Cohort Event Eligibility Form

ID NUMBER: ☐☐☐☐☐☐☐

CONTACT YEAR: ☐☐

FORM CODE: CEL
VERSION : A 05/05/2003

LAST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐

INITIALS: ☐☐

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

A. IDENTIFYING INFORMATION

1 a. Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1b. First Name................... ☐☐☐☐☐☐☐☐☐☐☐☐

1c. Middle Name................. ☐☐☐☐☐☐☐☐☐☐☐

1d. Social Security Number... ☐☐☐ / ☐☐ / ☐☐☐☐

2. Participant ID... ☐☐☐☐☐☐☐

3. Visit 1 date............................. ☐☐ / ☐☐ / ☐☐☐☐
                                          Month   Day   Year

4. Date of discharge or death...... ☐☐ / ☐☐ / ☐☐☐☐
                                          Month   Day   Year

If Item 3 is <u>not</u> earlier than Item 4, go to Item 16 on Screen 6

4a. Date of birth.......................... ☐☐ / ☐☐ / ☐☐☐☐

                                          Month   Day   Year

5. Source used to identify event:

                                      Cohort Annual Follow-Up   F

                                      Surveillance Procedures   S

                                      Other   O

6. Is this event a death?.. Yes   Y

                                 Go to Item 8, Screen 2. ——No   N

7. Is this event an <u>out of hospital</u> death, or a death for which hospitalization information cannot be located?

                                 Go to Item 13, Screen 5. —— Yes   Y

                                              No   N ☐☐

8a. Hospital Code Number: _____
         [If Code is 96 – 99, specify: _____]

8b. Can information on this hospitalization be located? ... Yes   Y

            If eligibility of this event cannot be determined, go to Item 19. a, Screen 6. ——— No   N

B. INFORMATION FROM HOSPITAL DISCHARGE INDEX OR FACE SHEET

9a. Hospital Record – Number:....................... ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

9b. How was eligibility established for this hospitalization?   Hospital Index   I
                                                     Face sheet   F
                                                       Other   O

[If eligibility is 0, specify: _____]

10. Hospital discharge diagnosis and procedure codes:

a. ☐☐☐☐ . ☐☐   j. ☐☐☐☐ . ☐☐   s. ☐☐☐☐ . ☐☐

b. ☐☐☐☐ . ☐☐   k. ☐☐☐☐ . ☐☐   t. ☐☐☐☐ . ☐☐

c. ☐☐☐☐ . ☐☐   l. ☐☐☐☐ . ☐☐   u. ☐☐☐☐ . ☐☐

d. ☐☐☐☐ . ☐☐   m. ☐☐☐☐ . ☐☐   v. ☐☐☐☐ . ☐☐

e. ☐☐☐☐ . ☐☐   n. ☐☐☐☐ . ☐☐   w. ☐☐☐☐ . ☐☐

f. ☐☐☐☐ . ☐☐   o. ☐☐☐☐ . ☐☐   x. ☐☐☐☐ . ☐☐

g. ☐☐☐☐ . ☐☐   p. ☐☐☐☐ . ☐☐   y. ☐☐☐☐ . ☐☐

h. ☐☐☐☐ . ☐☐   q. ☐☐☐☐ . ☐☐   z. ☐☐☐☐ . ☐☐

i. ☐☐☐☐ . ☐☐   r. ☐☐☐☐ . ☐☐

11a. Is a 402,410–414, 427, 428,or 518.4 code listed?....................................... Yes   Y
  No   N

b. Is a 430–438 code listed?... Yes   Y
  No   N

c. Is a 35–39, 88.5, 250, 390–459, 745–747, 794.3, 798, or 799 code listed?   Yes   Y
  No   N

> If all of Items 11a, 11b, and 11c are "NO" go to Item 12 on Screen 5. Otherwise, continue with Item 11d on Screen 4.

d. Are any of the following mentioned or suggested in the discharge summary? Yes   Y

No   N

<u>Acute:</u>   MI   Angina   Chest Pain   Ischemic heart Disease

           CHD   Unstable Angina   Cardiac Arrest   Atherosclerotic Heart Disease

<u>Or during this admission:</u>   CCU Care   Nitroglycerin   Cardiac Catherization

                                CABG   Elevated CK–MB   Coronary Angiography or Angioplasty

11e. Are any of the following mentioned or suggested in the discharge summary?   Yes   Y

                                                      No   N

<u>Acute:</u> Stroke   TIA   Cerebral Infarction   Cerebrovascular Disease

       Aphasia   Diplopia   Cerebral embolus   Lacunar (syndrome infarction)

       Dysarthria   Paralysis   Cerebral hemorrhage   Subarachnoid hemorrhage

<u>Or during this admission:</u>   Carotid endarterectomy   Cerebral angiolgraphy

                             CT/MRI Scan showing cerebrovascular findings

                             Neuro ICU Care [if in doubt, ask your surveillance MD.]

If <u>any</u> of Items 11a, 11b, 11d, <u>or</u> 11e is "Yes," go to Item 15 on Screen 5. Otherwise, continue with Item 12.

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12. Is this event an in-hospital death? ....   Yes   Y

                | Go to Item 16, Screen 6. |——No   N

C. INFORMATION FROM DEATH INDEX/CERTIFICATE

13a. Death Certificate Number: | | | | | | | | | | | | | | | | |

13b. Was an autopsy performed? ....Yes   Y

                                            No   N

14a. ICD code for <u>underlying</u> cause of death:..................... | | | | | . | |

Is the Code E10 – E14, 110, 111, 120 – 125, 146 – 151, 170, 197

(exclude 197.2), J81, J96, R96, R98, or R99 ....

Go to Item 15, Screen 6. ──── Yes	Y
No	N ──── Go to Item 17, Screen 6

D. ELIGIBLITIY

15. Record Y, indicating that event is eligible .... ─Yes   Y

Go to Item 19

16. Record N, indicating that event is not eligible .... ─No   N

Go to Item 19

17. Record N, indicating that event is a death and is not eligible.   No   N

18. *Question Deleted *

19. a. Was this event reported in the corresponding
Annual Follow-Up for this participant?   Yes   Y

Go to Item 20 ──── No   N

19b. Contact year of corresponding Annual Follow-up........................ ☐☐☐☐

19c. Letter of corresponding hospitalization from the Annual Follow-Up (if none enter "=".   ☐

E. ADMINISTRATIVE INFORMATION

20. Date of data collection:

☐☐ / ☐☐ / ☐☐☐☐
Month   Day   Year

21. Code number of person completing this form: ☐☐☐