostic ischemic ECG changes *ST-segment elevation or depression > 1 mm or T-wave inversion > 4 mm in two or more anatomically adjacent leads or left bundle branch block*	☐ Yes ☐ No

2) Documented or self-reported history of CAD *MI, percutaneous coronary interventions [PCIs], coronary artery bypass graft [CABG], known significant coronary stenosis [>50%]*	☐ Yes ☐ No
3) Greater than 6 hours since presentation to ED to time of consent	☐ Yes ☐ No
4) BMI >40 kg/m^2	☐ Yes ☐ No
5) Impaired renal function, as defined by local standard of care, for example, measured serum creatinine >1.5 mg/dL	☐ Yes ☐ No
6) Markedly elevated troponin, as defined by local standard of care	☐ Yes ☐ No
7) Hemodynamically or clinically unstable condition (BP systolic < 80 mm Hg, atrial or ventricular arrhythmias, persistent chest pain despite adequate therapy)	☐ Yes ☐ No
8) Known allergy to iodinated contrast agent	☐ Yes ☐ No
9) Currently symptomatic asthma	☐ Yes ☐ No
10) Documented or self-reported cocaine use within the past 48 hours (acute)	☐ Yes ☐ No
11) On Metformin therapy and unable or unwilling to discontinue for 48 hours after the CT scan	☐ Yes ☐ No
12) Contraindication to beta blockers (taking daily antiasthmatic medication): This exclusion only applies to patients with a heart rate > 65 bpm at sites using a non-dual source CT scanner	☐ Yes ☐ No
13) Participant with no telephone or cellphone number (preventing follow-up)	☐ Yes ☐ No
14) Participant with positive pregnancy test within 24 hours prior to CT scan. *For woman of childbearing potential, defined as: < 2 years of menopause in the absence of hysterectomy or tubal ligation.*	☐ Yes ☐ No
15) Participant unwilling to provide written informed consent.	☐ Yes ☐ No

ED Evaluation Timeline

1. Date of ED Presentation (mm/dd/yyyy):	
2. Time of ED Presentation (hh:mm):	
3. Date of Initial ED Evaluation (mm/dd/yyyy):	
4. Time of Completion of Initial ED Evaluation (hh:mm): (This is the time point at which the ED physician puts in the 1st set of orders.)	

Randomization & Consent

1. Date of Consent (mm/dd/yyyy):	
2. Time of Consent (hh:mm):	
3. Was the patient randomized?	☐ Yes ☐ No* If yes, ☐ SOC arm ☐ Interventional arm Randomization number ________________ If no, reason: ☐ **markedly** positive troponin ☐ positive pregnancy test ☐ patient withdrew consent ☐ other, specify____________
4. Date of Randomization (mm/dd/yyyy):	
5. Time of Randomization (hh:mm):	

MEDICAL HISTORY FORM

Cardiac Risk Factors and Medications

1. Hypertension	☐ Yes ☐ No ☐ Not Reported
2. Diabetes mellitus	☐ None ☐ Insulin requiring ☐ Non-insulin ☐ Not Reported
3. Hypercholesterolemia/hyperlipidemia	☐ Yes ☐ No ☐ Not Reported
4. Cocaine use	☐ Never ☐ Former ☐ Recent (last use >48 hours)
5. Tobacco use	☐ Never ☐ Former ☐ Current ☐ Not Reported
6. First degree relative with CAD/ACS/AMI: (male < 55 yrs, female < 65 yrs)	☐ Yes ☐ No ☐ Not Reported
7. Home medications:	
a. ACE-inhibitors/ARB	☐ Yes ☐ No
b. Aspirin	☐ Yes ☐ No
c. Nitrates	☐ Yes ☐ No
d. Beta-blockers	☐ Yes ☐ No
e. Calcium channel blocker	☐ Yes ☐ No
f. Statins	☐ Yes ☐ No
g. Niacin/fibrates	☐ Yes ☐ No
h. Insulin	☐ Yes ☐ No
i. Oral hypoglycemics	☐ Yes ☐ No

Medical History

1. Heart failure	☐ Yes ☐ No ☐ Not Reported

2. Peripheral vascular disease	☐ Yes	☐ No	☐ Not Reported
3. Chronic lung disease/COPD	☐ Yes	☐ No	☐ Not Reported
4. Cerebrovascular event (stroke)	☐ Yes	☐ No	☐ Not Reported

Pain Characteristics/Symptoms

Patient reported data:

1. Chief Complaint	☐ Anginal Chest Pain or equivalent ☐ Epigastric Pain ☐ Arm/Jaw/Shoulder Pain ☐ Shortness of Breath ☐ Other: ___________________________
2. Most recent Episode	Date (mm/dd/yyyy) Time (hh:mm) Duration (minutes): ______________________

ED VISIT FORM

Initial ED Vital Signs

Data collected by CRC from ED chart.

1. Weight:	lbs
2. Height:	inches
3. Resting heart rate:	bpm
4. Systolic BP:	mmHg
5. Diastolic BP:	mmHg
6. Presence of rales?	☐ Yes ☐ No ☐ Not Reported

ED Medications

Data collected from ED record. Select ALL that apply.

1. Aspirin	☐
2. Nitrates	☐
3. Beta blocker	☐
4. Morphine	☐
5. Heparin/ Low molecular weight heparin/ Fragmin/ Lovenox	☐
6. Plavix	☐

Laboratory Results

Data collected from ED record.

Test	Date	Time	Result	Not done
Creatinine (initial)			mg/dL	☐

Creatinine (2nd)			mg/dL	☐
Creatinine (3rd)			mg/dL	☐
CK-MB (initial)			ug/ml	☐
CK-MB (2nd)			ug/ml	☐
CK-MB (3rd)			ug/ml	☐
D-Dimer			ng/ml	☐

Troponin Values

Test	Troponin classification	Date	Time	Result	Range	Not done
Troponin (initial)	T ☐ I ☐			ug/ml	☐ Normal Enter Range:___ ☐ Borderline Enter Range:___ ☐ Elevated Enter Range:___	☐
Troponin (2nd)	T ☐ I ☐			ug/ml	☐ Normal Enter Range:___ ☐ Borderline Enter Range:___ ☐ Elevated Enter Range:___	☐
Troponin (3rd)	T ☐ I ☐			ug/ml	☐ Normal Enter Range:___ ☐ Borderline Enter Range:___ ☐ Elevated Enter Range:___	☐

Biomarker Testing

Did the patient consent to biomarker testing? ☐ Yes ☐No
If yes,
Draw #1: Was blood collected and stored? If less than 3 tubes collected, fill out protocol deviation form. ☐ Yes ☐ No Date (mm/dd/yyyy): Time (hh:mm):______________

Red tube specimen ID no _______________ How many daughter tubes? _______ Purple tube specimen ID no _______________ How many daughter tubes? _______ Green tube specimen ID no _______________ How many daughter tubes? _______
Draw #2: Was blood collected and stored? If less than 3 tubes collected, fill out protocol deviation form. ☐ Yes ☐ No Date (mm/dd/yyyy): Time (hh:mm):________________ Red tube specimen ID no _______________ How many daughter tubes? _______ Purple tube specimen ID no _______________ How many daughter tubes? _______ Green tube specimen ID no _______________ How many daughter tubes? _______
Draw #3: Was blood collected and stored? If less than 3 tubes collected, fill out protocol deviation form. ☐ Yes ☐ No Date (mm/dd/yyyy): _______________ Time (hh:mm):_____________________ Red tube specimen ID no _______________ How many daughter tubes? _______ Purple tube specimen ID no _______________ How many daughter tubes? _______ Green tube specimen ID no _______________ How many daughter tubes? _______

ECG FORM

Initial 12-Lead ECG Interpretation

Information entered into eCRF by CRC.

1. Date of initial ECG (mm/dd/yyyy):	
2. Time of initial ECG (hh:mm):	
3. ECG (electronic read)	HR _____________ bpm QT______________ms QTc______________ms

CT FORM

CCTA Technical Assessment

To be entered into eCRF by CRC.

1. Was CCTA performed For interventional arm: If not performed, please complete protocol deviation form or protocol violation form	☐ Yes ☐ No **If no,** indicate why not done: ☐ Definite ACS (positive troponin, ECG changes) ☐ Contrast extravasation ☐ Arrhythmias ☐ Claustrophobia ☐ Anaphylaxis ☐ ED physician decision ☐ Patient refusal/withdrawal ☐ Equipment failure ☐ Other: ________
A. Record Scanner Manufacturer/Model	Manufacturer: ☐ Siemens ☐ GE ☐ Philips ☐ Other ______________________ Model: ☐ Somatom Sensation 64 ☐ Lightspeed 64 ☐ Lightspeed VCT ☐ Dual Source ☐ Flash ☐ ICT ☐ Other _______________________
B. Hybrid Imaging (SPECT or PET)	☐ Yes ☐ No
C. Time CT ordered (hh:mm)	
D. Time CT performed (hh:mm)	
E. Time of CT interpretation (hh:mm)	
2. Calcium Scan If no, give reason and fill out protocol violation form	☐ Yes ☐ No
3. CTA	☐ Yes ☐ No
4. Intra CCTA vitals:	
Average HR during scan:	bpm
5. Pre-procedure medications:	☐ Yes ☐ No
a. Beta blocker IV	☐ Yes ☐ No If yes, ☐ Metoprolol ☐ Other __________ dose: _________ mg
b. Beta blocker PO	☐ Yes ☐ No ☐ Metoprolol ☐ Atenolol__________ dose: __________mg
c. Nitroglycerin SL	☐ Yes ☐ No If yes, dose:

6. Contrast agent:	☐ Isovue ☐ Omnipaque ☐ Optiray ☐ Vispaque ☐ Other Specify:_______________
a. **concentration mg iodine per ml**	☐ 300 ☐ 320 ☐ 350 ☐ 370
7. Completion of the CT scan	☐ Yes ☐ No If no, indicate why not done: Medical reason ☐ Patient refusal/withdrawal ☐ Equipment failure ☐ Other ☐ If other, specify: ________________

8. Prospectively gated/triggered cardiac CTA scan	☐ Yes ☐ No
9. Retrospectively gated cardiac CTA scan	☐ Yes ☐ No
10. Dose Length Product of CTA only:	mGY cm
11. Total Dose Length Product	mGY cm
12. CTDI Volume of CTA	mGy

CT Test Subject Physician Reading Form

To be completed by CT reader with signature next to physician ID on paper CRF; information entered on form by CRC.

1. Reading physician ID: (Please have CT Reader initial paper CRF)	
2. Calcium Score	
3. Coronary CTA Fill out the appropriate box to indicate the level of stenosis. If level of stenosis equals stent, please fill out the protocol violation form.	
a. Left Main	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐ 50-99% (significant/severe) ☐ 100% (occluded) ☐indeterminate ☐ stent**
b. LAD (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded) ☐indeterminate ☐ stent**
c. LCX (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded) ☐indeterminate ☐ stent**
d. RCA (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded) ☐indeterminate ☐ stent**
4. Overall study quality:	☐ Interpretable:

	☐ Uninterpretable:
5. **LV functional analysis performed:**	☐ Yes ☐ No Global LV function ☐ Abnormal ☐ Normal Global LV function in % ______ Regional Wall Motion Abnormality: ☐ Yes ☐ No If yes, match stenosis territory ☐ Anterior/apex ☐ Inferior/posterior ☐ Lateral
6. **If retrospectively gated, was tube modulation technique or a similar radiation safety technique used?**	☐ Yes ☐ No
7. **Incidental Findings**	☐ Yes ☐ No If yes, mark all that apply: • Coronary anomaly ☐ • Cardiac finding ☐ *If yes, specify ________________ • Pulmonary nodules requiring follow-up ☐ • Pulmonary Embolism ☐ • Pneumonia ☐ • Aortic Aneurysm ☐ • Other ☐ If yes, specify, __________ Requires follow up imaging ☐ Yes ☐ No
**If stent is present, please check the medical record (MR). If evidence of a stent is documented in the MR, fill out the protocol violation form.	

DIAGNOSTIC TESTING FORM

Nuclear Imaging

1. **Was nuclear imaging done?**	☐Yes ☐No
2. **What are the initials of the physician who reported it?**	
3. **Date/time test ordered:**	Date (mm/dd/yyyy): Time (hh:mm):
4. **Date/time test was performed:**	Date (mm/dd/yyyy): Time (hh:mm):
5. **Date/time of test interpretation:**	Date (mm/dd/yyyy): Time (hh:mm):
6. **Modality:**	☐Rest ☐Stress ☐Rest & Stress If stress, select one of the following: ☐ETT (go to qs.7) ☐ Pharmacologic (go to qs. 9)

7. **If ETT,**	☐Bruce ☐Modified Bruce ☐Naughton ☐Supine Bicycle ☐Upright Bicycle	Time to end of exercise ________min______sec METS__________________ %MPHR________________
8. ECG changes meeting criteria for ischemia?	☐Yes ☐No If yes, specify changes: o ST depression ☐Yes ☐No If yes, what is the maximum depression? _____mm o ST elevation ☐Yes ☐No If yes, what is the maximum elevation? _____mm o Ventricular arrhythmias ☐Yes ☐No o Other ☐Yes ☐No, if yes, specify	
10. If pharmacological, list the agent used:	☐Dobutamine ☐Dipyridamole ☐Adenosine ☐Regadenoson	
11. Rest protocol tracer: **administered activity /unit of activity**	☐ Technetium ☐ Tetrafosmin ☐ Thallium ______(Mega Bq/millicuries)	
12. Stress Protocol tracer **administered activity /unit of activity**	☐ Technetium ☐ Tetrafosmin ☐ Thallium ______(Mega Bq/millicuries)	
13. Was a Reinjection performed? **administered activity /unit of activity**	☐ Yes ☐ No If yes, fill out the following: Tracer ☐ Technetium ☐ Tetrafosmin ☐ Thallium ______(Mega Bq/millicuries)	
14. Was a Rubidium test performed? **rest** **stress**	☐Yes ☐No If yes, administered activity /unit of activity -______(Mega Bq/millicuries) administered activity /unit of activity -______(Mega Bq/millicuries)	
15. Completion of Protocol	☐ Not done ☐ Done and completed ☐ Performed but not completed Baseline Heart rate _____ bpm Peak Heart Rate ____________ bpm Systolic Blood Pressure at rest ______ mmHg Diastolic Blood Pressure at rest ______mmHg Systolic Blood Pressure at peak stress _____ mmHg Diastolic Blood Pressure at peak stress _____mmHg	

	Reached target HR?* ☐Yes ☐No ☐NA If no, was it converted to pharmacologic? ☐Yes ☐No If yes, choose the agent used: ☐ Dobutamine ☐ Dipyridamole ☐ Adenosine ☐ Regadenoson Did the patient develop symptoms of possible CAD (including CP, SOB) ☐Yes ☐No ☐equivocal (if the answer is yes or equivocal, go to qs 15)
16. If there were symptoms of possible CAD, enlist any other symptoms perceived by the patient.	Chest Pain ☐Yes ☐No If yes, did the chest pain limit exercising capacity? ☐Yes ☐No Shortness of Breath ☐Yes ☐No Hypotension ☐Yes ☐No VT or non sustained VT ☐Yes ☐No Patient request ☐Yes ☐No Abnormal BP response ☐Yes ☐No Other ☐Yes ☐No If yes, specify:
17. Was the perfusion in the anterior/apical myocardial territory normal?	☐Yes ☐No
18. Was the perfusion in the lateral myocardial territory normal?	☐Yes ☐No
19. Was the perfusion in the infero-posterior myocardial territory normal?	☐Yes ☐No
20. Resting gated LVEF	☐Not done __________ EF % ☐Normal ☐Abnormal
21. Post stress gated LVEF	__________ EF % ☐Normal ☐Abnormal
22. Transient Ischemic Dilatation	☐Yes ☐No ☐Not Mentioned
23. Was additional nuclear imaging performed?	☐Yes ☐No

Stress Echocardiogram

1. Was a stress echocardiogram performed?	☐Yes ☐No
2. What are the initials of the physician who reported it?	
3. Date/time test ordered:	Date (mm/dd/yyyy): Time (hh:mm):
4. Date/time test performed:	Date (mm/dd/yyyy): Time (hh:mm):
5. Date/time of test interpretation:	Date (mm/dd/yyyy): Time (hh:mm):
6. Modality:	Select one of the following: ☐ Exercise ☐ Dobutamine ☐ Other__________________
7. If Exercise:	☐Bruce ☐Modified Bruce ☐Naughton ☐Supine Bicycle ☐Upright Bicycle Time to end of exercise ________min______sec METS_________________ %MPHR_______________
8. If Dobutamine:	Maximum dobutamine dose given:- ___________________mcg/kg/min Atropine given?: ☐Yes ☐No If yes, dose:____________mg Handgrip use?: ☐Yes ☐No %MPHR_______________ Biphasic response ☐Yes ☐No
9. ECG changes:	☐Yes ☐No If yes, specify changes: ST depression ☐Yes ☐No If yes, what is the maximum depression? _____mm ST elevation ☐Yes ☐No If yes, what is the maximum elevation? _____mm Ventricular arrhythmias ☐Yes ☐No Other _____________ ☐Yes ☐No
10. Completion of protocol:	☐ Not done ☐ Done and completed ☐ Performed but not completed Baseline Heart Rate ___________ bpm (3 digits) Peak Heart Rate ______________ bpm Systolic Blood Pressure at rest ______ mmHg Diastolic Blood Pressure at rest ______mmHg Systolic Blood Pressure at peak stress _____ mmHg Diastolic Blood Pressure at peak stress _____mmHg Reached target HR? ☐Yes ☐No If no, was it converted to pharmacologic? ☐Yes ☐No If yes, choose the agent used:

	☐ Dobutamine ☐ Dipyridamole ☐ Adenosine ☐ Regadenoson Did the patient develop symptoms of possible CAD (including CP, SOB) ☐Yes ☐No ☐equivocal (if the answer is yes or equivocal, go to qs 11)

11. If there were symptoms of possible CAD, enlist any other symptoms perceived by the patient.	Chest Pain ☐Yes ☐No If yes, did the chest pain limit exercising capacity? ☐Yes ☐ No Shortness of Breath ☐Yes ☐No Hypotension ☐Yes ☐No VT ☐Yes ☐No Patient request ☐Yes ☐No Abnormal BP response ☐Yes ☐No Other ☐Yes ☐No If yes, specify:
12. Was the wall motion in the anterior/apical segment normal on stress?	☐Yes ☐No
13. Was the wall motion in the lateral segment normal on stress?	☐Yes ☐No
14. Was the wall motion in the infero-posterior segment normal on stress?	☐Yes ☐No
15. Resting LVEF	_____ EF% ☐Normal ☐Abnormal Scar existing on rest exam ☐Yes ☐No If yes, ☐ Anterior/apical ☐ inferior/posterior ☐ Lateral
16. Stress LVEF	_____ EF% ☐Normal ☐Abnormal If abnormal, severely decreased (<35% EF) ☐Yes ☐No
17. LV Dilatation at Peak Stress	☐Yes ☐No ☐Not Mentioned
18. ECHO Results:	☐Normal ☐Abnormal If abnormal, specify: ☐ Inducible ischemia ☐ MI/scar (no ischemia) ☐ Both

19. Was another Stress Echocardiogram done?	☐Yes ☐No

Transthoracic Echocardiogram (rest)

To be entered on form by CRC

1. Was a resting transthoracic echocardiogram performed?	☐Yes ☐No
2. What are the initials of the physician who performed the test?	
3. Date/time test ordered:	Date (mm/dd/yyyy): Time (hh:mm):
4. Date/time test performed:	Date (mm/dd/yyyy): Time (hh:mm):
5. Date/time of test interpretation:	Date (mm/dd/yyyy): Time (hh:mm):
6. Was the wall motion in the anterior/apical segment normal?	☐Yes ☐No
7. Was the wall motion in the lateral segment normal?	☐Yes ☐No
8. Was the wall motion in the infero-posterior segment normal?	☐Yes ☐No
9. LV function (Ejection fraction %)	__________%
10. Results:	☐Normal ☐Abnormal If abnormal, specify:
11. Was a resting transthoracic echocardiogram done again?	☐Yes ☐No

Exercise ECG Stress Test (Non-imaging only)

To be entered on form by CRC.

1. Was an exercise ECG stress test performed?	☐Yes ☐No
2. What are the initials of the physician who performed the test?	
3. Date/time test ordered:	Date (mm/dd/yyyy): Time (hh:mm):
4. Date/time test performed:	Date (mm/dd/yyyy): Time (hh:mm):

5. Date/time of test interpretation:	Date (mm/dd/yyyy): Time (hh:mm):
6. Type of Exercise protocol	☐Bruce ☐Modified Bruce ☐Naughton ☐Supine Bicycle ☐Upright Bicycle
7. Functional Capacity	Time to end of Treadmill ___________min_________sec METS__________________ %MPHR________________
8. Completed protocol?	☐ Not done ☐ Done and completed ☐ Performed but not completed Peak Heart Rate ___________ bpm (3 digits) Baseline Heart Rate _________ bpm Reached target HR? ☐Yes ☐No ☐NA If no, was it converted to pharmacologic? ☐Yes ☐No If yes, choose the agent used: ☐ Dobutamine ☐ Dipyridamole ☐ Adenosine ☐ Regadenoson Symptoms of possible CAD (including CP, SOB) ☐Yes ☐No ☐equivocal (If the answer is yes or equivocal, go to qs. 9)
9. If there were symptoms of possible CAD, enlist any other symptoms perceived by the patient.	Chest Pain ☐Yes ☐No If yes, did the chest pain limit exercising capacity? ☐ Yes ☐No If yes, ☐Ischemic ☐Equivocal Shortness of Breath ☐Yes ☐No Hypotension ☐Yes ☐No VT or non sustained VT ☐Yes ☐No Patient request ☐Yes ☐No Abnormal BP response ☐Yes ☐No Other ☐Yes ☐No If yes, specify:
10. Results:	☐Negative ☐Positive ☐Borderline If positive or borderline, select as appropriate: ☐ ST depression ☐Yes ☐No If yes, what was the maximum? _____ ☐ ST elevation ☐Yes ☐No If yes, what was the maximum? _____ ☐ Ventricular arrhythmias ☐Yes ☐No ☐ Other ☐Yes ☐No If yes, specify:_______
11. Was exercise ECG stress test done again?	☐Yes ☐No

Cardiac Catheterization

To be entered by the CRC

1. Was Cardiac Catheterization done?	☐Yes ☐No
2. Initials of physician who interpreted test:	
3. Date/time test ordered:	Date (mm/dd/yyyy): Time (hh:mm):
4. Date/time test performed:	Date (mm/dd/yyyy): Time (hh:mm):
5. Date/time of test interpretation:	Date (mm/dd/yyyy): Time (hh:mm):
6. Were there any complications to the procedure (as per cath lab ACC/NCDR instruction)?	☐Yes ☐No If yes, fill out **adverse event form**.
7. Mark the appropriate box to indicate the level of stenosis in each vessel:	
a. Left Main	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐ 50-99% (significant/severe) ☐ 100% (occluded) ☐indeterminate ☐ stent note: _________
b. LAD (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded)☐indeterminate ☐ stent note: _________
c. LCX (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded)☐indeterminate ☐ stent note: _________
d. RCA (any)	☐normal 0% ☐1-49% (non-significant/mild or minor) ☐50-69% (moderate) ☐70-99% (significant/severe) ☐ 100% (occluded)☐indeterminate ☐ stent note: _________
e. LV Gram	☐Normal ☐Abnormal
8. Did subject undergo revascularization?	☐Yes ☐No If yes, type of revascularization: ☐ PCI ☐ LM ☐Yes ☐No ☐ LAD ☐Yes ☐No ☐ LCX ☐Yes ☐No ☐ RCA ☐Yes ☐No ☐CABG
9. Radiation Exposure	Fluoro time _____ Min/sec Cine runs _____ Number Radiation Dose _____
10. Cardiac Catheterization done again?	☐Yes ☐No

PATIENT DISCHARGE FORM
Patient Discharge Information

1. Disposition:	☐Direct ED Discharge ☐Observational Unit admission ☐Hospital admission ☐Died prior to ED discharge; (If so, fill out SAE form) Date of death (mm/dd/yyyy): Time of death (hh:mm): ☐Left against medical advice (If so, fill out Protocol Deviation form) ☐Other, specify:
2. Date/time of index hospital discharge:	Date (mm/dd/yyyy): Time (hh:mm):
3. Was the subject admitted to the hospital? If so where?	☐Yes ☐No ☐Medical/surgical unit ☐Step down unit ☐ICU/CCU ☐Telemetry
4. Primary discharge diagnosis (Choose One):	☐Noncardiac chest pain ☐Non coronary cardiac chest pain ☐Acute Coronary Syndrome ☐Cardiac chest pain not meeting Acute Coronary Syndrome
5. If Non cardiac Chest Pain, (Choose one):	☐ Pulmonary embolism ☐ Pneumonia ☐ GERD ☐ Gastrointestinal ☐ Musculoskeletal ☐ Aortic dissection ☐ Non cardiac CP without clear alternate diagnosis ☐ Other, specify
6. If, Non coronary cardiac chest pain, (Choose One):	☐ Pericarditis/Myocarditis ☐ Valvular ☐ Cardiomyopathy ☐ Other ___________________________
7. If Acute Coronary Syndrome, (Choose One):	☐ Myocardial Infarction (defined as 1 and 2) 1. Anginal equivalent > 10 minutes AND 2. Typical rise and fall of cardiac biomarkers (record peak cTn _______ or peak CK-MB _____) (Provide Units and ULN:_________________) ☐ Unstable Angina (defined as 1 and 2) 1. Chest pain or anginal equivalent at

	rest or in an accelerating pattern 2. At least one objective sign : a. New ST-segment changes b. New TWI c. Positive stress-test with imaging showing ischemia d. Positive stress test without imaging resulting in increased anginal medication e. Cath >70% stenosis or thrombus f. CT angiography with >50% stenosis and LV dysfunction or >70% stenosis
8. Did the subject have any peri-procedural complications?	Stroke ☐Yes ☐No Bleeding ☐Yes ☐No Renal failure ☐Yes ☐No Anaphylaxis ☐Yes ☐No

48-72 HOUR FOLLOW UP FORM

48-72 Hour Follow Up

Complete only for patients discharged within 24 hours of ED presentation.

1. Was the 48-72 hour follow-up call completed?	☐ Yes ☐ No ☐ NA If No, Did the subject withdraw from the study? ☐ Yes ☐ No If yes, reason:________________________
2. Date of contact (mm/dd/yyyy):	
3. Time of contact (hh:mm):	
4. How many attempts were made to reach the patient?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5
5. Did subject die?* If yes, fill out SAE form.	☐Yes ☐No If yes, death reported how? ☐Relative ☐SSDI ☐Medical record
a. Date of death (mm/dd/yyyy):	
b. Time of death (hh:mm):	
c. Cause of death:	☐ CV death due to coronary heart disease ☐ CV death not directly due to coronary heart disease ☐ Non CV_death ☐ Other ____________
6. Did subject have recurrence of chest pain or anginal equivalent?	☐Yes ☐No If yes, provide, duration of longest episode:
7. Did subject return to ED?	☐Yes ☐No If yes, complete supplement form
8. Did subject return to OPD (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form
9. Was the patient admitted to the hospital?	☐Yes ☐No If yes, complete supplement form
10. Was an ongoing hospitalization prolonged for ischemic signs/symptoms?	☐Yes ☐No If yes, complete supplement form
11. Did subject have ECG changes (since index hospitalization/last contact)? *	☐ Yes * ☐ No If Yes, complete supplement form

12. Were Cardiac biomarkers obtained (since index hospitalization/last contact)?	☐Yes ☐No If Yes, complete supplement form
13. Was a stress test performed?* If yes, fill out SAE form	☐Yes * ☐No If yes, complete supplement form and provide report.
14. Was a coronary angiogram performed?* If positive, fill out SAE form.	☐Yes* ☐No If yes, complete supplement form and provide report.
15. Was a PCI performed?* If yes, fill out SAE form.	☐Yes * ☐No If yes, complete supplement form and provide report.
16. Did subject undergo heart revascularization? *If yes, fill out SAE form	☐Yes * ☐No If yes, complete supplement form and provide report.
17. Did the subject have any peri-procedural complications? * If yes, fill out SAE form	☐Yes * ☐No If yes, complete supplement form and provide report.
18. What source documents have been provided by site?	☐Discharge summary ☐Exercise testing report ☐Death note, certificate ☐Cardiac Cath/PCI report ☐Cardiology consultation note ☐CABG report ☐Biomarker report ☐Other, specify ☐ECG, during & after event

48-72 HOUR FOLLOW UP SUPPLEMENT FORM

1. Was the 48-72 hour follow-up call completed?	☐ Yes ☐ No ☐ NA If No, Did the subject withdraw from the study? ☐ Yes ☐ No If yes, reason:____
2. Date of contact (mm/dd/yyyy):	
3. Time of contact (hh:mm):	
4. How many attempts were made to reach the patient?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5
5. Did subject die?* If yes, fill out SAE form.	☐Yes ☐No If yes, death reported how? ☐Relative ☐SSDI ☐Medical record
a. Date of death (mm/dd/yyyy):	
b. Time of death (hh:mm):	
c. Cause of death:	☐ CV death due to coronary heart disease ☐ CV death not directly due to coronary heart disease ☐ Non CV_death ☐ Other _____________________
6. Did subject have recurrence of chest pain or anginal equivalent?	☐Yes ☐No If yes, provide, duration of longest episode:
7. Did subject return to ED?	☐Yes ☐No If yes, a. Date of return (mm/dd/yyyy): b. Time of return (hh:mm): c. Institution:

	d. Reason: ☐Recurrent chest pain* ☐Other, specify__________ *Fill out SAE form Discharged? ☐Yes ☐No If yes, e. Date (mm/dd/yyyy): f. Time (hh:mm):
8. Did subject return to OPD (since index hospitalization/last contact)?	☐Yes ☐No If yes, a. Date of return (mm/dd/yyyy): b. Time of return (hh:mm): c. Institution: d. Reason: ☐Recurrent chest pain* ☐Other, specify__________ *Fill out SAE form If yes, Discharged? ☐Yes ☐No If yes, e. Date (mm/dd/yyyy): f. Time (hh:mm):
9. Was the patient admitted to the hospital?	☐Yes ☐No If yes, a. Date of admission (mm/dd/yyyy): b. Institution: c. Reason: ☐Recurrent chest pain* ☐Other, specify__________ *Fill out SAE form Discharged? ☐Yes ☐No If yes, d. Date (mm/dd/yyyy): e. Time (hh:mm):
10. Was an ongoing hospitalization prolonged for ischemic signs/symptoms?	☐Yes ☐No If yes, a. Date of admission (mm/dd/yyyy): b. Institution:
11. Did subject have ECG changes (since index hospitalization/last contact)? *	☐ Yes * ☐ No If Yes, check appropriate boxes below and fill out SAE form: ☐ ST elevation >1mm ☐ ST depression >1mm ☐ TWI >1mm
12. Were Cardiac biomarkers obtained (since index hospitalization/last contact)? If yes, Peak cTn result?	☐Yes ☐No ☐Yes ☐No

Peak CK-MB result?	Provide peak cTn result: ______________ Provide cTn units: ______________ Provide cTn ULN: ______________ ☐Yes ☐No Provide peak CK-MB result: ______________ Provide CK-MB units: ______________ Provide CK-MB ULN: ______________
13. Was a stress test performed?* If yes, fill out SAE form	☐Yes * ☐No If yes, provide report. If yes, was it ETT☐ or nuclear imaging? ☐ If yes, you will need to fill out the ETT or Nuclear imaging questions.
14. Was a coronary angiogram performed?* If positive, fill out SAE form.	☐Yes* ☐No If yes, you will need to fill out the coronary angiogram questions and provide report.
15. Was a PCI performed?* If yes, fill out SAE form.	☐Yes * ☐No If yes, you will need to fill out the PCI questions and provide report.
16. Did subject undergo heart revascularization? *If yes, fill out SAE form	☐Yes * ☐No If yes, provide report. If yes, select method of revascularization: ☐CABG ☐Stent ☐Unknown
17. Did the subject have any peri-procedural complications? * If yes, fill out SAE form	Stroke ☐Yes ☐No Bleeding ☐Yes ☐No Renal failure ☐Yes ☐No Anaphylaxis ☐Yes ☐No
18. What source documents have been provided by site?	☐Discharge summary ☐Death note, certificate ☐Cardiology consultation note ☐Biomarker report ☐ECG, during & after event ☐Exercise testing report ☐Cardiac Cath/PCI report ☐CABG report ☐Other, specify

28 DAY FOLLOW UP FORM

1. Was the 28 day follow-up call completed?	☐ Yes ☐ No If No, Did the subject withdraw from the study? ☐ Yes ☐ No If yes, reason:_______________________________________
2. Date of contact (mm/dd/yyyy)	
3. How many attempts were made to reach the patient?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5
4. Did subject die (since index hospitalization/last contact)?	☐Yes ☐No If yes, death reported how? ☐Relative ☐SSDI ☐Medical record If yes, provide death note, certificate.
d. Date of death:	

e. Time of death (hh:mm):	
f. Cause of death:	☐ CV death due to coronary heart disease ☐ CV death not directly due to coronary heart disease ☐ Non CV death ☐ Other ____________________
4. Did subject have recurrence of chest pain or anginal equivalent (since index hospitalization/last contact)?	☐Yes ☐No If yes, provide, duration of longest episode:
5. Did subject return to ED (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
6. Did subject return to OPD (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
7. Was the patient admitted to the hospital (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
8. Was an ongoing hospitalization prolonged for ischemic signs/symptoms?	☐Yes ☐No If yes, complete supplement form and provide report
9. Did the subject have ECG changes (since index hospitalization/last contact)?	☐ Yes ☐ No If Yes, complete supplement form and provide a copy of the ECG
10. Were Cardiac biomarkers obtained (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form
11. Was a stress test performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
12. Was a coronary angiogram performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
13. Was a PCI performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
14. Did subject undergo heart revascularization (since index hospitalization/last contact)?	☐Yes ☐No If yes, complete supplement form and provide report
15. What source documents have been provided by site?	☐Discharge summary ☐Exercise testing report ☐Death note, certificate ☐Cardiac Cath/PCI report ☐Cardiology consultation note ☐CABG report ☐Biomarker report ☐Other, specify: ☐ECG, during & after event

28 DAY FOLLOW UP SUPPLEMENT FORM

1. Was the 28 day follow-up call completed?	☐ Yes ☐ No If No, Did the subject withdraw from the study? ☐ Yes ☐ No If yes, reason:________________________________
2. Date of contact (mm/dd/yyyy)	
3. How many attempts were made to reach the patient?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5
4. Did subject die (since index hospitalization/last contact)?	☐Yes ☐No If yes, death reported how?

	☐Relative ☐SSDI ☐Medical record If yes, provide death note, certificate.
g. Date of death:	
h. Time of death (hh:mm):	
i. Cause of death:	☐ CV death due to coronary heart disease ☐ CV death not directly due to coronary heart disease ☐ Non CV death ☐ Other ____________________
4. Did subject have recurrence of chest pain or anginal equivalent (since index hospitalization/last contact)?	☐Yes ☐No If yes, provide, duration of longest episode:
5. Did subject return to ED (since index hospitalization/last contact)?	☐Yes ☐No If yes, a. Date of return (mm/dd/yyyy): b. Time of return (hh:mm): c. Institution: d. Reason: ☐Recurrent chest pain ☐Other, specify_________ If yes, Discharged? ☐Yes ☐No If yes, please provide a copy of the report e. Date (mm/dd/yyyy): f. Time (hh:mm):
6. Did subject return to OPD (since index hospitalization/last contact)?	☐Yes ☐No If yes, a. Date of return (mm/dd/yyyy): b. Time of return (hh:mm): c. Institution: d. Reason: ☐Recurrent chest pain* ☐Other, specify_________ *Please provide a copy of the report
7. Was the patient admitted to the hospital (since index hospitalization/last contact)?	☐Yes ☐No If yes, a. Date of admission (mm/dd/yyyy): b. Institution: c. Reason: ☐Recurrent chest pain ☐Other, specify_________ If yes, Discharged? ☐Yes ☐No If yes, please provide a copy of the report d. Date (mm/dd/yyyy): e. Time (hh:mm):
8. Was an ongoing hospitalization prolonged for ischemic signs/symptoms?	☐Yes ☐No If yes, please provide a copy of the report

	a. Date of admission: b. Institution:
9. Did the subject have ECG changes (since index hospitalization/last contact)?	☐ Yes ☐ No If Yes, please provide a copy of the ECG If Yes, check appropriate boxes below ☐ ST elevation >1mm ☐ ST depression >1mm ☐ TWI >1mm
10. Were Cardiac biomarkers obtained (since index hospitalization/last contact)? **If yes,** **Peak cTn result?** **Peak CK-MB result?**	☐Yes ☐No ☐Yes ☐No Provide peak cTn result: ______________ Provide cTn units: ______________ Provide cTn ULN: ______________ ☐Yes ☐No Provide peak CK-MB result: ______________ Provide CK-MB units: ______________ Provide CK-MB ULN: ______________
11. Was a stress test performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, provide report. If yes, Was it ☐ ETT ☐ Nuclear Imaging If yes, fill out questions about ETT and Nuclear Imaging
12. Was a coronary angiogram performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, fill out questions about the coronary angiogram and provide report.
13. Was a PCI performed (since index hospitalization/last contact)?	☐Yes ☐No If yes, fill out questions about the PCI and provide report.
14. Did subject undergo heart revascularization (since index hospitalization/last contact)?	☐Yes ☐No If yes, fill out questions and provide report. Select method of revascularization: ☐CABG ☐Stent ☐Unknown
15. What source documents have been provided by site?	☐Discharge summary ☐Death note, certificate ☐Cardiology consultation note ☐Biomarker report ☐ECG, during & after event ☐Exercise testing report ☐Cardiac Cath/PCI report ☐CABG report ☐Other, specify:

ADVERSE EVENT FORM

1) AE Number	
2) Event Code	
3) Event Description	

4) Start Date (mm/dd/yyyy):	
5) End Date (mm/dd/yyyy):	☐ Continuing
6) Grade (1-4)	☐ 1 - Mild ☐ 2 - Moderate ☐ 3 - Severe ☐ 4 - Life-threatening
7) SAE?	☐ Yes ☐ No
8) Was patient withdrawn from study due to AE?	☐ Yes ☐ No
9) Relationship to study procedure	☐ 1 - Not related ☐ 2 - Unlikely Related ☐ 3 - Possibly Related ☐ 4 - Probably Related ☐ 5 - Definitely Related
10) Relationship to contrast (1-5)	☐ 1 - Not related ☐ 2 - Unlikely Related ☐ 3 - Possibly Related ☐ 4 - Probably Related ☐ 5 - Definitely Related
11) Relationship to underlying disease	☐ 1 - Not related ☐ 2 - Unlikely Related ☐ 3 - Possibly Related ☐ 4 - Probably Related ☐ 5 - Definitely Related
12) Action (1-5)	☐ 1 - No Action Taken ☐ 2 - Medication Given ☐ 3 - Non-drug therapy given ☐ 4 - ED visit ☐ 5 - Hospitalization /prolonged hospitalization
13) Outcome (1-5)	☐ 1 - Recovered ☐ 2 – Recovered with sequelae ☐ 3 - Ongoing ☐ 4 – Death ☐ 5 - Unknown
14) Did the subject have another AE?	☐ Yes ☐ No

SERIOUS ADVERSE EVENT FORM

Event Information	
1. Type of Report	☐ Initial Report ☐ 48-72 hour follow up
2. Date of this report (dd/mm/yyyy)	
Contrast Information	
3. Did the subject receive contrast? If yes, complete the following: Contrast agent: Dose	☐Yes ☐No ____________ ml ____________ml
4. Time to onset after injection:	__________
Event Details	
5. Indicate the nature of the diagnosis that best describes the event.	☐ Myocardial Infarction ☐ Bleeding ☐ Stroke ☐ Renal Failure ☐ Anaphylaxis ☐ Death ☐ Other medically important events ☐ Other, ______________________________
6. Date of onset (dd/mm/yyyy):	
7. Time of onset of event:	
8. Date of outcome (dd/mm/yyyy):	
9. Time of outcome:	
10. Seriousness	☐ Death : Date ____________ Time : _____ ☐ Resulted in a life-threatening illness or injury ☐ Resulted in a permanent impairment of a body structure or function ☐ Resulted in a hospitalization or prolongation of an existing hospitalization ☐ Required medical or surgical intervention to prevent permanent impairment or damage ☐Congenital anomaly or birth defect in offspring of the subject
11. Was this an unexpected SAE (not listed in the informed consent)	☐Yes ☐No
12. What was the relationship of the SAE to the **procedure?**	☐ Not related ☐ Possibly related ☐ Probably related ☐ Definitely related ☐ Unable to determine
13. What was the relationship of the SAE to the **contrast?**	☐ Not related ☐ Possibly related ☐ Probably related ☐ Definitely related ☐ Unable to determine
14. What was the relationship of the SAE to underlying disease?	☐ Not related ☐ Possibly related ☐ Probably related ☐ Definitely related

	☐ Unable to determine
15. Describe the event:	
16. Describe the action taken:	
17. Outcome:	☐ Resolved : Date (DD/MM/YYYY) ☐ Ongoing ☐Improved ☐Unchanged ☐Worsened ☐ Death - Was an autopsy performed? ☐Yes ☐No
18. Attached documentation:	☐Lab report (s) ☐ECG (s) ☐Discharge Summary ☐Admission History and Physical ☐Death Certificate ☐Other ________________
19. Did the subject have another SAE?	☐ Yes ☐ No

PROTOCOL DEVIATION FORM

A. Date of protocol deviation: (dd/mm/yyyy) ___ ___ - ___ ___- ___ ___ ___ ___
Time of protocol deviation: (military time) ___ ___: ___ ___

B. Deviation code: ______ (from list below)
C. Reason for Deviation: (i.e. lost to follow-up)____

Possible Deviation Codes
1 – CT Group – CT not performed (i.e. subject refusal)
2 – CT Group – (i.e. CT malfunction)
3 – Subject left hospital against medical advice (post-randomization)
4 – 2-3 day follow-up call was done out of window
5 – 28 days follow-up call was done out of window
6 – 1 year follow-up call was done out of window
7 – 2 year follow-up call was done out of window
8 – Biomarker testing issues (i.e. not enough blood, centrifuge broken, sample loss)
9 – Other: (specify) ____
Did the subject have another Protocol Deviation? ☐ Yes ☐ No

Note: Protocol Deviations must be reported to Pearl Zakroysky (pzakroysky@partners.org) immediately after deviation occurs. Deviations should also be reported, as required, according to site IRB policy.

PROTOCOL VIOLATION FORM

A. Date of protocol violation: (dd/mm/yyyy) ___ ___ - ___ ___- ___ ___ ___ ___
Time of protocol violation: (military time) ___ ___: ___ ___

B. Violation code: _______ (from list below)
C. Reason for Violation: (i.e. subject underwent CT with sent in place)___________________

Possible Violation Codes
1 – Subject was randomized but did not meet incl/excl criteria (specify which criteria): ________
2 – CT Group – CT not performed (i.e. no staff available to perform CT scan)
3 – Failure to sign informed consent
4 – Pregnancy test was not performed in applicable subject
5 – Qualifying labs not performed
6 – Qualifying ECG not performed
7 – Calcium scan not performed
8 – Contrast agent was not given
9 – Coronary CTA – stent was present
10 – 2-3 day follow-up call was not done
11 – 2 year follow-up call was not done
12 – Other: (specify) ____
Did the subject have another Protocol Violation? ☐ Yes ☐ No

Note: Protocol Violations must be reported to your IRB, as required, according to site IRB policy. PVs must also be reported to Pearl Zakroysky (pzakroysky@partners.org) immediately after knowledge of the event.