

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
HABCID	ACROSTIC	Month / Day / Year XxDATE	

LOCAL ADJUDICATION REPORT

1 Health ABC Event Form reference #: **XxEVREF**

2 Admission date: / / **XxADMDT**
Month Day Year

3 Discharge date: / / **XxDISDT**
Month Day Year

X is dataset dependent as follows:

- Hospitalization dataset: X=H**
- Hospitalization details dataset: (retains original WF prefix)**
- BPH dataset: X=B**
- Cancer dataset: X=C**
- Cardiovascular dataset: X=V**
- Carotid artery disease dataset: X=A**
- Death dataset: (retains original WF prefix)**
- Diabetis mellitus dataset: X=D**
- Fracture dataset: X=F**
- Gastrointestinal dataset: X=G**
- Osteoarthritis dataset: X=J**
- Peripheral arterial dataset: X=P**
- Psych dataset: X=S**
- Pulmonary dataset: X=L**
- Stroke/TIA dataset: X=T**
- Other diagnosis dataset: X=O**

x denotes the xth event of that type

4

Conditions/Diagnoses Present at this Hospitalization	Current Event?			Primary Reason for Hospitalization? <i>(Mark only one.)</i>	Go to Page #	
	Yes	No	Possible			
a. Myocardial infarction	WFDX01	①	①	②	①	Refer to CVD Adjudication Report
b. Angina pectoris, coronary insufficiency, or other ischemic heart disease	WFDX02	①	①	②	②	Refer to CVD Adjudication Report
c. Congestive heart failure or congestive cardiomyopathy	WFDX03	①	①	②	③	Refer to CVD Adjudication Report
d. Carotid artery disease	WFDX04	①	①	②	④	4
e. Peripheral arterial disease (aorta, iliac arteries, or below)	WFDX05	①	①	②	⑤	4
f. Stroke (CVA)	WFDX06	①	①	②	⑥	5
g. Transient ischemic attack	WFDX07	①	①	②	⑦	5
h. COPD/Emphysema/ Chronic bronchitis/Asthma	WFDX08	①	①	②	⑧	6
i. Pneumonia	WFDX09	①	①	②	⑨	6
j. Upper GI disease	WFDX10	①	①	②	10	WFDXPRM
k. Lower GI bleed	WFDX11	①	①	②	11	
l. Abdominal hernia	WFDX12	①	①	②	12	
m. Benign prostatic hyperplasia	WFDX13	①	①	②	13	
n. Diabetes mellitus	WFDX14	①	①	②	14	
o. Gallbladder disease	WFDX15	①	①	②	15	9
p. Cancer	WFDX16	①	①	②	16	Refer to Cancer Adjudication Report
q. Depression	WFDX17	①	①	②	17	---
r. Dementia	WFDX18	①	①	②	18	10
s. Osteoarthritis - Joint surgery for osteoarthritis	WFDX19	①	①	②	19	10
t. Fracture	WFDX20	①	①	②	20	Refer to Fracture Adjudication Report
u. <i>Other diagnoses</i>						
1. Diagnosis <i>(Please specify)</i>	Other diagnosis code:	WFDX21				
WFDXD21	WFDXCD21	①	①	②	21	
2. Diagnosis <i>(Please specify)</i>	Other diagnosis code:	WFDX22				
WFDXD22	WFDXCD22	①	①	②	22	
3. Diagnosis <i>(Please specify)</i>	Other diagnosis code:	WFDX23				
WFDXD23	WFDXCD23	①	①	②	23	

Draft



5 Documents attached (*Please mark all that apply*):

- ① Face sheet or physician attestation with ICD codes
- ① Discharge summary
- ① History and physical exam
- ① ECG
- ① Cardiac enzymes
- ① Cardiac catheterization
- ① Stress test
- ① Echocardiography
- ① Carotid dopplers
- ① Carotid angiogram
- ① Lower extremity doppler
- ① Lower extremity angiography
- ① Exercise test
- ① CT head
- ① MRI brain
- ① Neurology consult
- ① Chest x-ray report
- ① Arterial blood gases report
- ① Pulmonary function test results
- ① Microbiology report of blood culture, sputum culture, transtracheal aspirate, bronchial brushing, or biopsy
- ① Endoscopy report
- ① Upper GI report
- ① Angiography report
- ① Barium enema/lower GI report
- ① Radiology report
- ① Pathology report
- ① Other (*Please specify*):



6 CAROTID ARTERY DISEASE

Criteria *(Must include at least one of the following. Please mark all that apply):*

- AxCAD1** ① Symptomatic disease with carotid artery disease listed on the hospital discharge summary
- AxCAD2** ① Symptomatic disease with abnormal findings (> 50% stenosis) on carotid angiogram or doppler flow
- AxCAD3** ① Vascular or surgical procedure to improve flow to the ipsilateral brain

7 PERIPHERAL ARTERIAL DISEASE (AORTA, ILIAC ARTERIES, OR BELOW)

Diagnosis: *(Please mark the one category that applies best):*

- ① Lower extremity claudication
- ② Atherosclerosis of arteries of the lower extremities
- ③ Arterial embolism and/or thrombosis for the lower extremities
- PxPADDX** ④ Abdominal aortic aneurysm (AAA)
- ⑤ Thoracic aortic aneurysm/dissection
- ⑥ Atherosclerotic bowel infarction

Criteria *(Must include at least one of the following. Please mark all that apply):*

- PxPAD1** ① Ultrasonographically- or angiographically-demonstrated obstruction, or ulcerated plaque ($\geq 50\%$ of the diameter or $\geq 75\%$ of the cross-sectional area) demonstrated on ultrasound or angiogram of the iliac arteries or below
- PxPAD2** ① Absence of pulse by doppler in any major vessel of lower extremities
- PxPAD3** ① Exercise test that is positive for lower extremity claudication
- PxPAD4** ① Surgery, angioplasty, or thrombolysis for peripheral arterial disease
- PxPAD5** ① Amputation of one or more toes or part of the lower extremity because of ischemia or gangrene
- PxPAD6** ① Exertional leg pain relieved by rest and at least one of the following:
(1) claudication diagnosed by physician, or (2) ankle-arm systolic blood pressure ratio ≤ 0.8
- PxPAD7** ① Ultrasound, angiography, or CT-demonstrated diagnosis, other than lower extremities
- PxPAD8** ① Surgical or vascular procedure, other than lower extremities

8 STROKE (CVA)

Stroke Subtype:

- | | | |
|---|---------------------------------------|--|
| <input type="radio"/> Hemorrhagic | <input type="radio"/> Ischemic | <input checked="" type="radio"/> Unknown type TxCVA |
| <input checked="" type="radio"/> Subarachnoid | <input type="radio"/> Lacunae | |
| <input checked="" type="radio"/> Intracerebral | <input type="radio"/> Embolic | TxCVISC |
| <input checked="" type="radio"/> Unknown | <input type="radio"/> Atherosclerotic | |
| <input checked="" type="radio"/> Not applicable | <input type="radio"/> Unknown | |

TxCVHEM

TxCVISC

Criteria (Must include all of the following. Please mark all that apply):

- TxCVA1** Rapid onset of neurologic deficit attributed to obstruction or rupture of arterial system
- TxCVA2** Deficit lasting greater than 24 hours (unless death intervenes)
- TxCVA3** No evidence of cause due to tumor, trauma, infection, or other non-ischemic cause
- TxCVA4** New CT/MRI lesion consistent with clinical presentation

Was the stroke procedure related?

- Yes No Unknown **TxCVPRO**

9 TRANSIENT ISCHEMIC ATTACK

Criteria (Must include all of the following. Please mark all that apply.)

- TxTIA1** One or more episodes of focal neurologic deficit lasting 30 seconds to 24 hours
- TxTIA2** Maximal deficit in less than 5 minutes
- TxTIA3** Complete resolution
- TxTIA4** No head trauma before onset of event
- TxTIA5** No evidence of seizure



10 COPD/EMPHYSEMA/CHRONIC BRONCHITIS/ASTHMA

Diagnosis (Please mark all that apply):

- LxASTHM ① Asthma
- LxBRONC ① Chronic bronchitis
- LxCOPD ① COPD
- LxEMPHY ① Emphysema

Criteria (Please mark all that apply):

Symptoms of productive cough, dyspnea, or wheezing and one of the following:

(Please mark all that apply):

- LxCOPD1 ① Chest x-ray findings consistent with COPD
- LxCOPD2 ① Spirometry results consistent with COPD
- LxCOPD3 ① Arterial blood gases consistent with respiratory insufficiency
- LxCOPD4 ① Physical examination consistent with COPD
- LxCOPD5 ① Treatment with bronchodilators, corticosteroids, or oxygen

11 PNEUMONIA

Criteria (Must include at least one of the following. Please mark all that apply):

- LxPNEU1 ① Symptoms of cough, fever, or sputum production or findings of rales and/or dullness to percussion
- LxPNEU2 ① Chest X-ray showing new or progressive infiltrate, consolidation, cavitation, or pleural effusion

Organism identified:

- LxPNORG ① Yes ② No ③ Unknown

↓ Please specify:

LxPNORS

[Empty box for specifying organism]

[Empty box for page link]



12 UPPER GI DISEASE

Diagnosis classification (Please mark all that apply):

GxUGI1 ① Duodenal ulcer

GxUGI2 ① Gastric ulcer

GxUGI3 ① Ulcer, site unspecified

GxUGI4 ① Gastritis/gastric erosions/duodenal erosions

GxUGI5 ① Esophageal/gastric varices

GxUGI6 ① Other esophageal

GxUGI7 ① Neoplasia

GxUGIOT

GxUGI8 ① Other → Please specify:

[Empty text box for specifying other conditions]

GxUGI9 ① No source found

Did the condition result in clinically significant (≥ 3 point drop in hematocrit) bleeding?

GxUGBLD ① Yes ① No ⑨ Unknown

Criteria (Must include at least one of the following. Please mark all that apply):

GxUGCR1 ① Upper endoscopy diagnosis

GxUGCR2 ① Transfusion

GxUGCR3 ① Upper GI series diagnosis

GxUGCR4 ① Nasogastric tube

[Empty box for page link number]



13 LOWER GI BLEED

Diagnosis classification *(Please mark all that apply):*

GxLGI1 Diverticulosis/diverticulitis

GxLGI2 Angiodysplasia

GxLGI3 Neoplasia

GxLGI4 Colitis

Radiation **GxLGC01**

Ischemic **GxLGC02**

Infectious **GxLGC03**

Ulcerative **GxLGC04**

GxLGI5 Hemorrhoids

GxLGIOT

GxLGI6 Other → *Please specify:*

GxLGI7 No source found

Did the condition result in clinically significant (≥ 3 point drop in hematocrit) bleeding?

GxLGBLD Yes No Unknown

Criteria *(Must include at least one of the following. Please mark all that apply):*

GxLGCR1 Lower endoscopy diagnosis

GxLGCR2 Transfusion

GxLGCR3 Angiography diagnosis

GxLGCR4 Barium enema/lower GI series diagnosis

14 ABDOMINAL HERNIA

Diagnosis classification *(Please mark all that apply):*

- GxHERN1 ① Inguinal
- GxHERN2 ① Incisional
- GxHERN3 ① Umbilical

Criteria *(Must include at least one of the following. Please mark all that apply):*

- GxHRNC1 ① Noted on admission physical exam
- GxHRNC2 ① Hernia repair

15 BENIGN PROSTATIC HYPERPLASIA

Criteria *(Must include at least one of the following. Please mark all that apply):*

- BxBPH1 ① Current or prior history of symptoms of urinary obstruction
- BxBPH2 ① Digital exam evidence of prostate enlargement
- BxBPH3 ① Treatment with one of the following medications: Synarel, Lupron, Suprefact, Zoladex, DES, TACE, Megace, Androcur, Proscar

BxBPHDT

- BxBPH4 ① Surgical procedure (current event or history)

→

		/			/				
Month			Day			Year			

- BxBPH5 ① Urinary retention documented by IVP, ultrasound, catheterization

16 DIABETES MELLITUS

Diagnosis *(Please mark all that apply):*

- DxDIAB1 ① Hypoglycemia
- DxDIAB2 ① Hyperosmolar coma
- DxDIAB3 ① Diabetic ketoacidosis

17 GALLBLADDER DISEASE

Diagnosis classification *(Please mark all that apply):*

- GxGALL1 ① Gallstones (cholelithiasis)
- GxGALL2 ① Acute cholecystitis
- GxGALL3 ① Common bile duct stone (choledocholithiasis)

Criteria *(Must include at least one of the following. Please mark all that apply):*

- GxGALC1 ① Diagnosis made on ultrasound of gallbladder/common bile duct ERCP/CT scan/radionuclide scan
- GxGALC2 ① Cholecystectomy



18 DEMENTIA

Criteria *(Must include at least one of the following. Please mark all that apply):*

- SxDEM1** ① Chronic, progressive decline in cognitive function not explained by another acute and/or reversible disease process such as delirium, infection, new stroke, tumor, medication reaction, etc. (Terms synonymous with dementia may include senile dementia, senility, vascular dementia, multi-infarct dementia, or Alzheimer's disease, or other more specific type of dementia such as Parkinson's, Pick's disease, Creutzfeld-Jacob or Lewy Body dementia.)
- SxDEM2** ① In the presence of an acute and/or reversible disease process affecting cognitive function, a history of dementia before onset or after treatment/resolution of the other disease process.
- SxDEM3** ① Use of prescription medication specific to treatment of Alzheimer's disease, including Aricept (donepezil) and Cognex (tacrine).

19 OSTEOARTHRITIS - JOINT SURGERY FOR OSTEOARTHRITIS

Joint Involved *(Please mark all that apply.):*

- JxOAKNE** ① Knee → ① Right knee ② Left knee ③ Both right knee and left knee **JxOAKLR**
- JxOAHIP** ① Hip → ① Right hip ② Left hip ③ Both right hip and left hip **JxOAHLR**
- JxOAOTH** ① Other → *Please specify:*

JxOAOT1

Diagnoses for operated joint:

- JxOADX** ① Pre-operative X-ray evidence of OA or DJD: radiology report
- ② Pre-operative X-ray evidence of OA or DJD: no radiology report

Other diagnoses *(Please mark all that apply):*

- JxOADX1** ① Rheumatoid arthritis
- JxOADX2** ① Aseptic necrosis
- JxOADX3** ① Congenital hip disease

JxOADX4 ① Other *Please specify:*

JxOADXO



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H [] [] [] [] []	[] [] [] [] []	[] [] / [] [] / [] [] [] []	[] [] [] []
		Month Day Year	

DISCHARGE ABSTRACT FORM

1 Health ABC Event Form reference #: [] [] [] [] [] **EVREF**

2 Admission date: [] [] / [] [] / [] [] [] []
Month Day Year

3 Discharge date: [] [] / [] [] / [] [] [] []
Month Day Year

4 Vital status at discharge: Alive Deceased

5 Are any ICD-9 codes available?
 Yes No

Go to Question #6.

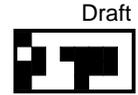
Go to Question #8.

6 ICD-9-CM Discharge Diagnosis Codes:

Record all ICD-9-CM diagnosis codes in the order they are listed on the hospital record face sheet.

1.	[] - [] [] [] . [] []	WEICDD01	11.	[] - [] [] [] . [] []	WEICDD11
2.	[] - [] [] [] . [] []	WEICDD02	12.	[] - [] [] [] . [] []	WEICDD12
3.	[] - [] [] [] . [] []	WEICDD03	13.	[] - [] [] [] . [] []	WEICDD13
4.	[] - [] [] [] . [] []	WEICDD04	14.	[] - [] [] [] . [] []	WEICDD14
5.	[] - [] [] [] . [] []	WEICDD05	15.	[] - [] [] [] . [] []	WEICDD15
6.	[] - [] [] [] . [] []	WEICDD06	16.	[] - [] [] [] . [] []	WEICDD16
7.	[] - [] [] [] . [] []	WEICDD07	17.	[] - [] [] [] . [] []	WEICDD17
8.	[] - [] [] [] . [] []	WEICDD08	18.	[] - [] [] [] . [] []	WEICDD18
9.	[] - [] [] [] . [] []	WEICDD09	19.	[] - [] [] [] . [] []	WEICDD19
10.	[] - [] [] [] . [] []	WEICDD10	20.	[] - [] [] [] . [] []	WEICDD20

For first diagnoses of myocardial infarction, angina and/or congestive heart failure, or for a fatal event which includes a diagnosis of myocardial infarction, angina and/or congestive heart failure (ICD-9-CM Codes 410, 411, 412, 413, 425.4, 428), complete the Cardiovascular Disease Adjudication Report. For fractures (ICD-9-CM Codes 800-804), complete the Fracture Adjudication Report. For new cancers (ICD9-CM Codes 140-208, 230-234), complete the Cancer Adjudication Report.



7 ICD-9-CM Procedure Codes:

Record all ICD-9-CM procedure codes in the order they are listed on the hospital face sheet.

1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	11.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	16.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	7.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	12.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	17.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	8.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	13.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	18.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	14.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	19.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	15.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	20.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

8 Did the participant stay in the Intensive Care Unit?

- Yes
 No
 Unknown

9 Comments:



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HABCID	ACROSTIC	Month / Day / Year	

CANCER ADJUDICATION REPORT

1 Health ABC Event Form reference #: **CxEVREF**

2 Date of diagnosis: / / **CxDXDT**
Month / Day / Year

3 Is a pathology/cytology report attached to this Cancer Adjudication Report?
 Yes No

Are other records attached to this Cancer Adjudication Report?
 Yes No

4 Primary cancer site (*Mark the one category that applies best.*):

CxCANCR

- | | | |
|--|---|--|
| <p>1 <input type="radio"/> Adrenal gland</p> <p>2 <input type="radio"/> Anus</p> <p>3 <input type="radio"/> Biliary tract, parts of (other unspecified)</p> <p>4 <input type="radio"/> Bladder</p> <p>5 <input type="radio"/> Bones, joints, articular cartilage</p> <p>6 <input type="radio"/> Brain</p> <p>7 <input type="radio"/> Breast</p> <p>8 <input type="radio"/> Cervix</p> <p>9 <input type="radio"/> Colon</p> <p>10 <input type="radio"/> Connective, subcutaneous, other soft tissue</p> <p>11 <input type="radio"/> Corpus uteri, endometrium</p> <p>12 <input type="radio"/> Endocrine glands, related structures</p> <p>13 <input type="radio"/> Esophagus</p> <p>14 <input type="radio"/> Eye and adnexa</p> <p>15 <input type="radio"/> Genital organs (other unspecified)</p> | <p>16 <input type="radio"/> Kidney</p> <p>17 <input type="radio"/> Larynx</p> <p>18 <input type="radio"/> Leukemia</p> <p>19 <input type="radio"/> Liver</p> <p>20 <input type="radio"/> Lung (bronchus)</p> <p>21 <input type="radio"/> Lymph nodes</p> <p>22 <input type="radio"/> Lymphoma, Hodgkin's disease</p> <p>23 <input type="radio"/> Lymphoma, non-Hodgkin's</p> <p>24 <input type="radio"/> Melanoma</p> <p>25 <input type="radio"/> Multiple myeloma</p> <p>26 <input type="radio"/> Oral (mouth, other unspecified)</p> <p>27 <input type="radio"/> Ovary</p> <p>28 <input type="radio"/> Palate</p> <p>29 <input type="radio"/> Pancreas</p> <p>30 <input type="radio"/> Parotid gland</p> | <p>31 <input type="radio"/> Peripheral nerves, ANS</p> <p>32 <input type="radio"/> Prostate</p> <p>33 <input type="radio"/> Rectosigmoid junction</p> <p>34 <input type="radio"/> Rectum</p> <p>35 <input type="radio"/> Respiratory system, thoracic organs (other unspecified)</p> <p>36 <input type="radio"/> Salivary glands, major</p> <p>37 <input type="radio"/> Stomach</p> <p>38 <input type="radio"/> Testis</p> <p>39 <input type="radio"/> Thyroid</p> <p>40 <input type="radio"/> Tongue</p> <p>41 <input type="radio"/> Urinary organs (other unspecified)</p> <p>42 <input type="radio"/> Uterus, not otherwise specified</p> <p>43 <input type="radio"/> Other <i>Please specify:</i></p> |
|--|---|--|

CxCANOT

44 Unknown

Draft



5 Is cancer confirmed?

Yes Uncertain No (see CxADJUD)

STOP.

6 Tissue or cell type (Mark the one category that applies best.):

- CxCELL
- 1 Adenocarcinoma
 - 2 Squamous cell or epidermoid carcinoma
 - 3 Sarcoma
 - 4 Transitional cell carcinoma
 - 5 Other → Please specify:
 - 9 Unknown

CxCELOT

7 Is there evidence of metastasis?

- 1 Yes
- 2 No
- 3 Possible
- 9 Not applicable

CxMETA

8 Criteria (Mark the one category that applies best.):

- CxCRIT
- 1 Written pathology report (including cytology or autopsy) confirming malignant neoplasia.
 - 2 Written report from radiologic or other non-invasive tests (CT, MRI, mammogram, ultrasound, etc.) consistent with malignancy.
 - 3 Other written reports by a physician, including clinic notes, progress notes, operative reports, and discharge summaries indicating that malignancy is present.
 - 4 Death certificate only as underlying cause.



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HABCID	ACROSTIC	Month Day Year	

CARDIOVASCULAR DISEASE ADJUDICATION REPORT

① Health ABC Event Form reference #: **VxEVREF**

② Admission Date: / / **VxADMDT**
 Month Day Year

③ Discharge Date: / / **VxDISDT**
 Month Day Year

Chest Pain or Anginal Equivalent

④ Was there an acute episode of pain, discomfort or tightness in the chest, arm or jaw, or shortness of breath?

① Yes ② No ③ Unknown

Go to Question #5.

a. Did the participant take or was s/he given nitrates or nitroglycerin for these symptoms?

① Yes ② No ③ Unknown

Were the symptoms relieved?

① Yes ② No ③ Unknown

b. Did any of the symptoms last for 20 minutes or longer?

① Yes ② No ③ Unknown



5 Did the participant have any of the following symptoms immediately prior to admission or during hospitalization?

Symptoms	Yes	No	Unknown
a. Night cough	①	①	②
b. Productive cough	①	①	②
c. Dyspnea at rest	①	①	②
d. Dyspnea on mild to moderate exertion (Walking on level)	①	①	②
e. Dyspnea on extreme exertion (Climbing)	①	①	②
f. Paroxysmal nocturnal dyspnea (PND)	①	①	②
g. Orthopnea	①	①	②
h. Dyspnea NOS/Shortness of breath	①	①	②

6 Did a physician report any of the following conditions?

Physical Exam	Yes	No	Unknown
Neck			
a. Neck vein distention/JVD	①	①	②
b. Carotid bruit	①	①	②
Lung			
c. Basilar rales or crackles only	①	①	②
d. Rales or crackles above bases	①	①	②
e. Wheezing	①	①	②
Cardiac			
f. S-3 Gallop	①	①	②
g. Cardiac murmur	①	①	②
Abdominal			
h. Hepatojugular reflux	①	①	②
i. Hepatomegaly	①	①	②
Extremities			
j. Peripheral/ankle edema	①	①	②



7 Was a chest x-ray done during this admission?

① Yes ② No ③ Unknown

Were any of the following findings reported to document a diagnosis of congestive heart failure?

	Yes	No	Unknown
a. Pulmonary venous congestion or pulmonary edema	①	②	③
b. Congestive heart failure	①	②	③
c. Pleural effusion	①	②	③
d. Cardiomegaly	①	②	③
e. Upper zone flow redistribution	①	②	③
f. Atelectasis	①	②	③
g. Chronic obstructive pulmonary disease	①	②	③
h. Pulmonary infiltrate/pneumonia	①	②	③

8 Were any of the following medications used to treat the participant?

	Yes	No	Unknown
a. ACE inhibitor	①	②	③
b. Angiotensin II receptor antagonists	①	②	③
c. Aspirin	①	②	③
d. Digitalis	①	②	③
e. Diuretics	①	②	③
f. Heparin	①	②	③
g. Nitroglycerine	①	②	③
h. Thrombolytics (TPA, Streptokinase)	①	②	③
i. Other (<i>Please specify</i>):			
_____	①	②	③
_____	①	②	③
_____	①	②	③



iii. Was LD-2 reported? *(Please refer to peak results. Mark only one response.)*

VxLD21 Yes

No

Go to Question d.

LD-1 ≥ LD-2

LD-1 < LD-2

VxLD22

d. Was Troponin reported?

VxTROP1 Yes

No

Go to Question #10.

i. Which Troponin was reported? *(Please refer to peak results. Mark only one response.)*

Troponin C

VxTROP2 Troponin I

Troponin T

ii. *(Please refer to peak results. Mark only one response.)*

Troponin at least 2x upper limit of normal

VxTROP3 Troponin > upper limit of normal but less than 2x upper limit of normal

Troponin within normal limits

10 Were electrocardiograms (ECGs or EKGs) recorded?

Yes

No

Unknown



11 MYOCARDIAL INFARCTION

Criteria *(Must include at least one of the following. Please mark all that apply):*

- Evolving diagnostic ECG pattern **VxECG1**
- Diagnostic ECG pattern and abnormal enzymes **VxECG2**
- Cardiac pain or ischemic symptoms and abnormal enzymes with either an evolving ST-T pattern or an equivocal ECG pattern **VxECG3**

Evidence of Q-wave?

- Yes
- No
- Unknown **VxQWAV**

Was the myocardial infarction procedure related?

- Yes
- No
- Unknown **VxMIPRC**

12 ANGINA PECTORIS, CORONARY INSUFFICIENCY, OR OTHER ISCHEMIC HEART DISEASE

Criteria *(Must include at least one of the following. Please mark all that apply):*

- VxANG1** Diagnosis of angina from a physician and treatment for angina (nitroglycerine, beta blocker or calcium channel blocker)
- VxANG2** CABG, PTCA or other coronary revascularization procedure and symptoms of chest pain, pressure, or an anginal equivalent
- VxANG3** Coronary angiography showing >70% obstruction of any coronary artery and symptoms of chest pain, pressure, or an anginal equivalent
- VxANG4** ST depression of more than 1 mm on exercise stress testing and symptoms of chest pain, pressure, or an anginal equivalent



13 CONGESTIVE HEART FAILURE OR CONGESTIVE CARDIOMYOPATHY

Criteria (**Must include at least one of the following. Please mark all that apply**):

- VxCHF1** ① Physician diagnosis of CHF and treatment including both a diuretic and digitalis or a vasodilator (eg. NTG, apresoline, ACE inhibitor)
- VxCHF2** ① Cardiomegaly and pulmonary edema on chest x-ray
- VxCHF3** ① Evidence of a dilated ventricle and global or segmental wall-motion abnormalities with decreased systolic function either by echocardiography or contrast ventriculography

VxCHFEJ

Ejection fraction (if noted in record): %

Source of result (**Please specify:** _____)

Subclassifications of CHF

a. Procedure related, within 72 hours (surgery, invasive radiologic -IVP, angiography, invasive medical - cardiac catheterization, colonoscopy)?

- ① Yes ② No **VxCHFPR**

b. Type of heart failure (based on echo, MUGA, cath, thallium, etc. from record)

- ① Systolic dysfunction (qualitative decrease in EF or wall motion)
- VxCHFTP** ② Diastolic dysfunction (preserved LV function with clinical CHF syndrome)
- ③ Both systolic and diastolic dysfunction
- ④ Unknown

c. Underlying causes of CHF (**The primary cause will be used in most analyses of CHF**):

- 1. Primary underlying cause? Cause Code #: **VxCHFC1** **VxCHFC6**
- 2. Other underlying causes? a. Cause Code #: **VxCHFC2** c. Cause Code #: **VxCHFC4** e. Cause Code #:
- b. Cause Code #: **VxCHFC3** d. Cause Code #: **VxCHFC5**

Cause codes

1. Coronary artery disease- MI, post-MI, ischemic cardiomyopathy
2. Valvular disease- aortic stenosis, mitral regurgitation, aortic insufficiency, mitral insufficiency, IHSS, VSD
3. Arrhythmia- includes atrial fibrillation, atrial flutter, heart block, SVT
4. Hypertensive- hypertensive CVD, LVH
5. Pulmonary disease- cor pulmonale, COPD, pulmonary hypertension, pneumonia, pulmonary embolism
6. Medication side effect/toxicity- Ca channel blocker, beta blocker, chemotherapy (adriamycin), alcohol, theophylline toxicity
7. Medication withdrawal- missed diuretics, non-compliance
8. Volume overload- excess IV fluids, transfusion, end-stage renal failure
9. Volume insufficiency- hemorrhage, GI bleed, shock
10. Other cardiomyopathy- Primary idiopathic, viral, metabolic, connective tissue disease, amyloidosis, hemochromatosis
11. Other cardiac- pericarditis, Dressler's syndrome, constrictive pericarditis, pericardial effusion, cardiac contusion
12. Other systemic- fever, sepsis



HABC Enrollment ID # HABCID	Acrostic ACROSTIC	Date Form Completed	Staff ID #
H [] [] [] [] []	[] [] [] [] []	[] [] / [] [] / [] [] [] []	[] [] [] []
		Month Day Year	

FRACTURE ADJUDICATION REPORT

① Health ABC Event Form reference #: [] [] [] [] [] **FxEVREF**

② Date of fracture: [] [] / [] [] / [] [] [] [] **FxFRXDT**
Month Day Year

③ Is a radiology report attached to this Fracture Adjudication Report?

① Yes ② No

Are other records attached to this Fracture Adjudication Report?
① Yes ② No

④ Fracture site (*Mark the one category that applies best. If multiple fractures, complete one Fracture Adjudication Report for each fracture.*):

<p>Elbow:</p> <p>1 <input type="radio"/> Lower end of humerus</p> <p>2 <input type="radio"/> Upper radius and/or ulna</p> <p>Foot (not toe):</p> <p>3 <input type="radio"/> One or more tarsal and/or metatarsal bones, heel and/or calcaneus</p> <p>Hand:</p> <p>4 <input type="radio"/> One or more metacarpal bone(s)</p> <p>Knee (patella):</p> <p>5 <input type="radio"/> Patella</p> <p>6 <input type="radio"/> Tibial plateau</p> <p>Lower arm or wrist:</p> <p>7 <input type="radio"/> Radius and/or ulna</p> <p>8 <input type="radio"/> One or more carpal bone (wrist)</p> <p>Lower leg or ankle:</p> <p>9 <input type="radio"/> Tibia and/or fibula</p> <p>10 <input type="radio"/> Ankle (very distal tibia/fibula and/or talus)</p> <p>Hip:</p> <p>11 <input type="radio"/> Neck of femur (transcervical, cervical)</p> <p>12 <input type="radio"/> Intertrochanteric fracture</p> <p>13 <input type="radio"/> Unspecified part of proximal femur</p>	<p>Pelvis:</p> <p>14 <input type="radio"/> Pelvis FxFRX</p> <p>Spine or back (vertebra):</p> <p>15 <input type="radio"/> Thoracic (dorsal) spine</p> <p>16 <input type="radio"/> Lumbar spine</p> <p>17 <input type="radio"/> Cervical spine</p> <p>Tailbone:</p> <p>18 <input type="radio"/> Sacrum and/or coccyx</p> <p>Upper arm (humerus), shoulder, or clavicle:</p> <p>19 <input type="radio"/> Humerus, upper end</p> <p>20 <input type="radio"/> Humerus, shaft or unspecified part</p> <p>21 <input type="radio"/> Clavicle</p> <p>22 <input type="radio"/> Scapula</p> <p>Upper leg (not hip):</p> <p>23 <input type="radio"/> Shaft of femur, including subtrochanteric region</p>
---	---



5 Side of fracture (**Mark only one answer.**):

- 1 Right
- 2 Left
- 3 Both sides
- 8 Not applicable (e.g., tailbone)
- 9 Unknown

FxFRXSD

6 Is fracture confirmed?

- Yes
 Uncertain
 No (**see FxADJUD**)

STOP.

7 Type of fracture (**Mark only one type.**):

- 1 Fragility (spontaneous or with modest trauma, such as a fall from a standing height)
- 2 Excessive traumatic (such as a motor vehicle accident or a high fall)
- 3 Pathologic (includes neoplasm, peri-prosthetic)
- 4 Stress (radiographic findings indicate stress fracture)
- 9 Unknown
- 5 Other → *Please specify:*

FxFRXTP

FxFRXOT

8 Criteria (**Mark the one category that applies best.**):

FxFRXCR

<p>1 Written radiology report states that a new, acute, or healing fracture of a bone is present.</p>
<p>2 Other written reports by a non-radiologist physician, including clinic notes, progress notes, ER notes, or operative reports, stating a new, acute, or healing fracture of a bone is present. Acceptable if based on a review of a radiograph (podiatrist reading is acceptable for foot fractures only).</p>
<p>3 The initial radiology report is uncertain or equivocal and subsequent report based on follow-up radiograph or bone scan is clearly diagnostic of a fracture or healing fracture.</p>
<p>4 Vertebral fracture documented in radiology report on AP or lateral thoracolumbar views.</p>
<p>5 Vertebral fracture documented in radiology report NOT based on AP or lateral thoracolumbar views.</p>



HABC Enrollment ID # H [] [] [] [] [] HABCID	Acrostic [] [] [] [] [] ACROSTIC	Date Form Completed [] [] / [] [] / [] [] [] [] Month / Day / Year	Staff ID # [] [] [] []
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REPORT OF DEATH

1 Health ABC Event Form reference #: [] [] [] [] [] **EVREF**

2 Date of reported death on Event Form: [] [] / [] [] / [] [] [] []
Month / Day / Year

3 Actual date of death on death certificate: [] [] / [] [] / [] [] [] [] **DOD**
Month / Day / Year

4 Where did the death occur as noted on death certificate?

- 1** Hospital (Inpatient) **2** Emergency Room **3** DOA **4** Nursing Home **5** Residence **6** Other

Please specify:

a. Is the Discharge Abstract Form attached to this Report of Death?

- 1** Yes **0** No

b. Is the Local Adjudication Form attached to this Report of Death?

- 1** Yes **0** No

5 Is a copy of the death certificate attached to this Report of Death form?

- 1** Yes **0** No

Was the death certificate certified by a coroner/medical examiner?

- 1** Yes **0** No

Attach coroner's/medical examiner's investigative report.

Please explain why not:

6 Was an autopsy performed?

- 1** Yes **0** No **9** Unknown **WDAUTOP**

Are the autopsy results attached to this Report of Death form?

- 1** Yes **0** No

Please explain why not:

WDLINK



7 Cause of death as written on the death certificate:

Immediate

Underlying

8 Actual adjudicated location of death (*Please mark ONLY one location*):

① Hospital (Inpatient)

② Emergency Room

③ Nursing Home

WDLOCA ④ Hospice (not within a hospital)

⑤ Residence

WDLOCAOT

⑥ Other → *Please specify:*

⑦ Unknown

9 Was the death witnessed?

① Yes

② No

③ Unknown

10 Synopsis of events surrounding death:



11 What is the classification of the underlying cause of death? (*Please select ONLY one cause.*)

1 Atherosclerotic cardiovascular disease

1 Definite fatal MI
2 Definite fatal CHD
3 Possible fatal CHD

2 Cerebrovascular disease

3 Atherosclerotic disease, other than coronary or cerebrovascular → *Please specify:*

4 Other cardiovascular disease



1 Valvular heart disease

2 Other → *Please specify:*

5 Cancer → *Please specify site:*

6 COPD

7 Pneumonia

8 Respiratory failure

9 Dementia

10 Diabetes

11 GI bleed

12 Renal failure

13 Sepsis

14 Other → *Please specify:*

12 Was the death procedure related?

1 Yes **0** No **9** Unknown



HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
HABCID	ACROSTIC	Month / Day / Year	

FINAL DEATH ADJUDICATION REPORT

1 Health ABC Event Form reference #: **EVREF**

2 What is the classification of the immediate cause of death? (*Please select ONLY one cause.*)

WGCAUSE1

1 Atherosclerotic cardiovascular disease

1 Definite fatal MI

2 Definite fatal CHD **WGACD1**

3 Possible fatal CHD

2 Cerebrovascular disease

WGACDOT1

3 Atherosclerotic disease, other than coronary or cerebrovascular → *Please specify:*

4 Other cardiovascular disease

WGOCD1

1 Valvular heart disease **WGOCDOT1**

2 Other → *Please specify:*

5 Cancer → *Please specify site:*

- 6 COPD
- 7 Pneumonia
- 8 Respiratory failure
- 9 Dementia

WGCANC1

- 10 Diabetes
- 11 GI bleed
- 12 Renal failure
- 13 Sepsis
- 14 Other → *Please specify:*

WGOTHER1

3 What is the classification of the underlying cause of death? (*Please select ONLY one cause.*)

WGCAUSE2

1 Atherosclerotic cardiovascular disease

<p>1 Definite fatal MI</p> <p>2 Definite fatal CHD WGACD2</p> <p>3 Possible fatal CHD</p>
--

2 Cerebrovascular disease

WGACDOT2

3 Atherosclerotic disease, other than coronary or cerebrovascular → *Please specify:*

--

4 Other cardiovascular disease

WGOCD2

1 Valvular heart disease

WGOCDOT2

2 Other → *Please specify:*

--

5 Cancer → *Please specify site:*

--

6 COPD

7 Pneumonia

8 Respiratory failure

WGCANC2

9 Dementia

10 Diabetes

11 GI bleed

12 Renal failure

WGOTHER2

13 Sepsis

14 Other → *Please specify:*

--

--

4 Was the death procedure-related?

Yes No Unknown **WGPROC**

5 Was the death fall-related?

Yes No Unknown **WGFALL**

6 Was there any mention of dementia in the death packet?

Yes No Unknown **WGDEM**

7 Was the final adjudication decision unanimous?

Yes No





HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YTID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YTACROS	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year YTDATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YTSTFID

DECEDENT PROXY INTERVIEW

I. Was the Decedent Proxy Interview completed?

- Yes: fully completed
 - Yes: partially completed **YTDPINT**
 - No: proxy refused
 - No: other reason (*Please specify:* _____)
-

II. Was an Event Form completed to report the participant's death?

- Yes **YTEVENT**
- No



DECEDENT PROXY INTERVIEW

HABC Enrollment ID #	Acrostic
H [] [] [] [] [] Y1ID	[] [] [] [] [] Y1ACROS

Date of last regularly scheduled contact: [] [] / [] [] / [] [] [] [] []
 Month / Day / Year Y1DATE3

Suggested Script: My name is [] from the health studies office at the University of []. Your [relationship] was a participant in the Health ABC Study. We recently learned of [his/her] death, and we want to express our condolences to you and your family. Your [relationship] played an important role in helping us learn more about aging and health by being a participant in our study. It is also important that we learn about some of the details of [his/her] health since their last regularly scheduled interview in [date of last contact]. Do you have a few minutes to answer some questions? (If no, ask when you can call back and arrange to do so.)

- What is your relationship to [name of Health ABC participant]?
 - 1 Spouse or partner Y1REL
 - 2 Child
 - 3 Family member (other than spouse or child) **Please specify:** _____
 - 4 Close friend
 - 5 Health care provider
 - 6 Other **Please specify:** Y1RELOTH
 - 7 Refused

- How often did you have contact with [him/her]?
 (Interviewer Note: Please mark only one answer.)
 - 1 Lived together → Go to Question #4.
 - 2 Daily (but did not live together)
 - 3 3 or more times a week Y1OFTCON
 - 4 Less than 3 times a week
 - 8 Don't know
 - 7 Refused

- What was the most frequent type of contact?
 - 1 Mostly in person
 - 2 Mostly by phone Y1FRQCON
 - 3 Both in person and by phone
 - 4 Other Please specify: _____
 - 8 Don't know
 - 7 Refused

DECEDENT PROXY INTERVIEW

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Y2ID	Y2ACROS

4. Because of a health or physical problem, did [name of Health ABC participant] have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?
(Interviewer Note: If the proxy responds "Did not do," probe to determine whether this was because of a health or physical problem. If the participant didn't walk because of a health or physical problem, mark "Yes." If the participant didn't walk for other reasons, mark "Did not do.")

1 Yes 0 No 8 Don't know 7 Refused 9 Did not do
Y2DWQMYN

Go to Question #5.

a. How long before [he/she] died did [he/she] start having difficulty?

→
Y2DWQTM1

- 1 Days (up to 31 days) Y2DWQTM2
2 Months (>1 month to 11 months)
3 Years (≥1 year)
8 Don't know

b. How much difficulty did [he/she] have?
(Interviewer Note: Read response options.)

- 1 A little difficulty
2 Some difficulty Y2DWQMDF
3 A lot of difficulty
4 Or were they unable to do it?
8 Don't know

5. Because of a health or physical problem, did [name of Health ABC participant] have any difficulty walking up 10 steps, that is about 1 flight, without resting?
(Interviewer Note: If the proxy responds "Did not do," probe to determine whether this is because of a health or physical problem. If the participant didn't walk up 10 steps because of a health or physical problem, mark "Yes." If the participant didn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Did not do.")

1 Yes 0 No 8 Don't know 7 Refused 9 Did not do
Y2DW10YN

Go to Question #6.

a. How long before [he/she] died did [he/she] start having difficulty?

→
Y2DW1TM1

- 1 Days (up to 31 days)
2 Months (>1 month to 11 months) Y2DW1TM2
3 Years (≥1 year)
8 Don't know

b. How much difficulty did [he/she] have?
(Interviewer Note: Read response options.)

- 1 A little difficulty
2 Some difficulty
3 A lot of difficulty Y2DIF
4 Or were they unable to do it?
8 Don't know

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Y3ID	Y3ACROS

DECEDENT PROXY INTERVIEW

6. Because of a health or physical problem, did (name of Health ABC participant) have any difficulty walking across a small room?

1 Yes
 0 No
 8 Don't know
 7 Refused
 Y3DWRMYN

↓ ↓ ↓ ↓ ↓

Go to Question #7.

a. How long before [he/she] died did [he/she] start having difficulty?

Y3DWRM1

- 1 Days (up to 31 days) **Y3DWRM2**
- 2 Months (>1 month to 11 months)
- 3 Years (≥ 1 year)
- 8 Don't know

b. How much difficulty did [he/she] have? (*Interviewer Note: Read response options.*)

- 1 A little difficulty
- 2 Some difficulty **Y3DWRDF**
- 3 A lot of difficulty
- 4 Or were they unable to do it?
- 8 Don't know

c. Did someone usually help [him/her] across a room?

- 1 Yes
 0 No
 8 Don't know
 Y3DWRHYN

7. Did (name of Health ABC participant) have to use a cane, walker, crutches, or other special equipment to help [him/her] get around?

1 Yes
 0 No
 8 Don't know
 7 Refused
 Y3EQUIP

↓ ↓ ↓ ↓ ↓

Go to Question #8.

a. How long before [he/she] died did [he/she] start using equipment to help [him/her] get around?

Y3EQU1M1

- 1 Days (up to 31 days) **Y3EQU1M2**
- 2 Months (>1 month to 11 months)
- 3 Years (≥ 1 year)
- 8 Don't know

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Y4ID	Y4ACROS

DECEDENT PROXY INTERVIEW

8. Because of a health or physical problem, did [name of Health ABC participant] have any difficulty getting in and out of bed or chairs?

1 Yes 0 No 8 Don't know 7 Refused **Y4DIOYN**



Go to Question #9.

a. How long before [he/she] died did [he/she] start having difficulty?

→
Y4DIOTM1

- 1 Days (up to 31 days)
- 2 Months (>1 month to 11 months) **Y4DIOTM2**
- 3 Years (≥1 year)
- 8 Don't know

b. How much difficulty did [he/she] have? (*Interviewer Note: Read response options.*)

- 1 A little difficulty
- 2 Some difficulty
- 3 A lot of difficulty **Y4DIODIF**
- 4 Or were they unable to do it?
- 8 Don't know

c. Did [he/she] usually receive help from another person when [he/she] got in and out of bed or chairs?

1 Yes 0 No 8 Don't know **Y4DIORHY**

9. Did [name of Health ABC participant] have any difficulty bathing or showering?

1 Yes 0 No 8 Don't know 7 Refused **Y4BATHYN**



Go to Question #10.

a. How long before [he/she] died did [he/she] start having difficulty?

→
Y4BATM1

- 1 Days (up to 31 days)
- 2 Months (>1 month to 11 months) **Y4BATM2**
- 3 Years (≥1 year)
- 8 Don't know

b. How much difficulty did [he/she] have? (*Interviewer Note: Read response options.*)

- 1 A little difficulty
- 2 Some difficulty **Y4BATHDF**
- 3 A lot of difficulty
- 4 Or were they unable to do it?
- 8 Don't know

c. Did [he/she] usually receive help from another person in bathing or showering?

1 Yes 0 No 8 Don't know **Y4BATHRH**

DECEDENT PROXY INTERVIEW

10. Did [name of Health ABC participant] have any difficulty dressing?

1 Yes
 0 No
 8 Don't know
 7 Refused
 Y5DDYN

↓ ↓ ↓ ↓

Go to Question #11.

a. How long before [he/she] died did [he/she] start having difficulty?

<input type="text"/> <input type="text"/>	}	<input type="radio"/> 1 Days (up to 31 days) <input type="radio"/> 2 Months (>1 month to 11 months) <input type="radio"/> 3 Years (≥1 year) <input type="radio"/> 8 Don't know	Y5DDTM2
Y5DDTM1			

b. How much difficulty did [he/she] have? *(Interviewer Note: Read response options.)*

1 A little difficulty
 2 Some difficulty
 3 A lot of difficulty
 4 Or were they unable to do it?
 8 Don't know

Y5DDIF

c. Did [he/she] usually receive help from another person in dressing?

1 Yes
 0 No
 8 Don't know
 Y5DDRHYN

11. Because of a health or physical problem, did [name of Health ABC participant] have any difficulty taking medication for [himself/herself]?

1 Yes
 0 No
 9 Did not take medications
 8 Don't know
 7 Refused
 Y5MEDDIF

↓

a. How long before [he/she] died did [he/she] start having difficulty?

<input type="text"/> <input type="text"/>	}	<input type="radio"/> 1 Days (up to 31 days) <input type="radio"/> 2 Months (>1 month to 11 months) <input type="radio"/> 3 Years (≥1 year) <input type="radio"/> 8 Don't know	Y5MEDTM2
Y5MEDTM1			

HABC Enrollment ID #	Acrostic
H <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Y6ID	Y6ACROS

12. Did [name of Health ABC participant] have any problems with [his/her] memory?

Yes No Don't know Refused
Y6MEM

Go to Question #13.

a. How long before [he/she] died did [he/she] start having difficulty with [his/her] memory?

→ Days (up to 31 days)
 Months (>1 month to 11 months) **Y6MEMTM2**
 Years (≥1 year)
 Don't know
Y6MEMTM1

b. Did [his/her] trouble with memory begin suddenly or slowly?

Suddenly
 Slowly
 Don't know **Y6MEMBEG**

c. Had the course of memory problems been a steady downhill progression, an abrupt decline, stayed the same, or got better?

Steady downhill progression
 Abrupt decline
 Stayed the same (no decline) **Y6MEMPRG**
 Got better
 Don't know

d. Was a doctor aware of [his/her] memory problems?

Yes No Don't know **Y6MEMDR**

i. What did the doctor believe was causing [his/her] memory problems?

(Interviewer Note: Please mark only one answer.)

<input type="radio"/> Alzheimer's disease	<input type="radio"/> Parkinson's disease
<input type="radio"/> Confusion	<input type="radio"/> Stroke Y6MEMDX
<input type="radio"/> Delerium	<input type="radio"/> Nothing wrong
<input type="radio"/> Dementia	<input type="radio"/> Other (Please specify)
<input type="radio"/> Depression	_____
<input type="radio"/> Multiinfarct	<input type="radio"/> Don't know



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Y7ID	Y7ACROS

DECEDENT PROXY INTERVIEW

13. Since *[name of Health ABC participant's]* last regularly scheduled interview about *[number of months since last interview]* months ago, had *[she/he]* been to see a doctor, nurse practitioner, or other health care provider? **Y7MCPROV**

Yes No Don't know Refused

14. Since *[name of Health ABC participant's]* last regularly scheduled interview about *[number of months since last interview]* months ago, had *[she/he]* gone to an emergency room or urgent care center? **Y7MCER**

Yes No Don't know Refused

15. Did *[name of Health ABC participant]* receive any care from a hospice or palliative care team? **Y7MCHPAL**

Yes No Don't know Refused

a. Did anyone speak to *[him/her]* or to you about the possibility of hospice or palliative care? **Y7MCHPAS**

Yes No Don't know

16. Since *[name of Health ABC participant's]* last regularly scheduled interview about *[number of months since last interview]* months ago, did *(he/she)* receive care at home from a visiting nurse, home health aide, nurse's aide, or home hospice? **Y7MCVN**

Yes No Don't know Refused

17. In the past *[x]* months, did *[name of Health ABC participant]* stay overnight as a patient in a...?

a. Nursing home	Y7NURSE	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused
b. Rehabilitation center	Y7REHAB	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused
c. Assisted living or personal care home	Y7ASTLIV	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused
d. Inpatient hospice	Y7HOSPIC	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know	<input type="radio"/> Refused

Now I am going to ask you about some medical conditions that *[name of Health ABC participant]* might have had.

18. Had a doctor or other health care professional ever told *[name of Health ABC participant]* that *[he/she]* had weak or failing kidneys? **Y7TKIDFL**

Yes No Don't know Refused

19. Had a doctor or other health care professional ever told *[name of Health ABC participant]* that *(he/she)* had a condition that might be life threatening? **Y7TILT**

Yes No Don't know Refused

DECEDENT PROXY INTERVIEW

Interviewer Note: Refer to Data from Prior Visits Report to see how many months have passed since the following questions on medical conditions were asked.

Please think about the past [x] months, which was the last time we collected information about [name of Health ABC participant's] medical conditions.

- 20.** In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] had a heart attack, angina, or chest pain due to heart disease?
- Yes No Don't know Refused

A. Was [he/she] hospitalized overnight for this problem?

Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. [] [] [] [] [] b. [] [] [] [] [] [] c. [] [] [] [] [] []

Go to Question #21.

- 21.** In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] had congestive heart failure?
- Yes No Don't know Refused

A. Was [he/she] hospitalized overnight for this problem?

Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. [] [] [] [] [] b. [] [] [] [] [] [] c. [] [] [] [] [] []

Go to Question #22.

- 22.** In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] had a stroke, mini-stroke, or TIA?
- Yes No Don't know Refused

A. Was [he/she] hospitalized overnight for this problem?

Yes No

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization. Record reference #'s below:

a. [] [] [] [] [] b. [] [] [] [] [] [] c. [] [] [] [] [] []

Go to Question #23.

DECEDENT PROXY INTERVIEW

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H [] [] [] [] [] [] [] []	[] [] [] [] [] [] [] []

23. In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] had cancer? We are specifically interested in hearing about a cancer that was diagnosed for the first time in the past [x] months.

- Yes
 No
 Don't know
 Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. [] [] [] [] [] []
 b. [] [] [] [] [] []
 c. [] [] [] [] [] []

24. In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] had pneumonia?

- Yes
 No
 Don't know
 Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. [] [] [] [] [] []
 b. [] [] [] [] [] []
 c. [] [] [] [] [] []

25. In the past [x] months, was [name of Health ABC participant] told by a doctor that [he/she] broke or fractured a bone(s)?

- Yes
 No
 Don't know
 Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. [] [] [] [] [] []
 b. [] [] [] [] [] []
 c. [] [] [] [] [] []

26. Was [name of Health ABC participant] hospitalized overnight for any other reasons in the past [x] months?

- Yes
 No
 Don't know
 Refused

**Complete a Health ABC Event Form(s), Section I, for each event.
Record reference #'s and reason for hospitalization below.**

a. [] [] [] [] [] [] Reason for hospitalization: _____	b. [] [] [] [] [] [] Reason for hospitalization: _____	c. [] [] [] [] [] [] Reason for hospitalization: _____
d. [] [] [] [] [] [] Reason for hospitalization: _____	e. [] [] [] [] [] [] Reason for hospitalization: _____	f. [] [] [] [] [] [] Reason for hospitalization: _____



DECEDENT PROXY INTERVIEW

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YFID	YFACROS

27. What was [name of Health ABC participant's] exact date of death?
(Interviewer Note: If proxy is unsure of exact date of death, please record their best guess, and mark "Proxy unsure of exact date" response option.)

YFDOD

/ /

Month Day Year

YFDODRF

Proxy unsure of exact date

28. Where did [name of Health ABC participant] die? *(Interviewer Note: Mark only one location.)*

- 1 Hospital (Inpatient)
- 2 Emergency Room
- 3 Nursing Home
- 4 Hospice (not within a hospital)
- 5 Residence
- 6 Other → Please specify:
- 9 Unknown

YFLOCA

YFLOCAOT

29. Has a Health ABC Event Form recording the death already been completed?

1 Yes

Record reference # below:

YFREF29A

0 No

YFHOSREF

Complete a Health ABC Event Form, Section IV.
 Record reference # below:

YFREF29B

30. Did [name of Health ABC participant's] death come as a surprise to you?

1 Yes

0 No

8 Don't know

7 Refused

YFDSURPR

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YGID	YGACROS

DECEDENT PROXY INTERVIEW

31. Please describe exactly what happened to your [relationship].
(Interviewer Note: If additional space is needed, please write comments on the back of this page.)

Interviewer Note: If proxy already answered Question #32 or #33 in their description recorded above, please do not specifically ask these questions. Based on the description in Question #31, please record the answers in the appropriate spaces below.

32. Was someone with your [relationship] when [he/she] died?
(Interviewer Note: "With" means being in the same room or building.)

- Yes
 No
 Don't know
 Refused
 YGDTHWHO

No Don't know

↓ ↓

How long was it between when [name of Health ABC participant] was last seen alive and when [he/she] died?

33. Did [name of Health ABC participant] complain of any symptoms, such as chest pain, headache, extreme tiredness, or lack of appetite any time before [his/her] death?

- Yes
 No
 YGDTHSYM

↓

a. Please describe:

b. What actions, if any, were taken for the symptom(s), such as taking any medications, or going to the doctor?

DECEDENT PROXY INTERVIEW

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YHID	YHACROS

34. Do you know the main cause of your *[relationship]* death?
1 Yes **0** No **8** Don't know **7** Refused **YHDTWHY**

a. What was the cause of *[his/her]* death?

35. In the last week of *[name of Health ABC participant's]* life, was *[he/she]* on medicines for *[his/her]* pain?
1 Yes **0** No **8** Don't know **7** Refused **YHMEDPN**

a. Did you or your family receive any information about those medicines?
1 Yes **0** No **8** Don't know **YHMEDIN**

b. Would you have wanted more information about those medicines?
1 Yes **0** No **8** Don't know **YHMEDIM**

c. In that last week, did *[name of Health ABC participant]* receive too much, too little, or just the right amount of medication for *[his/her]* pain?
1 Too much medication
2 Too little medication **YHMEDAMT**
3 Just the right amount of medication
8 Don't know

36. In the last week, did *[he/she]* have trouble breathing?
1 Yes **0** No **8** Don't know **7** Refused **YHTRBBR**

a. Which of these treatments were used to help *[him/her]*? (**Interviewer Note: Mark all that apply.**)

-1 Medicine(s) **-1** Oxygen **-1** Breathing machine **-1** Other **YHTRBBOT**

YHTRBBD **YHTRBBO** **YHTRBBOM**

i. Did you or your family receive any information about the medicines that were used? **YHTRBBI**
1 Yes **0** No **8** Don't know

ii. Would you have wanted more information about the medicines?
1 Yes **0** No **8** Don't know **YHTRBBMI**

Please specify:

YHTRBBS

b. In that last week, how much help with *[his/her]* breathing did *[name of Health ABC participant]* receive? Less than was needed, or about the right amount?
1 Less than was needed **2** About the right amount **8** Don't know **YHTRBBH**



DECEDENT PROXY INTERVIEW

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YKID	YKACROS

Now think about **7 days** before [name of Health ABC participant's] death.

40. Where was [name of Health ABC participant] residing at this time?

- 1 Own residence YKRES7D
- 2 Independent living facility
- 3 Family/friend residence NOT because of poor health
- 4 Family/friend residence because of poor health
- 5 Nursing home
- 6 Hospital
- 9 Free-standing hospice
- 10 Other **Please specify:**
- 8 Don't know
- 7 Refused

41. Was there a single doctor or other health care professional in charge of [name of Health ABC participant's] care during this time?

- 1 Yes
- 0 No
- 8 Don't know
- 7 Refused YKDOC7

i. Was there more than one provider, none with priority for [name of Health ABC participant's] care during this time?

- 1 Yes
- 0 No
- 8 Don't know YKDOC7S

a. What is the provider's name?

YKD7NDK

Don't know

b. What is the provider's specialty (for example, oncology, cardiology, etc.)?

-1 YKD7SDK

Don't know



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H [] [] [] [] [] YLID	[] [] [] [] [] YLACROS

DECEDENT PROXY INTERVIEW

Now think about the day *[name of Health ABC participant]* died.

42. Where was *[name of Health ABC participant]* residing at this time?

- 1 Own residence YLRESDAY
- 2 Independent living facility
- 3 Family/friend residence NOT because of poor health
- 4 Family/friend residence because of poor health
- 5 Nursing home
- 6 Hospital
- 9 Free-standing hospice
- 10 Other *Please specify:* YLRESDYO
- 8 Don't know
- 7 Refused

43. Was there a single doctor or other health care professional in charge of *[name of Health ABC participant's]* care during this time?

- 1 Yes
 0 No
 8 Don't know
 7 Refused
 YLDOCDAY

i. Was there more than one provider, none with priority for *[name of Health ABC participant's]* care during this time?

- 1 Yes
 0 No
 8 Don't know
 YLDOCSY

a. What is the provider's name?

YLDOGDYN

YLDDYNDK

Don't know

b. What is the provider's specialty (for example, oncology, cardiology, etc.)?

YLDOCDYS

YLDDYSK

-1 Don't know



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YMID	YMACROS

DECEDENT PROXY INTERVIEW

This next series of questions asks about *[name of Health ABC participant's]* last week, i.e., the last 7 days of life.

44. In *[his/her]* last week, was it always clear to you who was in charge of *[name of Health ABC participant's]* care?
 Yes No Don't know Refused **YMINCHG**

45. In that last week, was there any problem with doctors or other health care professionals not knowing enough about *[name of Health ABC participant's]* medical history to provide the best possible care?
 Yes No Don't know Refused **YMNOTKN**

46. In *[name of Health ABC participant's]* last week of life, did you talk with any of *[his/her]* doctors or other health care professionals yourself?
 Yes No Don't know Refused **YMTLKDR**

a. In that last week, did the doctor or other health care professional check to see what you understood about *[name of Health ABC participant's]* medical condition and care?
 Yes No Don't know **YMUNDDR**

b. Do you know if the doctor or other health care professional had a conversation with *[name of Health ABC participant]* to make sure *[he/she]* understood their medical condition and care as well?
 Yes No Don't know **YMCONVDR**

c. How much information did the doctor or other health care professional provide you about *[name of Health ABC participant's]* medical condition or care? Would you say not enough information, just the right amount, or more than was needed?
 Not enough **YMINFDR**
 Just right amount
 More than was needed
 Don't know

d. Was there a problem understanding what any doctor or other health care professional was saying to you about *[name of Health ABC participant's]* medical condition?
 Yes No Don't know **YMPUNDDR**

e. Do you feel that the doctors and other health care professionals you talked with listened to your concerns about *[name of Health ABC participant's]* medical condition?
 Yes No Don't know **YMDRLIST**

f. Did any doctor or other health care professional tell you when *[name of Health ABC participant's]* condition might worsen?
 Yes No Don't know **YMDRCW**

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YNID	YNACROS

47. In the last week of [his/her] life, did [name of Health ABC participant's] doctor or other health care professional order any new tests, procedures, or treatments?

1 Yes 0 No 8 Don't know 7 Refused YNICTTX

a. What was ordered? *(Interviewer Note: Record below.)* YNICTXWDK

YNICTXWA

-1 Don't know

b. Did you or [name of Health ABC participant] have an opportunity to ask questions about this?
 1 Yes 0 No 8 Don't know YNICTTXQ

c. Did you or [name of Health ABC participant] have the opportunity to express any concerns or opinions about it?
 1 Yes 0 No 8 Don't know YNICTTXC

d. How much information did you or [name of Health ABC participant] get about possible side effects or complications? Would you say not enough information, just the right amount, or more than was needed? YNICTXI

1 Not enough
 2 Just right amount
 3 More than was needed
 8 Don't know

48. In your opinion, in that last week of [name of Health ABC participant's] life, were decisions made about [his/her] care with enough input from [him/her] or [his/her] family?

1 Yes 0 No 8 Don't know 7 Refused YNDMAFHE

Now, thinking in general about [name of Health ABC participant] before [she/he] died . . .

49. Were all treatment or care decisions made with full agreement among all family members?

1 Yes 0 No 8 Don't know 7 Refused YNDMDFH

50. Did [name of Health ABC participant] have specific wishes or plans about the types of medical treatment [he/she] did or did not want while dying?

1 Yes 0 No 8 Don't know 7 Refused YNTXDIE

51. To the best of your knowledge, did [name of Health ABC participant's] doctor or other health care professional speak to [him/her] or you about [his/her] wishes about medical treatment?

1 Yes 0 No 8 Don't know 7 Refused YNTXDIES



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YPID	YPACROS

DECEDENT PROXY INTERVIEW

52. In the last week of *[name of Health ABC participant's]* life, did *[he/she]* receive any medical procedures or treatments that were inconsistent with *[his/her]* previously-stated wishes?

1 Yes
 0 No
 8 Don't know
 7 Refused
 YPPRFNW

53. Did you *[or your family]* receive any information about what to expect when *[he/she]* was dying?

1 Yes
 0 No
 8 Don't know
 7 Refused
 YPEXPDI

54. Would you have wanted more information about what to expect when *[he/she]* was dying?

1 Yes
 0 No
 8 Don't know
 7 Refused
 YPWANTMI

55. Is there anything else you'd like to share about *[name of Health ABC participant's]* health care in *[his/her]* last week of life?

1 Yes
 0 No
 8 Don't know
 7 Refused
 YPELSESH

Interviewer Note: Record proxy's response below.

YPELSESS

DECEDENT PROXY INTERVIEW

56. Is there anything else you'd like to share about how the health care could have been improved for [name of Health ABC participant]?

- 10 Yes
 00 No
 80 Don't know
 70 Refused
 YQCAREIM

Interviewer Note: Record proxy's response below.

YQCAREIN

57. **Interviewer Note: Please answer the following question based on your judgement of the proxy's responses to the Decedent Proxy Interview.**

On the whole, how reliable do you think the proxy's responses to the Decedent Proxy Interview are?

- 10 Very reliable
 20 Fairly reliable
 YQRELY
 30 Not very reliable
 80 Don't know