

Fax this form, EKG & Lab to 888-764-8218

**LEVEL 1 HEART ATTACK
Transfer Data Sheet**

Patient Name: _____
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Date:	
Hospital:	
Ht. _____	Wt: _____
Allergies:	
<input type="checkbox"/> Contrast allergy	

Times	
Symptom onset	_____ : _____
ED arrival	_____ : _____
EKG	_____ : _____
Level 1 Call	_____ : _____
Transport arrival	_____ : _____
ED Exit	_____ : _____

Transport:
<input type="checkbox"/> Air <input type="checkbox"/> Ground

Level 1 Criteria
<input type="checkbox"/> ST ↑ 1mm in 2 or more contiguous leads
<input type="checkbox"/> New LBBB
<input type="checkbox"/> Symptom onset within 12 hours

EKG Changes
<input type="checkbox"/> Inferior (II, III, AVF)
<input type="checkbox"/> Anterior (V 1 -4)
<input type="checkbox"/> Lateral (I, AVL, V 5-6)

Patient Condition
<input type="checkbox"/> CPR
<input type="checkbox"/> VT / VF
<input type="checkbox"/> Cardiogenic Shock
<input type="checkbox"/> Stable

Lab (Fax results ASAP)
Hgb _____ K _____ Cr _____
Reminder: Urine HCG on women 12-50 years

Past Medical History
<input type="checkbox"/> Major surgery (past 6 months)
<input type="checkbox"/> Trauma (past 30 days)
<input type="checkbox"/> Bleeding disorders
<input type="checkbox"/> Stroke (past 6 months)
<input type="checkbox"/> Cancer / neoplasm
<input type="checkbox"/> Pulmonary disorders
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chronic kidney disease (Cr>2)

Past Cardiac History		
<input type="checkbox"/> MI	<input type="checkbox"/> PCI	<input type="checkbox"/> CABG
<input type="checkbox"/> CHF	<input type="checkbox"/> Atrial Fibrillation	
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> ICD (defibrillator)	

Protocol Medications
<input type="checkbox"/> Aspirin _____ mg chewed/PO @ _____
<input type="checkbox"/> Plavix _____ mg PO @ _____
<input type="checkbox"/> Heparin Loading 60u/kg IV (4,000 units max) Time given: _____
<input type="checkbox"/> Heparin Infusion 12 units/kg/hr (1,000 units max) Time started: _____
<input type="checkbox"/> Lopressor 5 mg IV x _____ Times given: _____
<input type="checkbox"/> Thrombolytics
<input type="checkbox"/> TNKase
<input type="checkbox"/> Retavase
(List other meds that might effect bleeding: such as, lovenox, coumadin, integrillin)

ED Physician: _____ Primary Physician: _____ Phone: _____