REFER STUDY: Nurse CRF

PATIENT INITIALS ID NUMBER

General instructions

Each patient is provided with a unique 5 -digit ID number. Please enter this code at the top right hand corner of every page.

CRF completion

Units are provided for all measurements. Data should be entered in the units provided. If necessary please convert values to the unit specified.

Dates must be entered in the format DD MM YYYY using a leading zero if necessary.

Any errors should be corrected with a single strike through without obliterating the original entry. Any corrections should be initialled and dated.

Please check the calibration of all instruments prior to start

Stadiometer: Check recorded height of standard 1 metre rule once the instrument is set up and record the result.

Scales: The zero setting on the scales should be checked by pressing the reset button with the scales empty. This should read 0.00.

Taking measurements

Height: Participants should be asked to stand on the stadiometer. Please check:

- *Feet:* Ankles should be together and resting on the bar at the back. Ensure the participant doesn't stand on tiptoe.
- *Arms:* Should be resting at sides.
- *Head:* Should face straight ahead.

Weight: Participants should stand as reasonable straight if possible.

Blood Pressure: Subject should sit at the measurement table and rest their arm on the table. The cuff should be placed around the upper arm with the bladder centre over the artery. Ensure that the upper arm is at chest level.

Blood sampling

- Prepare label for vaccutainer
- Wash hands between patients and wear rubber gloves.
- Ensure patient is sitting comfortably and check for previous problems with blood sampling.
- Clean the area with an alcohol wipe if obviously unclean. Allow skin to dry.
- After venepuncture raise subjects arm and ask patient to apply cotton wool to avoid bruising
- Dispose of needle in sharps box.

Any second attempt must be in the opposite arm.

REFER STUDY: Nurse CRF: PATIENT DETAILS 1

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Consent form Date consented _ _ / _ _ / _ _ _ _

Please tick to confirm:	*Yes*	*No*
• Consent form completed and signed	☐	☐
• One copy given to patient	☐	☐
• One copy filed in medical notes	☐	☐
• One copy kept for research file	☐	☐

Date of birth ☐☐ ☐☐ ☐☐☐☐

DD MM YY

Gender ☐ Male ☐ Female

Post Code …….. ……..

REFER STUDY: Nurse CRF: PATIENT DETAILS 1

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Marital status

Single	☐	Divorced	☐
Married	☐	Separated	☐
Cohabiting	☐	Widowed	☐

Your occupation (if retired – occupation before retirement)

……

If married or cohabiting, partners occupation

……

Your ethnic origin

White British ☐
White Irish ☐
White - Other Background ☐

Mixed – White & Black Caribbean ☐
Mixed – White & Black African ☐
Mixed – White & Asian ☐

Asian / Asian British – Indian ☐
Asian / Asian British - Bangladeshi ☐
Asian / Asian British – Other background ☐
Black / Black British - Caribbean ☐
Black / Black British - African ☐
Black / Black British – Other background ☐
Other – Chinese ☐

Other – Any other ethnic group ☐ Please specify:…….

REFER STUDY: Nurse CRF: CLINICAL HISTORY 1

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Clinical History

Previous MI	☐	Angina	☐
Arrhythmias (specify type below)	☐	Heart Failure	☐
Cardiac Devices (PPM / ICD)	☐	Revascularisation (CABG/PTCA)	☐
High cholesterol	☐	Hypertension	☐
H/O of rheum/scarlet fever	☐	Valve Surgery	☐
Diabetes	☐	Peripheral artery disease	☐
Stroke	☐	TIA	☐
COPD	☐	Stomach ulcer	☐
Arthritis	☐	Depression	☐
Other	☐	Kidney Problems	☐

Shortness of Breath
Other *please specify:*
……

Do you have a family history of :	**Yes**	**No**	**Don't know**
Heart attack (<65 years of age)	☐	☐	☐
High blood pressure (<65 years of age)	☐	☐	☐
Diabetes	☐	☐	☐

Do you get short of breath when you walk? ☐ ☐

If yes, how far can you manage when walking on level ground at your own pace: …….. yards

For how long can you keep walking: …..… mins

If no, is there any other reason that you have to stop walking?

……

REFER STUDY: Nurse CRF: CLINICAL HISTORY 2

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

	Yes	No
Do you get shortness of breath?	☐	☐
a) walking up hill	☐	☐
b) climbing upstairs	☐	☐
c) walking on the level with someone of you own age	☐	☐
d) during heavy housework (lifting/moving heavy furniture)	☐	☐
e) during moderate housework (vacuuming, sweeping)	☐	☐
f) during leisure activities	☐	☐

If yes, please specify activity: ……..

g) during light housework (dusting, washing dishes)	☐	☐
h) while washing or dressing	☐	☐
i) sitting at rest	☐	☐
j) lying down in bed	☐	☐
k) Do you wake during the night with shortness of breath	☐	☐

If yes, how many pillows do you sleep on? ……

How long have you had these symptoms ……. months …….. years

Are your symptoms? Improving ☐ stable ☐ getting worse ☐

Do you get tired easily yes ☐ no ☐

Do your ankles/feet swell yes ☐ no ☐

Do you get chest pain yes ☐ no ☐

REFER STUDY: Nurse CRF: CLINICAL HISTORY 3

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Do you have a cough in the daytime	yes	☐	no	☐
Do you have a cough at night	yes	☐	no	☐
Do you get wheezy	yes	☐	no	☐
Do you cough up phlegm	yes	☐	no	☐

Which one is your main symptom that brought you to this consultation?

Shortness of breath	☐
Tiredness	☐
Ankle swelling	☐
Chest pain	☐
Cough	☐
None	☐

What diagnosis were you given?

None	☐
Heart trouble	☐
Heart failure	☐
Angina	☐
Bronchitis/asthma	☐
Other	☐

If other please specify: ……

REFER STUDY: Nurse CRF: TREATMENT 1

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Are you under the care of a Consultant Cardiologist? **Yes** ☐ **No** ☐

Name:……

Hospital:……

Date (approximately) referred: _ _ / _ _ / _ _ _ _

Number of previous hospitalisations with Cardiac Events ☐☐

Details with dates:

1)…… .Date: ……

2)…… .Date: ……

3)…… .Date: ……

4)…… .Date: ……

5)…… .Date: ……

Has your GP recently (e.g since the consultation when this study was discussed) referred you for a chest x-ray? **Yes** ☐ **No** ☐

Before this consultation with your GP: -

Have you ever had?	**Yes**	**No**
An electrical recording of your heart (ECG)	☐	☐
A chest X-ray because of ill health	☐	☐

If yes, was it normal ☐ abnormal ☐ don't know ☐

	Yes	**No**
An ultrasound recording of your heart (echo)	☐	☐

Do you have a Cardiac device?

No cardiac device ☐ Standard pacemaker ☐ ICD (defibrillator) ☐

REFER STUDY: Nurse CRF: TREATMENT 2

PATIENT INITIALS ID NUMBER

Medication

	Name	Dose / Day
Diuretic		
Digoxin		
ACE Inhibitor		
Angiotensin Receptor Blocker		
Beta Blocker		
Oral Nitrate		
Calcium Antagonist		
Other Hypertensive		
Anti - arrhythmic Drug		
Lipid Lowering Drug		
Anti Platelet		
Anticoagulant		
Others		
Over The Counter		

REFER STUDY: Nurse CRF: LIFESTYLE 1

PATIENT INITIALS ☐☐ ID NUMBER ☐☐☐☐☐☐

Have you ever smoked yes ☐ no ☐

If you <u>have</u> smoked - Do you still smoke yes ☐ no ☐

<u>If NO</u>, how long ago did you give up smoking ……..... months ……..... years

For how many years did you smoke …….. years

How many did you smoke each day: cigarettes ☐ cigars ☐ Grams ☐
Tobacco

<u>If YES</u>, for how many years have you smoked ..... years

How much do you smoke each day cigarettes ☐ cigars ☐ Grams ☐
Tobacco

Do you drink alcohol yes ☐ no ☐

If <u>yes</u>, how much do you drink in an average week (number)

½ pints of beer ☐ glasses of wine ☐ measure of spirits ☐

REFER STUDY: Nurse CRF: PHYSICAL EXAM 1

PATIENT INITIALS ID NUMBER

Physical Examination

Pulmonary function FEV[1] l/min FVC l/min

Height . metres **Weight** kg

Waist Circumference cm **Hip Circ** cm

Blood pressure / mm Hg
systolic *diastolic*

After 5 mins or more mm Hg
systolic *diastolic*

Resting Pulse Beats per minute

Rhythm Regular Irregular

Peripheral oedema Present Absent

Lung Auscultation

Clear Creps

Basal Creps

Extensive

Wheeze

Reduced Air entry / dullness

Other

Please specify .....

REFER STUDY: Nurse CRF: QUESTIONNAIRE 1

PATIENT INITIALS ID NUMBER

Questionnaires

SF 12 Completed Yes ☐ No ☐

Reason if no: ……

EQ-5D questionnaire completed Yes ☐ No ☐

Reason if no: ……

Blood sampling

Consent for blood sampling obtained? Yes ☐ No ☐

Reason if no: ……

Blood sample obtained? Yes ☐ No ☐

Reason if no: ……