Bench to Bassinet
Pediatric Cardiac Genomics Consortium: CHD GENES
Form 107: Medical History/Outcomes Abstraction, Subject <= 1year
Version: B - 11/01/2010

SECTION A: ADMINISTRATIVE INFORMATION

A1. Study Identification Number:

A2. Study Visit:

A3. Date Form Completed: *MM/DD/YYYY*

SECTION B: NON-CARDIAC SURGERIES

	Yes	No	Unknown	Source Pending
B1. Non-cardiac Surgery:	○	○	○	○

- a. Abdominal Surgery: (check all that apply) ☐
  - i. Appendectomy ☐
  - ii. Bowel Resection ☐
  - iii. Duodenal Atresia Repair ☐
  - iv. Exploratory Laparotomy ☐
  - v. LADS Procedure ☐
  - vi. Ostomy Procedure ☐
  - vii. Other ☐
    - a. Specify:
- b. Adenoidectomy ☐
- c. Bronchoscopy ☐
- d. Dental Surgery ☐
- e. Dermatologic Procedure ☐
- f. Diaphragmatic Plication ☐
- g. Endoscopy ☐
- h. Esophageal Atresia ☐
- i. Esophagoscopy ☐
- j. Eye Surgery ☐
  - i. Specify:
- k. Gastrostomy Tube / Jejunostomy Tube Placement ☐
- l. HEENT ☐
  - i. Specify:
- m. Hernia / Hydrocele Repair ☐
- n. Liver Surgery: (check all that apply) ☐
  - i. Kasai ☐
  - ii. Other ☐
    - a. Specify:
- o. Myringotomy Tubes ☐
- p. Neuro Surgery ☐
- q. Nissen Fundoplication Procedure ☐
- r. Orchiopexy ☐
- s. Orthopedic Surgery: (check all that apply) ☐
  - i. Congenital Anomaly ☐
  - ii. Scoliosis ☐

iii. Other ☐

a. Specify: _____

t. Palate Procedure ☐

u. Thoracic Non-Cardiac Surgery ☐

v. Tonsillectomy ☐

w. Tracheal Repair / Reconstruction ☐

x. Tracheotomy ☐

y. Urogenital:
(check all that apply) ☐

i. Hypospadias Repair ☐

ii. Undescended Testes Surgery ☐

iii. Urethral / Bladder ☐

iv. Other ☐

a. Specify: _____

z. Ventriculoperitoneal Shunt ☐

a. Other ☐

i. Specify: _____

SECTION C: CARDIAC SURGERIES AND PROCEDURES

	Yes	No	Unknown	Source Pending
C1. Cardiac Catheterization Procedures	○	○	○	○

a. Procedure Code: _____ View Code List

b. Specify: _____

c. Procedure Date: _____ *MM/DD/YYYY*

	Yes	No	Unknown	Source Pending
C2. Cardiac Surgeries:	○	○	○	○

a. Surgical Code: _____ View Code List

b. Specify: _____

c. Surgery Date: _____ *MM/DD/YYYY*

	Yes	No	Unknown	Source Pending
C3. Arrhythmia requiring treatment:	○	○	○	○

a. Arrhythmia Type:

- ○ Atrial
- ○ AVB
- ○ Ventricular
- ○ Unknown
- ○ Source Pending

b. Arrhythmia Treatment (check all that apply):

i. Cardioversion ☐

ii. Catheter Ablation ☐

iii. ICD ☐

iv. Pacemaker ☐

v. Pharmacologic ☐

vi. Other ☐

a. Specify: _____

	Yes	No	Unknown	Source Pending
C4. Non-fatal, out of hospital Cardiac Arrest:	○	○	○	○

a. Date of most recent event: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C5. Extracorporeal Membrane Oxygenation (ECMO) in Intensive Care Unit:	○	○	○	○

a. Indication: (check all that apply)

i. Arrest ☐

ii. Arrhythmia ☐

iii. Heart Failure ☐

iv. Unable to wean from bypass ☐

v. Other ☐

a. Specify:

b. Date of most recent event: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C6. Ventricular Assist Device Placement:	○	○	○	○

a. Indication:

- ○ Arrest
- ○ Arrhythmia
- ○ Heart Failure
- ○ Unable to wean from bypass
- ○ Other
- ○ Unknown
- ○ Source Pending

i. Specify:

b. Date: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C7. Pacemaker Placement:	○	○	○	○

a. Indication:

- ○ Atrial Tachycardia
- ○ AV Block
- ○ Sinus Node Dysfunction
- ○ Ventricular Dysfunction / dyssynchrony
- ○ Ventricular Tachycardia
- ○ Other
- ○ Unknown
- ○ Source Pending

i. Specify:

b. Date: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C8. Implantable Cardioverter Defibrillator (ICD) Placement:	○	○	○	○

a. Indication:

- ○ Primary Prevention
- ○ Secondary Prevention
- ○ Unknown
- ○ Source Pending

b. Date: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C9. Cardiac Transplant List:	○	○	○	○

a. Date: *MM/DD/YYYYY*

	Yes	No	Unknown	Source Pending
C10. Status Post Cardiac Transplant:	○	○	○	○

a. Transplant Date: *MM/DD/YYYY*