



SLEEP HEART HEALTH STUDY

ELECTROCARDIOGRAM PHYSICIAN REVIEW FORM

Field Site ID: _ _

Participant ID#: _____

Alpha Code: _ _ _ _ _

The following ECG findings are considered SHHS Alerts.

1. Were any of the following noted:

	Yes	No	
a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Heart rate <45 beats per minute or >120 beats per minute
b.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Ventricular tachycardia
c.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Acute myocardial infarction
d.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Complete AV block
e.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Second degree AV block

3. Were any other conditions noted:

1 Yes 0 No **→ Skip to item 4.**

a. 1st other condition:
_____ specify

b. 2nd other condition:
_____ specify

c. 3rd other condition:
_____ specify

d. 4th other condition:
_____ specify

e. 5th other condition:
_____ specify

The following findings are considered SHHS abnormalities.

2. Were any of the following noted:

	Yes	No	
a.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Any finding which includes a reference to ischemia or pericarditis
b.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Wolff-Parkinson-White (WPW) or ventricular pre-excitation pattern
c.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Left Bundle Branch Block
d.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Prolonged QT interval
e.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Atrial fibrillation or flutter
f.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	RBBB + LAH (Bifascicular block)
g.	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Frequent/Multifocal PVC's

4. Physician name (please print):

5. Physician signature:

6. Date ECG reviewed:
_ _ month _ _ day _ _ year

