



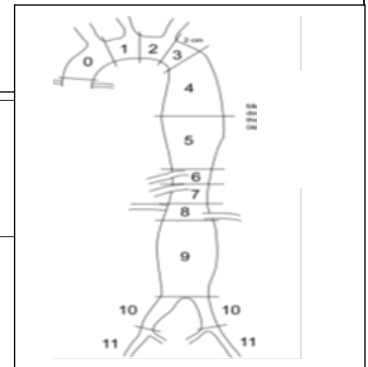
596 Davis Drive  
Newmarket, ON L3Y 2P9

Health Record #: \_\_\_\_\_ Complete or place barcoded patient label here  
 Patient Name: *(Print first, last)* \_\_\_\_\_  
 DOB: mm / dd / yy Age: \_\_\_\_\_  Female  Male  
 OHIP #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Account #: \_\_\_\_\_ Date of Admission: mm / dd / yy

**Surgical Services**

**Aortic Aneurysm (AA) Repair Vascular Registry Data Collection Form**  
*Intra-Operative*

<b>INTRA-PROCEDURE</b>	
Admission Date: <u>mm</u> / <u>dd</u> / <u>yy</u>	
Procedure Date: <u>mm</u> / <u>dd</u> / <u>yy</u>	Day Procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Initial Treating Healthcare Professional <i>(Physician name)</i> : _____	
Additional Treating Healthcare Professional <i>(Physician name)</i> : _____	
Priority Level (Urgency): <input type="checkbox"/> Elective <input type="checkbox"/> Urgent <input type="checkbox"/> Emergent	
American Society of Anesthesiologists (ASA) Class: <input type="checkbox"/> Normal/Healthy <input type="checkbox"/> With Mild Systemic Disease <input type="checkbox"/> With Severe Systemic Disease <input type="checkbox"/> Systemic Dysfunction that is a Constant Threat Life <input type="checkbox"/> Moribund/Not Expected to Survive without Operation	
<b>PROCEDURE DETAILS - EVAR</b>	<b>INTRA OP ANTICOAGULATION:</b> <input type="checkbox"/> Heparin <input type="checkbox"/> Other
Procedure Complexity: <input type="checkbox"/> Standard <input type="checkbox"/> Moderate <input type="checkbox"/> Advanced	Total IV Heparin dosage: _____
Moderate Aneurysm Location: <input type="checkbox"/> Juxtarenal <input type="checkbox"/> Aortoiliac	
Graft Type Used: <input type="checkbox"/> Standard	
Arterial Injury: <input type="checkbox"/> No <input type="checkbox"/> Single site <input type="checkbox"/> Multiple sites	
Conversion to Open: <input type="checkbox"/> Yes* <input type="checkbox"/> No	
If Yes*, reason: _____	
Proximal Graft Sealing Zone: <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 - Left <input type="checkbox"/> Zone 10 - Right <input type="checkbox"/> Zone 11 - Left <input type="checkbox"/> Zone 11 - Right	
Distal Graft Attachment Zone: <input type="checkbox"/> Zone 8 <input type="checkbox"/> Zone 9 <input type="checkbox"/> Zone 10 - Left <input type="checkbox"/> Zone 10 - Right <input type="checkbox"/> Zone 11 - Left <input type="checkbox"/> Zone 11 - Right	
Adjunct (Conduit) Procedure: <input type="checkbox"/> None <input type="checkbox"/> Stent-Graft <input type="checkbox"/> iliac-femoral bypass <input type="checkbox"/> Other	
Estimated Blood Loss: _____ mL	
Blood Transfusion (PRBC only): _____ units	
Total Contrast Volume Used: _____ mL	
Radiation Dose: _____ mGy	
Fluoroscopy Time: _____ min(s)	
Endoleak at Completion: <input type="checkbox"/> None <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Type III <input type="checkbox"/> Type IV	
<b>PROCEDURE DETAILS – OPEN AORTIC ANEURYSM REPAIR</b>	
<b>INTRA OP ANTICOAGULATION:</b> <input type="checkbox"/> Heparin <input type="checkbox"/> Other – Total IV Heparin dosage: _____	
Conversion from EVAR: <input type="checkbox"/> Yes* <input type="checkbox"/> No – If Yes*, time to conversion: <input type="checkbox"/> ≤ 30days <input type="checkbox"/> > 30 days	
Procedure Complexity: <input type="checkbox"/> Standard <input type="checkbox"/> Moderate	
Moderate Aneurysm Location: <input type="checkbox"/> Juxtarenal <input type="checkbox"/> Aortoiliac	
Approach: <input type="checkbox"/> Anterior <input type="checkbox"/> Retroperitoneal	





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**Surgical Services**

***Aortic Aneurysm (AA) Repair Vascular Registry Data Collection Form***

*Intra-Operative*

Proximal Anastomosis:

- Zone 8  Zone 9  
 Zone 10 - Left  Zone 10 - Right  Zone 11 - Left  Zone 11 - Right

Distal Anastomosis:

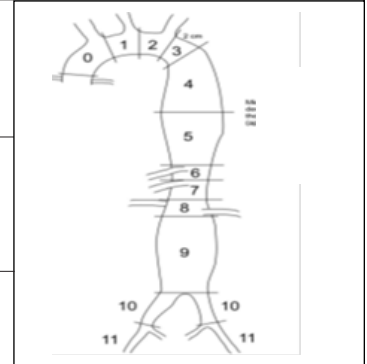
- Zone 8  Zone 9  
 Zone 10 - Left  Zone 10 - Right  Zone 11 - Left  Zone 11 - Right

Estimated Blood Loss: \_\_\_\_\_ mL

Autologous Blood Transfusion: \_\_\_\_\_ mL

Blood Transfusion (PRBC only): \_\_\_\_\_ units

Thromboembolectomy:  Yes  No



**Name:** *(print first, last)* \_\_\_\_\_ **Designation:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** mm / dd / yy

PVI = Peripheral Vascular Intervention

