PERCUTANEOUS CORONARY INTERVENTION REPORT

Complete a Percutaneous Coronary Intervention Report for every coronary intervention procedure performed. If a patient undergoes coronary intervention on more than one occasion during a single stay, complete a separate form for each occasion, even if both procedures occurred on the same day.

ITEMS FOR WHICH INSTRUCTIONS HAVE BEEN REVISED FOR 2001

Procedural Information:

Heparin – Clarification on when to code this data item.

Major Events Following Angioplasty:

Stroke – Revised Definition

Lesion Specific Information

Angiojet and Intravascular Ultrasound – Clarification on coding these procedures.

Pre-Angioplasty Risk Factors:

CHF – New definition.
MVA – Revised definition.

Note: For purposes of reporting post procedural events and pre-operative risk factors, an angioplasty procedure begins when the guide wire is inserted into a vessel unless otherwise noted.

ITEM-BY ITEM INSTRUCTIONS

PFI NUMBER: The PFI Number is a Permanent Facility Identifier assigned by the Department of Health. Enter your facility's PFI Number as shown in Attachment A.

SEQUENCE NUMBER: If your facility assigns a sequence number to each case on a chronological flow sheet or similar log, enter the sequence number here. The sequence number is not required for the Percutaneous Coronary Intervention Reporting System, but the item has been included on the form in case your facility finds it useful in identifying and tracking cases.

SECTION I. PATIENT INFORMATION	
MEDICAL RECORD NUMBER	Enter the patient's medical record number.
SOCIAL SECURITY NUMBER	Enter the patient's social security number as shown in the medical record. If the medical record does not contain the patient's social security number, leave this item blank. Do not ask the patient for the social security number for the sole purpose of reporting it on this form.
AGE IN YEARS	Enter the patient's age at admission to the hospital. If the patient=s exact age cannot be determined, enter your best estimate.
DATE OF BIRTH	Enter the patient's exact date of birth, if known; otherwise, leave this item blank.
SEX	Check the appropriate box.
ETHNICITY	Check the appropriate box.
RACE	Check the appropriate box. For white Hispanics, check "White"; for black Hispanics, check "Black." "Other" refers to races other than white or black, such as Asian or American Indian.
RESIDENCE	Enter the county code of the patient's principal residence, as shown in Attachment B. If code 99 (*outside New York State*), print the name of the state or country in the space provided.
HOSPITAL ADMISSION DATE	Enter the date of admission for the current hospital stay.
SECTION II. PROCEDURAL INFORMATION	
HOSPITAL THAT PERFORMED DIAGNOSTIC CATH	If the angioplasty was preceded by a diagnostic catheterization, enter the name of the hospital in the space provided. If the catheterization was at a cardiac diagnostic center in New York State, enter its PFI Number from Attachment A; if done at a Veterans Administration hospital in New York State, enter "8888"; if done outside New York State, enter "9999". If there was no diagnostic catheterization, leave this item blank.
PRIMARY PHYSICIAN PERFORMING ANGIOPLASTY	Enter the name and license number of the primary physician who performed the angioplasty procedure.
DATE OF ANGIOPLASTY	Enter the date on which the angioplasty procedure was performed.
DIAGNOSTIC CATH DURING SAME CATH LAB VISIT	If a <u>full</u> diagnostic catheterization was performed during the same cath lab visit as the angioplasty procedure, check AYes≅; if not, check ANo≅.
OTHER PCI THIS ADMISSION	For patients who have had an additional PCI during this admission, check “Yes” and report the date of this other procedure. Otherwise, check “No”.
PCI PRIOR TO THIS ADMISSION AT THIS HOSPITAL	For patients who have had a PCI prior to this admission at this hospital, check “Yes” and report the date of this previous procedure. If only the month and year are known, use 01 for the day and write in the correct the month and year. If only the year is known, write in 01/01 for the month and day and the correct year.

SECTION II. PROCEDURAL INFORMATION (cont.)	
CARDIAC ENZYMES	Report results of pre and post procedural cardiac enzyme measures. CAC guidelines recommend one pre and two post procedural enzyme measures at intervals indicated on the form. Troponin may be used in place of CK-MB iso-enzyme. **NOTE: Pre-enzyme measures should be reported if drawn within 1 day prior to the procedure.**
PROCEDURAL RELATED RX	Check all that apply.
! Heparin	Check the box if Thrombin Inhibitors including unfractionated Heparin, fractionated Heparin (low molecular weight) or direct thrombin inhibitors were administered within 6 hrs. pre-procedure or anytime post-procedure. Do not report Heparin administered as a bolus just prior to the start of the procedure.
! IV NTG Within 24 Hours Proc	Check if IV Nitroglycerin was received at any time within 24 hours before procedure for ongoing myocardial ischemia or left ventricular failure, clinical evidence of which should be contained in the patient's record.
! IV GPIIBIIIA Platelet Inhibitors (i.e. ReoPro, Aggrastat, Integrelin)	Check the box if IV GPIIBIIIA Platelet Inhibitors were administered during or within 3 hours after the procedure.
! Oral GPIIBIIIA Platelet Inhibitors	Check the box if Oral GPIIBIIIA Platelet Inhibitors were administered prior to or after the procedure.
! Thrombolytics	Check the appropriate box to indicate if, and at what time interval, thrombolytics were administered. If thrombolytics were not administered because they were contra-indicated, check AContraindicated≅.

SECTION III. MAJOR EVENTS FOLLOWING PCI	
! Check all of the listed major events which occurred during or after the angioplasty. If none of the listed events occurred, check "None." (Check at least one box in this section.) Please Note; a documented pre-operative condition which persists post-operatively with no increase in severity is not a post-procedural event.	
0. NONE	
1. STROKE *(NEW NEUROLOGICAL DEFICIT)* 24 HOURS OR LESS	Permanent new focal neurological deficit occurring intra-operatively to 24 hours after the procedure.
1A. STROKE (NEW NEURO-LOGICAL DEFICIT) > 24 HOURS	Permanent new focal neurological deficit occurring 24 or more hours post-procedure.
7. ACUTE OCCLUSION AT SITE OF ANGIOPLASTY	Acute occlusion, complete or partial, resulting in reduction of flow through the dilated artery. Usually caused by thrombosis, intimal flap, or dissection. An occlusion which is reopened before the patient leaves the catheterization laboratory and stays open should not be reported even if the vessel is then reopened. However, an occlusion requiring the patient=s return to the laboratory should be reported even if the vessel is then reopened. Include any occlusion of the targeted or treated vessel, in any location within the vessel or within its proximal or distal branches (including the left artery).

SECTION III. MAJOR EVENTS FOLLOWING PCI (cont.)	
8. ARTERIAL OR VENOUS INJURY AT CATH ENTRY SITE, REQUIRING SURGERY	Any such injury, including those requiring femoral or brachial embolectomy, evacuation of a hematoma, repair of false aneurysm, or closure of arterial-venous fistula. Report occlusions which occur at other coronary arterial sites related to the angioplasty.
10. RENAL FAILURE, DIALYSIS	Contrast-induced nephropathy requiring dialysis. Do not check this item if Risk Factor 24 (*Renal Failure, Dialysis*) was checked.
14. EMERGENCY BYPASS SURGERY, HEMODYNAMICALLY UNSTABLE	The patient is taken to the operating room on an emergency basis in an unstable condition, with ongoing chest pain, ECG changes, and hypotension.
15. EMERGENCY BYPASS SURGERY, HEMODYNAMICALLY STABLE	The patient is taken to the operating room in a stable condition because of a complication of angioplasty.
17. STENT THROMBOSIS	Formation of a blood clot in the stented segment of the artery and/or adjacent area. This usually results in an acute occlusion, chest pain or development of an acute MI. Stent thrombosis usually occurs within 30 days following the procedure. ***! Note: Stent Thrombosis should be reported as a post procedural event even if it does not become apparent until after the patient is discharged from the hospital.***
SECTION IV. DISCHARGE INFORMATION	
DISCHARGE STATUS	If the patient was discharged from the hospital alive, indicate the discharge destination. If the patient died, check the appropriate box to indicate specifically where the death occurred.
HOSPITAL DISCHARGE DATE	Enter the date the patient was discharged from the hospital. If the patient died in the hospital, the hospital discharge date is the date of death.
SECTION V. PERI-PROCEDURAL MI INFORMATION	
! Report the timing of the following events if any or all of them lead to or occurred during the hospital admission. If the event occurred both prior to and after the PCI, check ABoth≅	
NO MI	The patient was not hospitalized for or experienced a MI during the PCI admission.
NEW ABNORMAL WALL MOTION	As determined by EKG, ECHO or Nuclear Medicine.
NEW Q WAVES	Defined as 0.03 seconds in width and/or > one third of the total QRS complex in two or more continuous leads.
NEW ST ELEVATION	>1 mm. in two or more continuous leads.
NEW ST9 OR T9	New ischemic changes on EKG appearing as ST depression, T-Wave inversion or both.
NEW LEFT BUNDLE BRANCH BLOCK	
TIMI # II	Evidence of total vessel occlusion or high-grade lesion with a TIMI flow of less than or equal to II.

SECTION V. PERI-PROCEDURAL MI INFORMATION (cont.)	
ISCHEMIC TYPE CHEST PAIN	Characteristic ischemic type chest pain > 20 minutes in duration and not relieved by Nitroglycerin.
TIME FROM ONSET OF CHEST PAIN TO HOSPITAL ADMISSION	Report in hours. Round to the nearest half hour. For example a patient report of 13 hr, would be reported a 1.5. A patient report of 2 hrs 10 mins would be reported as 2.0. Over 99 hours would be reported as 99.9. **Leave blank if not applicable or not reported.**
ONGOING ISCHEMIA AT TIME OF PROCEDURE	Check this box if the patient is experiencing chest pain and acute ST or T-Wave changes at the start of the PCI.
SECTION VI. PRE-INTERVENTION RISK FACTORS (answer all that apply)	
PRIORITY	Check the appropriate box.
! **Elective**	All cases not classified as urgent or emergency as defined below.
! **Urgent**	The patient is too ill or unstable to be discharged from the hospital, but is not classified as emergency as defined below.
! **Emergency**	Patients requiring emergency procedures will have ongoing, refractory, unrelenting cardiac compromise, with or without hemodynamic instability. Typical patients include those in arrest with CPR administered immediately prior to the procedure, shock, ongoing ischemia including rest angina or acute evolving MI or equivalent within 24 hours of procedure, or pulmonary edema requiring intubation.
HEIGHT	Enter the patient's height in centimeters.
WEIGHT	Enter the patient's weight in kilograms.
EJECTION FRACTION	Record the ejection fraction taken closest to the cardiac procedure. When a calculated measure is unavailable, the ejection fraction should be estimated visually from the ventriculogram or by echocardiography. If an ejection fraction is unavailable, check "Unknown". ***! Note: Intraoperative direct observation of the heart is not an adequate basis for a visual estimate of the ejection fraction.***
EJECTION FRACTION MEASURE	Check the appropriate box indicating the method used to measure the ejection fraction. The types listed are: 1. LV Angiogram 2. Echocardiography (*Transthoracic*) 3. Radionuclide Studies 4. TEE Including Intraoperative 8. Other 9. Unknown

SECTION VI. PRE-INTERVENTION RISK FACTORS (cont.)	
ANGINA: CCS FUNCTIONAL CLASS	Check the box corresponding to the patient's Canadian Cardiovascular Society Functional Class, as defined in Attachment C. ***! Note: The determination of functional class should be based on the typical level of exertion required to produce angina. For example, a single episode of anginal pain at rest does not qualify a patient as Class IV.***
ANGINA TYPE	Check the box indicating the patient=s angina type.
! Stable	Angina without a change in frequency or pattern for the 6 weeks prior to this procedure. Angina is controlled by rest and/or oral or transcutaneous medications.
! Unstable	Angina is increasing in frequency in the last 6 weeks, including new onset. Angina is produced by less effort or provocation and occurring in a crescendo pattern. Angina can be experienced at rest and pain may last for longer periods of time and be more difficult to relieve. Includes progressive, rest and variant.
VESSELS DISEASED	For each diseased vessel, check the appropriate box to indicate the percent diameter stenosis. Include all diseased vessels, even branches.
LESION-SPECIFIC INFORMATION	Complete one line for each lesion for which PCI was attempted, and one line for each non-attempted lesion with diameter stenosis of 50% or more--even if the lesion has been bypassed. If there are more than seven lesions, report the seven most significant.
! Location	Enter the code indicating the location of the lesion, as shown in Attachment D. Please note that Attachment D now includes location codes 51 through 72 for lesions located in grafts. For a lesion in a "sequential" graft going to two of the major coronary systems, complete a separate line for each coronary artery jeopardized (*LAD, LCX, RCA*). See examples in Attachment D.
! Bypassed (*A OR V*)	If the lesion has been bypassed by a vein graft, enter "V"; if bypassed by an artery graft, enter "A".
! Lesion Type	Enter code A, B, or C to describe the lesion type, as defined in Attachment E.
! % Pre-Op Stenosis	Enter the pre-angioplasty percent diameter reduction. Measurement with calipers is recommended.
! Previous PCI	Use the following codes to indicate if the lesion is restenotic following a previously successful PCI. 0 -- No Restenosis 1 -- Restenosis, No Previous Stent Placed in the Vessel 2 -- Restenosis, Stent Previously Placed in Vessel

SECTION VI. PRE-INTERVENTION RISK FACTORS (cont.)	
LESION-SPECIFIC INFORMATION (cont.)	
! Primary and Secondary Device	For the purposes of this report, any attempt to cross a lesion with a guide wire constitutes attempted angioplasty. Using the procedural code list (Attachment F), indicate the primary device used. If the lesion was not attempted, place a AO≅ under primary device. If a secondary device was used, indicate the device used in the appropriate box. (Secondary Device is not a required field and you do not have to place a code in the box.) The attending physician is responsible for determining the primary and secondary devices. Angiojet procedures are coded as procedure 9 "Other". Intravascular ultrasound performed as a diagnostic procedure is not coded as a PCI.
! Stent	If a stent was placed in the vessel, write a A1" in the box; if no stent was placed, write a A0" in the box.
! Radiation	Check if any radiation was placed in the vessel regardless of the source (i.e. pre-radiated stent, radiation of the lesion by different technique).
! % Post-Op Stenosis	If PCI was attempted on this lesion, enter the percent diameter reduction immediately following angioplasty. Measurement with calipers is recommended. If PCI was not attempted, leave post-op stenosis blank.
NONE OF THE PRE-INTERVENTION RISK FACTORS LISTED BELOW WERE PRESENT	If none of the risk factors 1 through 34 were present, check this box.
PREVIOUS PCI's	If the patient had one or more previous PCI's, check the appropriate box to indicate the number of previous PCI's. Include any procedures during the current stay.
PREVIOUS MI (*MOST RECENT*)	If the patient had one or more myocardial infarctions before the angioplasty procedure, report the length of time since the most recent MI. If less than 24 hours, check box 4, 5 or 6. If 24 hours or more, enter the number of days in the space provided. If 21 days or more, enter "21".

SECTION VI. PRE-INTERVENTION RISK FACTORS (cont.)	
PERIPHERAL VASCULAR DISEASE	
8. Stroke	A history of stroke, with or without residual deficit.
9. Carotid/Cerebrovascular	Angiographic or ultrasound demonstration of at least 50% narrowing in a major cerebral or carotid artery (common or internal only), history of non-embolic stroke, or previous surgery for such disease. A history of bruits or transient ischemic attacks is not sufficient evidence of carotid/cerebrovascular disease.
10. Aortoiliac	Angiographic demonstration of at least 50% narrowing in a major aortoiliac vessel, previous surgery for such disease, absent femoral pulses, or inability to insert a catheter or intra-aortic balloon due to iliac aneurysm or obstruction of the aortoiliac arteries. ***! Note: Tortuosity of the vessel alone does not constitute aortoiliac disease. Abdominal Aortic Aneurysm (AAA), history of aorto-bifemoral bypass, or absence of a femoral pulse on either the right or left do constitute aortoiliac disease.***
11. Femoral/Popliteal	Angiographic demonstration of at least 50% narrowing in a major femoral/popliteal vessel, previous surgery for such disease, absent pedal pulses, or inability to insert a catheter or intra-aortic balloon due to obstruction in the femoral arteries. ***! Note: Both dorsalis pedis (DP) and posterior tibial (PT) need to be absent in one foot to code; a negative popliteal pulse alone does not constitute femoral/popliteal disease; medications for peripheral vascular disease without indication of femoral/popliteal disease do not support coding.***
HEMODYNAMIC INSTABILITY AT TIME OF PROCEDURE	**! Determined just prior to commencement of the angioplasty procedure. Changes in condition after that point do not support coding of shock or unstable. These patients usually have hypotension and low cardiac output.** ***Clinical evidence of hypotension or low cardiac output and evidence that support was given must be contained in the patient's record.***
12. Unstable	The patient requires pharmacologic or mechanical support to maintain blood pressure or output. ***! Note: The following conditions alone do not constitute hemodynamic instability: IV Nitroglycerin, IV Heparin, IABP inserted for pain control, inability to place IABP because of tortuous and diseased vessels.***
13. Shock	Acute hypotension (*systolic blood pressure < 80 mmHg*) or low cardiac index (*<2.0 liters/min/m^2*), despite pharmacologic or mechanical support.
33. CPR	The patient requires cardiopulmonary resuscitation within one hour of the procedure.
14. MORE THAN ONE PREVIOUS MI	Clinical or ECG evidence of more than one previous myocardial infarction.
15. HYPERTENSION HISTORY	Blood pressure greater than 140/90, history of hypertension, or current treatment for hypertension.

SECTION VI. PRE-INTERVENTION RISK FACTORS (cont.)	
17. ECG EVIDENCE OF LEFT VENTRICULAR HYPERTROPHY	Pre-angioplasty electrocardiogram shows evidence of Left Ventricular Hypertrophy. A diagnosis by echocardiogram is permitted only for documented case of left bundle branch block and/or pacing. Minimal voltage criteria is not sufficient documentation to code LVH.
18. CONGESTIVE HEART FAILURE, CURRENT	Within 2 weeks prior to the procedure, a physician has diagnosed CHF by one of the following: • Paroxysmal nocturnal dyspnea (PND) • Dyspnea on exertion (DOE) due to heart failure, or • Chest X-Ray showing pulmonary congestion. ***! Note: Pedal edema or dyspnea alone are not diagnostic. Patient should also have received diuretics, digoxin, or vasodilator therapy such as ace inhibitors***.
19. CONGESTIVE HEART FAILURE, PAST	Between 2 weeks to 6 months prior to the procedure, a physician has diagnosed CHF by one of the following: • Paroxysmal nocturnal dyspnea (PND) • Dyspnea on exertion (DOE) due to heart failure, or • Chest X-Ray showing pulmonary congestion. ***! Note: Pedal edema or dyspnea alone are not diagnostic. Patient should also have received diuretics, digoxin, or vasodilator therapy such as ace inhibitors***.
20. MALIGNANT VENTRICULAR ARRHYTHMIA	Recent (*within the past 7 days*) recurrent ventricular tachycardia or ventricular fibrillation requiring electrical defibrillation or the use of intravenous antiarrhythmic agents. Excludes a single episode of VT or VF occurring within 6 hours of a diagnosis of a myocardial infarction and responding well to treatment.
21. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	∩ Patients who require chronic (*longer than three months*) bronchodilator therapy to avoid disability from obstructive airway disease, *or* ∩ Have a forced expiratory volume in one second of less than 75% of the predicted value or less than 1.25 liters, *or* ∩ Have a room air $pO_2 < 60$ or a $pCO_2 > 50$. ***! Note: COPD should not be checked unless the patient's record contains documented evidence of the above criteria, regardless of how much the patient may have smoked.***
22. DIABETES REQUIRING MEDICATION	The patient is receiving either oral hypoglycemics or insulin.
23. RENAL FAILURE, CREATININE > 2.5 mg/dl	Pre-angioplasty creatinine greater than 2.5 mg/dl.
24. RENAL FAILURE, DIALYSIS	The patient is on chronic peritoneal or hemodialysis.
25. IMMUNE SYSTEM DEFICIENCY	Chronic use, continuing until the angioplasty procedure, of steroids, anti-neoplastic therapy, cyclosporine, or other immunosuppressive therapy; or presence of AIDS.
26. IABP REQUIRED AT START OF PROCEDURE	The patient arrives in the cath lab with an intra-aortic balloon pump in place, or requires its insertion before commencement of the angioplasty procedure, for ongoing myocardial ischemia, left ventricular failure, or shock, clinical evidence of which should be contained in the patient's record. Excludes IABP necessitated by a complication of angioplasty.

SECTION VI. PRE-INTERVENTION RISK FACTORS (cont.)	
27. C-P BYPASS REQUIRED AT START OF PROCEDURE	The patient requires cardiopulmonary bypass at the commencement of the angioplasty procedure. Excludes C-P bypass necessitated by a complication of angioplasty.
28. PREVIOUS OPEN HEART SURGERY	Previous open heart surgery, either coronary or valvular.
30. SMOKING HISTORY, IN PAST 2 WEEKS	The patient has smoked any tobacco products, or used chewing tobacco, within the past two weeks.
31. SMOKING HISTORY, IN PAST YEAR	The patient has smoked any tobacco products, or used chewing tobacco, within the past year. It is unnecessary to check this item if 30 was checked.
32. EMERGENCY PCI DUE TO DX CATH COMPLICATION	Catheterization related dissection or obstruction of coronary artery during diagnostic catheterization, requiring immediate, unplanned angioplasty to treat closure or threatened closure of vessel.
34. STENT THROMBOSIS	Formation of a blood clot in the stented segment of the artery and /or adjacent area. This usually results in an acute occlusion, chest pain or development of an acute MI. Stent thrombosis usually occurs within 30 days following the procedure.
SECTION VII. PERSON COMPLETING REPORT	
! Enter the name of the person completing the report.	

PERCUTANEOUS CORONARY INTERVENTION REPORT – 2001

PFI NUMBERS FOR CARDIAC DIAGNOSTIC AND SURGICAL CENTERS

ATTACHMENT A

PFI #	HOSPITAL
0 0 0 1	Albany Medical Center Hospital
0 1 1 6	Arnot-Ogden Medical Center
1 4 3 8	Bellevue Hospital Center
1 4 3 9	Beth Israel Medical Center/Petrie Campus
1 1 6 4	Bronx-Lebanon Hospital Center, Fulton Division
1 2 8 6	Brookdale Hospital Medical Center
1 2 8 8	The Brooklyn Hospital Center, Downtown Campus
0 2 0 7	Buffalo General Hospital
3 0 1 3	Catholic Medical Center of Brooklyn & Queens Mary Immaculate Hospital
1 6 3 4	Catholic Medical Center of Brooklyn & Queens @ St. John's Queens Hospital
0 9 7 7	Cayuga Medical Center at Ithaca
0 1 3 5	Champlain Valley Physicians Hospital Medical Center
0 2 0 8	Children's Hospital - Buffalo
1 6 2 6	City Hospital Center at Elmhurst
1 2 9 4	Coney Island Hospital
0 6 3 6	Crouse-Irving Memorial Hospital
0 8 2 9	Ellis Hospital
0 2 1 0	Erie County Medical Center
0 4 0 7	Genesee Hospital - Rochester
1 0 0 5	Glens Falls Hospital
0 7 7 9	Good Samaritan Hospital of Suffern
0 9 2 5	Good Samaritan Hospital Medical Center- West Islip
1 4 4 5	Harlem Hospital Center
0 9 1 3	Huntington Hospital

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PFI #	HOSPITAL
1300	Interfaith Medical Center, Jewish Hosp. Med. Ctr. of Brooklyn Division
1629	Jamaica Hospital
1450	Lenox Hill Hospital
1302	Long Island College Hospital
1630	Long Island Jewish Medical Center
1304	Lutheran Medical Center
1305	Maimonides Medical Center
0746	Mary Imogene Bassett Hospital
0213	Mercy Hospital - Buffalo
1306	Methodist Hospital of Brooklyn
0215	Millard Fillmore Hospital
3058	Montefiore Med. Ctr., Jack D. Weiler Hosp. of A.Einstein College Division
1169	Montefiore Medical Center, Henry & Lucy Moses Division
1456	Mount Sinai Hospital
0528	Nassau County Medical Center
1458	New York Hospital
1637	The New York Hospital Medical Center of Queens (Formerly Booth Memorial)
1306	The New York Methodist Hospital (Formerly Methodist Hospital of Brooklyn)
1463	NYU Medical Center
0541	North Shore University Hospital
0066	Olean General Hospital - Main
0471	Park Ridge Hospital
1464	Presbyterian Hospital in the City of New York
0411	Rochester General Hospital
0367	Samaritan Medical Center

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ATTACHMENT A

PFI #	HOSPITAL *Cont.*
0818	Saratoga Hospital
1473	Sister's of Charity Medical Center @ Bayley Seton Campus
1072	Sound Shore Medical Center of Westchester
0527	South Nassau Communities Hospital
0924	Southside Hospital
1176	St. Barnabas Hospital
0598	St. Elizabeth Hospital
0563	St. Francis Hospital - Roslyn
0870	St. James Mercy Hospital
0943	St. John's Episcopal Hospital, Smithtown (St. Catherine of Siena Medical Center)
0630	St. Joseph's Hospital Health Center - Syracuse
0599	St. Luke's Memorial Hospital Center - New Hartford (Faxton)
1466	St. Luke's Roosevelt Hospital Center, Roosevelt Hospital Division
1469	St. Luke's Roosevelt Hospital, St. Luke's Hospital Division
0005	St. Peter's Hospital
0412	St. Mary's Hospital – Rochester (Park Ridge Hosp Genesse St Campus)
1471	St. Vincent's Hospital and Medical Center of New York
1738	St. Vincent's Medical Center of Richmond (Sister's of Charity @ St. Vincent's)
1740	Staten Island University Hospital - North
0413	Strong Memorial Hospital
0058	United Health Services Wilson Hospital Division
0245	University Hospital - Stony Brook
1320	University Hospital of Brooklyn
0635	State University Hospital Upstate Medical Center
0181	Vassar Brothers Hospital
1139	Westchester County Medical Center, Westchester Co. Med. Ctr. Division

ATTACHMENT A

PFI #	HOSPITAL *Cont*
0 5 1 1	Winthrop-University Hospital
0 1 0 3	Woman's Christian Association
8888 Catheterization Laboratory at a Veterans Administration Hospital in New York State (*for use only in this reporting system; not an official Permanent Facility Identifier*)	
9999 Catheterization Laboratory Outside New York State (*for use only in this reporting system; not an official Permanent Facility Identifier*)	

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ATTACHMENT B

Residence Codes

The county codes shown below are also used in the SPARCS Discharge Data Abstract:

01 Albany
02 Allegany
03 Broome
04 Cattaraugus
05 Cayuga
06 Chautauqua
07 Chemung
08 Chenango
09 Clinton
10 Columbia
11 Cortland
12 Delaware
13 Dutchess
14 Erie
15 Essex
16 Franklin
17 Fulton
18 Genesee
19 Greene
20 Hamilton
21 Herkimer
22 Jefferson
23 Lewis
24 Livingston
25 Madison
26 Monroe
27 Montgomery
28 Nassau
29 Niagara
30 Oneida
31 Onondaga
32 Ontario
33 Orange
34 Orleans
35 Oswego
36 Otsego
37 Putnam
38 Rensselaer
39 Rockland
40 St. Lawrence
41 Saratoga
42 Schenectady
43 Schoharie
44 Schuyler
45 Seneca
46 Steuben
47 Suffolk
48 Sullivan
49 Tioga
50 Tompkins
51 Ulster
52 Warren
53 Washington
54 Wayne
55 Westchester
56 Wyoming
57 Yates
58 Bronx
59 Kings
60 Manhattan
61 Queens
62 Richmond

88 Unknown

99 Outside NYS

ATTACHMENT C

Definitions Of CCS Functional Classes

Canadian Cardiovascular Society (CCS) Functional Classification

Class I Ordinary physical activity, such as walking or climbing stairs, does not cause angina. Angina may occur with strenuous or rapid or prolonged exertion at work or recreation.

Class II There is slight limitation of ordinary activity. Angina may occur with walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals or in the cold, in the wind, or under emotional stress, or walking more than two blocks on the level, or climbing more than one flight of stairs under normal conditions at a normal pace.

Class III There is marked limitation of ordinary physical activity. Angina may occur after walking one or two blocks on the level or climbing one flight of stairs under normal conditions at a normal pace.

Class IV There is inability to carry on any physical activity without discomfort; angina may be present at rest.