

Follow-up TRIAD Medical Chart Abstraction Instructions

For Use with TRIAD Follow-Up Chart Review Instrument Version F6.4

These instructions correspond with the final version of the Follow-up Chart Review Instrument (Version F6.4). This is the final version of these instructions; only minor changes have been made since the previous version. For additional information, refer to the current version of the TRIAD Follow-up Medical Chart Abstraction Clarifications & Reminders. To ensure consistent chart review procedures across sites, the "reminders" will be revised and distributed whenever issues raised by coordinators or abstractors result in further clarification of the instructions.

TRIAD participants who have consented to a medical chart review will be identified by the Translational Research Center (TRC). For each chart review assigned to an abstractor, the TRC will provide the information in the shaded box on page one of the instrument. These three items specify the participant's TRIAD Subject ID number and follow-up review period interval:

Study Subject ID Number: the identification number assigned to the patient. TRIAD identification numbers are 6 digits, leading with a single digit numeric identifier for each site:	
Hxxxxx:	1NNNNN
Ixxxxx:	2NNNNN
Kxxxxx Pxxxxxxxx:	3NNNNN
Mxxxxxxxx:	4NNNNN
Nxx Jxxxxx:	5NNNNN
Txxxx:	6NNNNN
Follow-up Review Chart Period End Date: the day of the second TRIAD CATI interview or written survey.	
Follow-up Review Chart Period Start Date: the day immediately following the first CATI interview or written survey. Example: if the first TRIAD patient CATI interview date was 06/18/2000 the Follow-up review period start date will be 6/19/2000.	

Chart abstractors should review relevant outpatient and inpatient medical information documented in the patient medical record during the follow-up review period. These records include but are not limited to visit notes, progress notes, physician's letters, procedure summaries, discharge summaries, consultant notes, medication records, history and physical (H&P), problem lists, vascular surgery assessments, diabetes education notes, emergency room and urgent care records, and lab or other test reports. Except for subject death information, medical documents dated before the review period start date or after the end date should not be considered. Also, abstractors should not examine or consider information recorded by the TRIAD abstractor during the patient's baseline chart review.

The abstractor's goal is to record data that accurately reflects the health information documented in the patient's medical record by the health care providers. Ignore symptom checklists and other self-reported information provided only by the patient (or proxy for the patient) and not corroborated by the health care provider. Abstractors should record requested information only and avoid writing comments on data entry portion (pp. 1-12) of the instrument.

For the **Patient Medical History** section (items 3-11), abstractors should review and consider medical documentation covering the entire follow-up review period. Based on these medical records, abstractors will indicate if the patient has a record of **EVER** having the listed conditions, treatments, and risk factors.

For the **Medical Events During Follow-up Review Period** section (items 12-44), abstractors will record information regarding health care and medical events **OCCURRING DURING THE SPECIFIED FOLLOW-UP REVIEW PERIOD**. This section includes information concerning health care visits, body weight, blood pressure readings, diagnostic tests and exams, medical events, surgeries, procedures, and medications. Abstractors must not record information in this section if the medical documentation does not clearly denote that the event or test occurred during the review period. For example, if a visit note states "last foot exam normal" without mention of a date, the reviewer should not consider this exam because it may have occurred prior to the review period start date. However, if a visit note states "last month's foot exam normal" and the entire month prior to that visit was within the review period, the abstractor should count this examination. For Current Medications (item 43), abstractors will identify selected diabetes, BP, lipid, depression, and anti-psychotic medications taken or prescribed during review period which were not stopped or discontinued prior to the review period end date. See page 15 of this document for a list of the medication categories included. A complete list of drugs (by category) begins on page 17.

Before submitting completed chart review forms, the abstractor should record the following two items in the unshaded box on page one of the chart review instrument:

Date Medical Chart Abstraction Completed:

the date the abstractor completes the record review.

Abstractor's ID Number:

the abstractor's 5-digit identification number (assigned by the TRC).

Instructions: PATIENT DEMOGRAPHICS

(Items 1-2)

- 1. PATIENT'S DATE OF BIRTH:** Record the month, day, and (four-digit) year of the patient's birth.
- 2. PATIENT'S GENDER:** Check the appropriate box to indicate whether the patient is male or female.

Instructions: PATIENT MEDICAL HISTORY

(Items 3-11)

For this section, abstractors will review patient records covering the entire follow-up review period. For each patient, refer to page one of the instrument for the exact start and end dates of the review period.

Medical history documented during the review period should be considered without regard to treatment date, event date, or condition onset date. Based on the records reviewed, check the "Yes" or "No" box on the instrument to indicate if the patient has a record of EVER having the listed condition, treatment, or risk factor. If the records reviewed do not clearly document the listed item, check "No". Do not skip any item (except #5a and #5b if "No" to item #5). Data abstraction should be based on consideration of all information in the medical records reviewed except information presented as reported by the patient or proxy for the patient and not corroborated by a health care provider.

Obviously, comments regarding a condition to be "ruled out" or appearing in a Family History list should be ignored. For example, abstractors should take care that comments such as "R/O MI" and "Fhx: MI" are not interpreted as meaning the patient has had a myocardial infarction (MI). The comment "Probable MI" also does not warrant checking "Yes" for MI. The comment "history of MI" or "Heart Attack 1987" does warrant a "Yes". Check "Yes" for a condition if it documented anywhere in the records reviewed without a modifier (for example: if the comment "probable MI" appears in one place and "MI '87" appears in another place, the reviewer should check "Yes" for history of MI). A diagnosis appearing in a current problem list with an onset date later than the end of the review period should not be counted. To be counted, the diagnosis must have been recorded into the medical record on or before the review period end date.

Abstractors are looking for clinician observation rather than their own interpretation. For example, do not interpret blood pressure values: the notation "BP 175/92" does not warrant checking "Yes" for history of hypertension if the medical records do not somewhere explicitly document hypertension (see item #3a for specific HTN inclusions). Similarly, a total cholesterol value of 230 mg/dl is not Hyperlipidemia unless so documented or interpreted by a health care provider. Abstractors should not base decisions upon their own interpretation of an EKG report or any other test result.

3. HISTORY OF CARDIOVASCULAR RISK FACTOR OR VASCULAR DISEASE:

Check "Yes" or "No" to each item to indicate if the patient has a record of the listed risk factor or disease.

- a. Hypertension (HTN) - includes ↑BP, HBP, HCVD (hypertensive cardiovascular disease), and HASHD (hypertensive arteriosclerotic heart disease).
- b. Hyperlipidemia/Hypercholesterolemia - includes hypertriglyceridemia, dyslipidemia, and "elevated lipids".
- c. Cigarette Smoking - does not include pipe or cigar smoking. Does include unspecified tobacco use (e.g., "current smoker" or "Quit smoking four years ago").
- d. Transient Ischemic Attack (TIA) - may also be recorded as a "mini" or "mild" stroke with no permanent damage.
- e. Cerebral Vascular Accident (CVA) - may also be recorded as a stroke. Does not include carotid bruits or asymptomatic disease documented by Doppler or angiogram without history of stroke.
- f. Hemiplegia - includes cerebrovascular accident (CVA) with residual weakness or paralysis of an arm or leg or both. Includes hemiparesis.
- g. Angina - may also be recorded as angina pectoris.
- h. Myocardial Infarction (MI) - may also be recorded as heart attack or AMI.
- i. Congestive Heart Failure (CHF) – may also be recorded as cardiac failure/heart failure.
- j. Other Coronary Heart Disease (CHD) or Coronary Artery Disease (CAD) - includes cardiovascular disease and arteriosclerotic heart disease. Does not include valvular heart disease.
- k. Peripheral Vascular Disease (PVD) / (PVOD) / Claudication: includes intermittent claudication, bypass for arterial insufficiency, and untreated thoracic or abdominal aortic aneurysms (AAA) of 6 cm or more.

4. HISTORY OF VASCULAR TREATMENT: Check "Yes" or "No" to each item to indicate if the patient has a record of the listed vascular treatment/surgeries.

- a. Carotid Endarterectomy
- b. Coronary Angioplasty
- c. Coronary Bypass - CABG
- d. Peripheral Vascular Angioplasty or Bypass - includes femoropopliteal "Fem-Pop" bypass.

5. HISTORY OF END-STAGE RENAL DISEASE (ESRD): Check "Yes" for item 5 if the patient has a record of ESRD, dialysis, or kidney transplant, otherwise check "No". If "No", skip to item 6. Otherwise, check the following treatments "Yes" or "No" to indicate if the patient has ever received:

- a. Dialysis (peritoneal or hemodialysis - includes HD, PD, CAPD and CCPD), or
- b. Kidney transplant.

6. HISTORY OF MICROALBUMINURIA: Check "Yes" or "No" to indicate if the patient has a record of microalbuminuria. For example, if the comment "microalbumin positive" appears in a visit note, check "Yes". If records do not clearly document microalbuminuria, check "No".

7. HISTORY OF DIABETIC NEPHROPATHY: Check "Yes" or "No" to indicate if the patient has a record of diabetic nephropathy. If records do not document nephropathy, check "No". Confirming documentation includes any of the following diagnoses:

Diabetic nephropathy (DN)	Chronic renal insufficiency (CRI)
Nephropathy	Renal insufficiency
Diabetic kidney disease	Proteinuria
End-stage renal disease (ESRD)	Azotemia
Acute renal failure (ARF)	Diffuse diabetic or nodular glomerulosclerosis
Chronic renal failure (CRF)	Kimmelstiel-Wilson disease
Chronic renal disorder	

8. HISTORY OF DIABETIC PERIPHERAL NEUROPATHY: Check "Yes" if the patient has a record of diabetic peripheral neuropathy; otherwise check "No". If records indicate peripheral neuropathy due to a cause other than diabetes (for example, neuropathy secondary to alcoholism, Lyme disease, vitamin deficiency, metal poisoning, HIV infection, syphilis, or diphtheria), check "No".

9. HISTORY OF COMPLETE AMPUTATION OF BOTH FEET: Check "Yes" or "No" to indicate if the patient has had BOTH feet amputated. Mark "Yes" only if both feet were completely amputated. Note: AKA indicates "above knee amputation", BKA indicates "below knee amputation".

10. HISTORY OF RETINAL LASER TREATMENT: Check "Yes" or "No" to indicate whether the patient ever had eye laser treatment/surgery for proliferative retinopathy or macular edema. Check "Yes" if the records indicate "panretinal photocoagulation" or "focal photocoagulation". Retinal laser treatment does not include the following: LASIK therapy for refractive error, laser trabeculoplasty for glaucoma, and YAG laser for cataract.

11. HISTORY OF DIABETIC RETINOPATHY: Check "Yes" or "No" to indicate whether the patient has a record of diabetic retinopathy. If records do not indicate diabetic retinopathy, check "No". Do not include macular degeneration without mention of diabetes.

Diabetic Retinopathy Inclusion Examples:

Non-proliferative Diabetic Retinopathy (NPDR)	Rubeosis Iridis
Background diabetic retinopathy (BDR)	Cotton wool spots
Background retinopathy	Retinal blot hemorrhages
Macular Edema (ME)	Venous beading/looping
Clinically Significant Macular Edema (CSME)	Blot hemorrhage
Proliferative Diabetic Retinopathy with or without high risk characteristics (PDR or PDR with HRC)	Hard exudates
Intraretinal microvascular abnormalities (IRMA)	Microaneurysms
Diabetic retinal or eye changes	Soft exudates
Macular changes with retinopathy	Panretinal photocoagulation (PRP), focal photocoagulation, or laser treatment of the eyes (excluding LASIK therapy for refractive error, laser trabeculoplasty for glaucoma, and YAG laser for cataract).
New vessels on the disc (NVD)	
New vessels elsewhere on the retina (NVE)	
Preretinal or vitreous hemorrhage	

Instructions: MEDICAL EVENTS DURING FOLLOW-UP REVIEW PERIOD

(Items 12-44)

For this section, abstractors will review patient records covering the review period specified on page one of the instrument. All tests and other events considered in this section MUST have occurred during the review period. Throughout this section, the date of "the last" occurrence of a visit or procedure means the last occurrence during the review period. Similarly, the date of "the first event" or "the first procedure" means the first occurrence during the review period. Ignore lab tests or other events if they occurred before the review period start date or were documented after the review period end date. If the medical records are unclear regarding whether an event occurred during the review period, abstractors should ignore the event. For example, if eleven of twelve months of the year 2001 are within the review period and the records denote that a dilated eye exam was performed in 2001 (without mention of month of exam), this eye exam should not be counted.

This section includes fifteen frequency items that require the abstractor to ascertain the number of times various events, tests, or procedures occurred during the review period. If the records reviewed are unclear regarding the number of times an event occurred, the abstractor should record the minimum number that must have occurred based on the records reviewed. Abstractors should not "double count" events mentioned in two different places unless documented dates or other information clarify that the records are not referring to the same event. The final two pages of the TRIAD Chart Review instrument provide worksheets for these fields, i.e., the number of:

Outpatient visits to a PCP, nurse practitioner, endocrinologist or diabetologist (12a.)	Glycosylated hemoglobin (GLYCO), HbA1c, or Fructosamine tests (16a.)	Catastrophic hypoglycemia (36a.) Carotid endarterectomy (37a.) Coronary angioplasty (38a.)
Clinical care manager visits [non-PCP] (15a.)	Foot exams (26b.) Dilated eye exams (29b.)	Coronary bypass (CABG) (39a.) Peripheral vascular angioplasty / bypass (40a.)
Clinical care manager telephone consultations [non-PCP] (15b.)	TIA (33a.) CVA (34a.) MI (35a.)	Kidney transplant (42a.)

This instrument was created and developed by the TRIAD Study, 2002.

Regarding lab data fields in this section:

Include lab tests only if the results are documented or there is a statement that the test was performed; do not include if the medical records merely show that the test was ordered.

If both a direct and calculated value are listed for the same date, use the direct value. If a lab report and office note have different results for the same day and time, use the lab slip information. Laboratory values included in medical record correspondence may be used.

If the records indicate that a lab test was performed during the review period, the abstractors should "count" it even if no test result is documented. When this occurs and the test missing a documented result is the last one within the review period, the abstractor should check "Yes" (indicating the test was done) and should leave the corresponding value field blank.

Use the date drawn or collected as the date of the test. If unable to determine the date of the test, use the date of the report (if available).

Date fields in this section are either **mm/dd/yy** or **mm/yy** format. For mm/dd/yy format fields, record a date only if month, day, and year of the event can be ascertained from the records reviewed. For mm/yy format fields, record a date only if month and year of the event can be ascertained. Skip any date field for which the proper date can not be ascertained. Also, do not record partial dates (e.g., do not record "12/__/01" or "__/01").

For lab test, foot exam, eye exam, retinal photo, EKG, and cardiac stress test date fields, abstractors are asked to record the date of the **LAST** occurrence of the event during the review period. All of these date fields are mm/dd/yy format. Leave these date fields blank if the date of the last occurrence can not be ascertained from the records reviewed. For example, if total cholesterol was measured four times during the review period and the date of the test is documented for the first three occurrences but not the fourth, leave the total cholesterol date field blank. Lab tests and exams with undocumented or inexact dates take precedence over ones with an exact date only when the inexact one is definitely within the review period and occurred after the event with an exact date.

For surgical procedures, TIAs, CVAs, MIs, catastrophic hypoglycemia, and initiation of dialysis, abstractors are asked to record the date of the **FIRST** occurrence of the event during the review period. Except for TIA, CVA, and MI, all of these date fields are mm/yy format. Leave these date fields blank if the appropriate date of first occurrence can not be ascertained from the records reviewed. For example, if the records show that a patient had coronary angioplasty performed on two separate occasions during the review period but do not indicate when the first procedure occurred, check "Yes" to item #38, enter "2" for #38a, and leave "Month and Year of 1st Procedure" blank (regardless of whether the records document the date of the 2nd procedure). For the event categories described in this paragraph, events with undocumented or inexact dates take precedence over ones with an exact date only when the inexact one occurred during the review period and before the other event.

The TIA, CVA, and MI items in this section each have four (mm/dd/yy format) date of event fields. Abstractors are to record the date (if known) of the 1st, 2nd, 3rd, and/or 4th review period occurrence. Leave individual event date fields blank if the corresponding date can not be ascertained from the records reviewed. For example, if the year 2001 is entirely within the review period and the only note concerning CVA states "Patient had a stroke on 03/15/01; it was her third stroke of the year" the abstractor should: (1) check "Yes" to #34, (2) record "3" in #34a, and (3) record "09/15/01" for Date of 3rd Event (while leaving the 1st, 2nd, and 4th event dates blank). Whenever the records indicate more than four events of any type (i.e., TIA, CVA, or MI), abstractors should record corresponding known dates for only the first four.

12. DID THE PATIENT HAVE ANY OUTPATIENT VISITS TO A PCP, NURSE PRACTITIONER, ENDOCRINOLOGIST OR DIABETOLOGIST DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had any outpatient visits to a primary care provider (PCP), nurse practitioner (i.e., an NP serving as Primary Care Provider), endocrinologist or diabetologist. Exclude telephone encounters. Exclude visits to other specialists, ER visits, urgent care visits, and visits for lab tests, infusions, flu or allergy injections. If "No", skip to question 15. If "Yes":

a. Record the total number of outpatient visits in the categories included above.

Note: if more than fifteen visits, record "16" visits (i.e., do not record a number greater than 16 in this field).

13. WAS WEIGHT RECORDED AT A VISIT INCLUDED IN #12A? Check "Yes" or "No" to indicate if the patient's weight was measured and recorded during the review period at a visit included in number 12a. If "No", skip to question 14. If "Yes":

a. Record the weight that was last reported within the review period at a visit included in item #12a. **Record the value to the nearest 1/10 unit and circle the unit of measure: kg or lbs.** The unit must be circled. If the medical records do not display the unit of measure for the last recorded weight, the abstractor should look for weights recorded elsewhere in the records to ascertain the correct unit of measure to circle. (Note: 2.2 lbs. = 1 kg)

14. WAS A BLOOD PRESSURE READING TAKEN AT ANY VISIT INCLUDED IN #12A? Check "Yes" or "No" to indicate if the patient's blood pressure was measured during the review period at a visit included in number 12a. If no blood pressure readings were taken, skip to question 15. If "Yes":

a. Record the value of the systolic pressure last measured at one of these visits.

b. Record the value of the diastolic pressure last measured at one of these visits and indicate date.

A reading is usually recorded systolic/diastolic.

Reference systolic b.p. readings can range from (70-300);

diastolic b.p. readings can range from (40 -140).

15. DID THE PATIENT HAVE ANY VISITS TO OR TELEPHONE CONSULTATIONS WITH A (NON-PCP) CLINICAL CARE MANAGER DURING THE REVIEW PERIOD? Check "Yes" or "No". A clinical care manager may be a nurse, nurse practitioner, pharmacist, certified diabetes educator or other "non-physician" health care professional who addresses specific issues of the patient's disease management but is NOT considered the patient's primary care provider. Issues addressed for diabetes may include dietary education, self-management education, glucose control, blood pressure control, lipid control, and smoking cessation. Include (non-PCP) case management cluster visits. Exclude visits counted in #12a. If "No", go to question 16. If "Yes":

a. Record the number of (non-PCP) clinical care manager visits during the review period.

b. Record the number of (non-PCP) clinical care manager telephone consultations during the review period.

16. WAS A GLYCOSYLATED HEMOGLOBIN, HbA1c, OR FRUCTOSAMINE TEST PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had a glycosylated hemoglobin, HbA1c, or Fructosamine test during the review period. If no tests were performed, skip to question 17. If "Yes":

- a) Record the total number of glycosylated hemoglobin, HbA1c, and Fructosamine tests performed. Note: if a lab performs two of these tests on the same date from the same specimen, for example a glycohemoglobin and an A1c assay, count the A1c test rather than the glycohemoglobin test; do not count these as two tests.

Note: Include Fructosamine tests in 16a only; do not record Fructosamine tests in 16b or 16c.

- b) Record the value of the last HbA1c or glycohemoglobin test during the review period.

- c) Record the upper limit of the normal range for the last HbA1c or glycohemoglobin test and the date this test was performed.

Note: Do not use a stated "desirable range" or "goal" as a proxy for a test's upper limit of normal. If the upper limit of the normal range for the last test cannot be ascertained from information in the medical record, leave the upper limit field blank. However, if this limit is shown for an earlier recorded result for the same assay (by the same lab), assume that this upper limit also applies to the last test for which the limit is not explicitly shown.

Regarding unit of measure: record test values as "%". Reference HbA1c tests can range from (4.0-16.0%); upper limit of normal for HbA1c can range from (5.0-6.5%). Reference glycosylated hemoglobin tests can range from (5.0-20.0%); upper limit of normal for glycosylated hemoglobin can range from (7.0-9.0%).

Glycosylated hemoglobin and HbA1c tests may be recorded as:

Glycated hemoglobin	Glycohemoglobin A1C	A1 or A1c
Glycohemoglobin	Hemoglobin A1	Hemoglobin A1c
Glyco	HbA1	HbA1c.

17. WAS TOTAL CHOLESTEROL (TC) MEASURED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient's total cholesterol was measured during the review period. If no tests were performed, skip to question 18. Otherwise, record the value of the patient's total cholesterol last measured during the review period and indicate the date.

Regarding unit of measure: record test values as "mg/dl".
Reference Total Cholesterol values can range from (80-600 mg/dl).

18. WERE TRIGLYCERIDES (TG) MEASURED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had their triglyceride level measured during the review period. If no tests were performed, skip to question 19. Otherwise, record the triglyceride value last measured during the review period and indicate the date.

Regarding unit of measure: record test values as "mg/dl".
Reference Triglyceride values can range from (40-5000) mg/dl and occasionally higher.

19. WAS HDL CHOLESTEROL MEASURED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient's HDL was measured during the review period. If no tests were performed, skip to question 20. Otherwise, record the value of the patient's HDL last measured during the review period and indicate the date.

Regarding unit of measure: record test values as "mg/dl".
Reference HDL cholesterol values can range from (20-150 mg/dl).

20. WAS LDL CHOLESTEROL MEASURED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient's LDL was measured or calculated during the review period. If no tests were performed, skip to question 21. Otherwise, record the patient's last LDL value during the review period and indicate the date.

Regarding unit of measure: record test values as "mg/dl".
Reference LDL cholesterol values can range from (20-300 mg/dl).

21. WAS SERUM CREATININE MEASURED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient's serum creatinine level was measured during the review period. Do not record urine creatinine values. If no tests were performed, skip to question 22. Otherwise, record the serum creatinine value last measured during the review period and indicate the date.

Regarding unit of measure: record test values as "mg/dl". Reference Serum Creatinine values range from (0.4 - 15 mg/dl).

22. WAS A DIPSTICK URINALYSIS PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had a dipstick urinalysis during the review period. If no tests were performed, skip to question 23. Otherwise, check only one response to indicate the result of the last protein value measured and record the date of that test. Regarding dipstick results, any comment or notation such as "urine protein OK", "negative", "-", or "zero" should be interpreted as "0 mg/dl". If a dipstick reading is recorded as "urine protein positive", check "1+". If a dipstick reading is recorded as "4+", check "3+".

Negative may be recorded as 0 mg/dl

Trace may be recorded as 15 mg/dl

1+ may be recorded as 30 mg/dl

2+ may be recorded as 100 mg/dl

3+ may be recorded as 500 mg/dl

23. WAS A MICROALBUMINURIA OR QUANTITATIVE URINE PROTEIN TEST PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had at least one of the four listed urine microalbuminuria or quantitative urine protein tests. Do not include serum albumin tests. If no tests were performed during the review period, skip to question 24. If the comment "microalbumin positive" appears in a visit note, check "Yes" to item # 6 (History of Microalbuminuria) but do not record a result in this section based on that comment. If "Yes" to question 23:

a. Check "Yes" for each test in the list below that was performed during the review period. Check "No" if there is no record of the listed test being performed. Indicate "Yes" or "No" for all four items:

- a1. Urine Microalbumin/Creatinine ratio
- a2. Urine Protein/Creatinine ratio
- a3. Urine Microalbumin (without Creatinine)
- a4. Quantitative Urine Protein (without Creatinine)

b. Record the last value during the review period for the first test appearing on the list above that is checked "Yes" and indicate the unit of measure and date of that test. For this item, the order of the list takes precedence over the date of the test. For example, if two tests were performed during the review period, one a Urine Microalbumin/Creatinine ratio and the other a Urine Protein/Creatinine ratio, record the Urine Microalbumin/Creatinine ratio value regardless of which of these two tests was performed last.

Regarding unit of measure, indicate units by checking the appropriate boxes in the numerator and denominator columns; check one box in each column. Urine Microalbumin/Creatinine ratio values are often recorded as "mg/g". Urine Protein/Creatinine ratio values often have no unit of measure. Urine Microalbumin values are often recorded as "ug/ml". Quantitative Urine Protein values are often recorded as "g/24hr.

NUMERATOR

- 1 grams or grams creatinine(g)
- 2 milligrams or milligrams creatinine (mg)
- 3 micrograms or micrograms creatinine (ug or mcg)
- 4 "NO UNIT"

DENOMINATOR

- 1 grams (g)
- 2 milligrams (mg)
- 3 micrograms (ug or mcg)
- 4 "NO UNIT"
- 5 milliliters (ml)
- 6 deciliters (dl)
- 7 liters (l)
- 8 TV or TUV
- 9 24 (i.e., "24 hr.")

24. WAS AN EKG PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had an electrocardiogram (EKG or ECG) during the review period. If no test was performed, skip to question 25. Otherwise, record the date of the last EKG during the review period. Include EKG tests performed as a component of a cardiac stress test. See item #25 below for additional information regarding cardiac stress tests. Abstractors should assume that all cardiac stress tests include an EKG.

25. WAS A CARDIAC STRESS TEST PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if an exercise stress test, pharmacologic stress test, nuclear medicine stress test, or echocardiographic stress test was performed during the review period. If "No", skip to question 26.

If "Yes":

- a. Record the date of the last cardiac stress test performed during the review period.
- b. Check the appropriate box to indicate whether the last test included exercise or pharmacologic stress. Check only one box. Exercise may be noted as treadmill or bicycle. Pharmacologic stress may be noted as Persantine/dipyridamole, adenosine, or dobutamine. If the medical records document a cardiac stress test without indicating type of stress (e.g., "Stress EKG negative"), check the "UTD" box.
- c. Check the appropriate box to indicate whether the last stress test included EKG only, EKG and radioisotope imaging, or EKG and echocardiogram. Check only one box. Abstractors should assume that all cardiac stress tests include an EKG. For example, check "EKG and echo" if the only cardiac stress test documentation is the comment "dobutamine echo completed today". Check "EKG and radioisotope imaging" if the last cardiac stress test documentation denotes any of the following:
 - nuclear myocardial perfusion imaging
 - thallium scan
 - technetium Sestamibi (MIBI) scan
 - Cardiolite
 - Myoview
 - SPECT thallium Scan
 - MUGA (multiple gated acquisition) scan
 - ERNA (equilibrium gated radionuclide angiography)
 - RNA (radionuclide angiography)
 - RVG (radionuclide ventriculography)
 - gated blood pool scan
 - SPECT (single-photon computed tomography) scan.

Check "EKG only" if documentation of the last cardiac stress test does not indicate either radioisotope imaging or echocardiogram.

26. WAS A FOOT EXAM PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had a foot exam performed by any health care practitioner or technician during the review period. Include foot exams taking place in any setting (outpatient, emergency room, or inpatient). If no exams were performed, skip to question 27. Exclude range of motion (ROM) exams; patient self-report of foot condition; documentation of general extremity or lower extremity exam without mention of the foot; comments such as "1+, 2+ edema" without mention of location, and comments such as "no clubbing, cyanosis, or edema (CCE)". Examples of acceptable foot examination notation include:

Visual Inspection:

Feet WNL (within normal limits)
 Smooth atrophic skin
 Nail abnormalities /
 onchomycosis
 Toe nail clipping
 Fissuring
 Callus
 Blisters
 Dry skin
 Athlete's foot or tinea pedis
 Macerated skin
 Foot lesions
 Cyanosis of the toes/feet
 Edema of the feet
 Pedal edema
 Skin exam of foot
 Capillary refill
 Dependent rubor
 Deformities
 Claw toe deformity
 Prominent metatarsal heads
 Other structural changes in the
 foot

Sensory Examination:

Impaired sensation
 Tuning fork
 Monofilament
 Babinski (toes downgoing / toes
 upgoing)
 Impaired vibration sensation
 "Intact to touch"
 Temperature sensation
 Light touch
 Pin prick
 Sensation in feet

Vascular Examination

Doppler check
 Dorsalis pedis (DP)
 Posterior tibialis (PT)
 Pedal pulse
 Pulses of feet
 Noninvasive vascular testing of
 feet
 Circulation in feet
 Temperature of feet
 Ankle BP/arm BP ratio
 Ankle/Brachial Index (ABI)

If one or more foot exams were performed during the review period:

- a) Record the date of the last foot exam.
- b) Check the appropriate box to indicate the total number of foot exams performed during the review period.
- c) Specify the exam components performed during the review period and the result of the last exam for each type. For c1-c4, check "Yes" if there is documentation indicating that the particular exam component was performed, otherwise check "No".

Note: c1. *Visual inspection of the feet*
 c2. *10 gram Monofilament test*

 c3. *Sensory examination other than monofilament*
 c4. *Vascular examination.*

For each type of exam component checked "Yes", indicate the result of the last exam component of that type by checking "Normal", "Abnormal", or "UTD" (if result is not documented). For each exam component that was not performed, leave the test result item blank.

For monofilament tests performed, check "Yes" to c2 even if the records do not specify "10 gram monofilament". If "Yes" to c2, indicate the date of the last foot exam that included a monofilament test.

For c5 (Unable to determine type of exam), check "Yes" if there were one or more foot exams of unspecified type during the review period, otherwise check "No". If "Yes", record the result of the last undetermined type exam in c5a.

Note: any documented abnormalities constitute an abnormal result. These include notation of calluses, lesions, deformities, infection, ulcers, amputation, nail changes, onchomycosis, fissuring, blisters, athlete's foot, tinea pedis, Babinski upgoing, cyanosis of the toes or feet, pedal edema, dependent rubor, prominent metatarsal heads, dry, peeling, atrophic, or macerated skin, or other abnormality. Abnormal results may be recorded "Abnormal", "Diminished" or "Absent". Normal results may be recorded as "Normal", "Present", "Feet are OK", or "Feet are within normal limits".

27. WERE ONE OR MORE DIABETIC FOOT ULCERS PRESENT DURING THE REVIEW PERIOD? Check "Yes" if the review period records document the presence of a diabetic foot ulcer (note: the records must specify foot ulcer; do not include notation of blisters, calluses, or "red spots"). Otherwise, check "No".

If "No", skip to question 28.

If "Yes":

- a. Check "Yes" if the records reviewed indicate that a new diabetic foot ulcer was diagnosed during the review period. Check "No" if the records reviewed give no suggestion of a new diabetic foot ulcer during the review period; check "UTD" if the records reviewed are unclear (for example, if a foot ulcer is mentioned only at the first foot exam with no indication whether the ulcer appeared before or after the start of the review period).

Note: a foot ulcer recurrence at the location of a fully healed ulcer should be considered a new ulcer.

28. WERE ANY LOWER EXTREMITY AMPUTATIONS PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had any lower extremity amputations during the review period. If "No", skip to question 29.

If "Yes", record the month and year of the first amputation and check "Yes" or "No" to **each specific procedure**. For example, if the only lower extremity amputation procedure during the review period was a left AKA, record the month and year of this event, check "No" to 28a through 28g, check and "Yes" to 28h.

- | | |
|-------------------------------|------------------------------|
| a. Right toe or toes | e. Left toe or toes |
| b. Right forefoot | f. Left forefoot |
| c. Right leg below knee (BKA) | g. Left leg below knee (BKA) |
| d. Right leg above knee (AKA) | h. Left leg above knee (AKA) |

29. WAS A DILATED EYE EXAM PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate if the patient had a dilated eye exam during the review period. If no dilated exams were performed, go to question 30. All diabetic retinal exams performed by ophthalmologists should be considered a dilated exam. Exams performed for other indications (e.g., glaucoma, injury, foreign bodies, or herpes keratitis) should be counted only when the medical record explicitly indicates a dilated eye exam. Similarly, exams performed by a PCP or optometrist should be counted only when a dilated eye exam is explicitly indicated.

Note: in dilated exams, drops are put in the patient's eyes to increase pupil diameter. Dilated eye exams may be abbreviated Dil, DL, DI, or DFE.

If one or more dilated eye exams were performed during the review period:

- a) Record the date of the last dilated eye exam.
- b) Record the total number of dilated eye exams performed.
- c) Indicate the person(s) who performed the exam(s), i.e., if appropriate, check "Yes" to #29c1, #29c2, and/or #29c3. If the records document a dilated eye exam for which the type of professional is not documented, check "Yes" for UTD (i.e., #29c4).
 - c₁. Ophthalmologist: physician (MD or DO) who specializes in the diagnosis, medical, and surgical treatment of diseases of the eye.
 - c₂. Optometrist: person trained to practice primary eye and vision care (OD) for the diagnosis and prevention of associated disorders; not a physician, does not perform surgery.
 - c₃. PCP: primary care physician (MD).
 - c₄. Unable to Determine: Check "Yes" if the patient had one or more dilated eye exams for which the type of professional performing the exam is not specified in the medical records; otherwise, check "No". Note: if this item is checked "Yes", do not check "No" for #29c1, #29c2, or #29c3.

30. WERE RETINAL PHOTOS SUBMITTED TO AN EYE CARE PROFESSIONAL DURING THE REVIEW PERIOD? Check "Yes" if the medical records document that retinal or fundus photos were taken and submitted to an eye care professional during the review period; otherwise check "No". If "No" skip to question 31. If "Yes", record the date of the most recently taken retinal photos submitted during the review period.

31. WHAT IS THE RETINOPATHY STATUS? Check one box to indicate the most severe condition noted in the medical records. Note: items 31a. through 31e. are listed in increasing order of severity.

- a. No retinopathy. *Check this box only if the review period records indicate that the patient has no retinopathy. If retinopathy status is not documented in the review period records, check box "f" rather than box "a".*
- b. Diabetic Retinopathy noted, level not specified - report of diabetic retinopathy, however severity of condition not reported. Does not include macular degeneration without mention of retinopathy.
- c. Non-proliferative Diabetic Retinopathy (NPDR) or background diabetic retinopathy (BDR). Includes IRMA (intraretinal microvascular abnormalities).
- d. Macular Edema or Clinically Significant Macular Edema (ME or CSME).
- e. Proliferative Diabetic Retinopathy (PDR). Includes NVD or NVE, vitreous hemorrhages, retinitis proliferans, fibrous proliferans, and PDR with High Risk Characteristics (HRC).
- f. UTD- check this box if there is no record of retinopathy status or if the appropriate status category cannot be ascertained.

32. WAS RETINAL LASER TREATMENT PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had eye laser treatment/surgery for proliferative retinopathy or macular edema during the review period. If "No", skip to question 33. Note: retinal laser treatment includes "panretinal photocoagulation" and "focal photocoagulation" but does not include LASIK therapy for refractive error, laser trabeculoplasty for glaucoma, or YAG laser for cataract.

33. TRANSIENT ISCHEMIC ATTACK (TIA) DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the records reviewed document that the patient had one or more transient ischemic attacks during the review period. If "No", skip to question 34. Note: TIAs may be recorded as a "mini" or "mild" strokes with no permanent damage. If "Yes", record the number of TIAs during the review period and corresponding event dates (if known) beginning with the date of the first TIA during the review period.

34. CEREBRAL VASCULAR EVENT (CVA) DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the records reviewed document that the patient had one or more cerebral vascular accidents during the review period. If "No", skip to question 35. Note: Cerebral Vascular Accident (CVA) may be recorded as a stroke. If "Yes", record the number of CVAs during the review period and corresponding event dates (if known) beginning with the date of the first CVA during the review period.

35. MYOCARDIAL INFARCTION (MI) DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the records reviewed document that the patient had one or more myocardial infarctions during the review period. If "No", skip to question 36. Note: Myocardial Infarction (MI) may be recorded as heart attack or AMI. If "Yes", record the number of MIs during the review period and corresponding event dates (if known) beginning with the date of the first MI during the review period. Record date of MI diagnosis in the corresponding event field for an MI occurring during the follow-up review period for which the event date is not documented (as might be the case for a silent MI). If it is possible that an MI diagnosis date refers to a review period MI recorded in one of the previous event date fields, do not record the diagnosis date and do not "double count" this MI.

36. CATASTROPHIC HYPOGLYCEMIA DURING THE REVIEW PERIOD? Check "Yes" if the review period records document that the patient had a hypoglycemic event during the review period in conjunction with one or more of the following events: death, neurological insult requiring hospitalization, myocardial infarction, injury to the patient requiring hospitalization, or injury to the another person requiring hospitalization. Otherwise, check "No". If "No", go to question 37. If "Yes", indicate the total number of events and the month and year of the first event during the review period.

Note: Abstractors should accept any of the following as documentation of hypoglycemia: blood glucose less than 50 mg/dl; one or more manifestations of severe hypoglycemia (e.g., confusion, irrational or uncontrollable behavior, convulsions or coma reversed by oral carbohydrates, subcutaneous glucagon or intravenous glucose); and prodromal symptoms such as sweating, palpitation, anxiety, hunger or blurred vision remembered by the patient as occurring shortly before the event occurred. Hypoglycemic events may also be denoted as "insulin shock" or "insulin reaction". Intravenous glucose may be noted as "IV Dextrose" or "D-50".

37. WAS CAROTID ENDARTERECTOMY PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had carotid endarterectomy surgery during the review period. If "No", skip to question 38. If "Yes", record the total number of occasions this procedure was performed during the review period and the month and year of the first procedure during the review period.

38. WAS CORONARY ANGIOPLASTY PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had coronary angioplasty treatment/surgery during the review period. If "No", skip to question 39. If "Yes", record the total number of occasions this procedure was performed during the review period and the month and year of the first procedure during the review period.

39. WAS A CORONARY BYPASS (CABG) PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had coronary bypass (CABG) surgery during the review period. If "No", skip to question 40. If "Yes", record the total number of occasions this procedure was performed during the review period and the month and year of the first procedure during the review period. Note: count distinct operative procedures, for example, a three-vessel coronary artery bypass performed during a single operative procedure counts as 1 event.

40. WAS PERIPHERAL VASCULAR ANGIOPLASTY OR BYPASS PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had peripheral vascular angioplasty or peripheral vascular bypass surgery during the review period. If "No", skip to question 41. If "Yes", record the total number of occasions this procedure was performed during the review period and the month and year of the first procedure during the review period.

41. WAS DIALYSIS INITIATED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether peritoneal dialysis or hemodialysis was initiated during the review period (includes HD, PD, CAPD and CCPD). If "No", skip to question 42. If "Yes", record the month and year of the first initiation during the review period.

42. WAS A KIDNEY TRANSPLANT PERFORMED DURING THE REVIEW PERIOD? Check "Yes" or "No" to indicate whether the patient had kidney transplant surgery during the review period. If "No", skip to question 43. If "Yes", record the total number of times a kidney transplant was performed during the review period and the month and year of the first transplant during the review period.

43. CURRENT MEDICATIONS: Check "Yes" if any drugs on the numbered list on pages 13-16 of the instrument were taken or prescribed during the review period and were not discontinued or stopped prior to the end of this period; otherwise check "No". If "Yes", record the number of all such "current" medications in the spaces provided on page 11 of the instrument.

Do not include "Aspirin" if documentation indicates that aspirin was not used at least three times per week or was not prescribed for use at least three times per week (for example, do not include if documented as "ASA prn", "as needed", or "for pain"). Medication list item #19 (aspirin) includes ASA, ECA (enteric coated aspirin), acetylsalicylic acid, or any product containing aspirin. An extensive list of products containing aspirin appears on page 19 of this document.

When recording medication numbers on the Chart Review instrument, the abstractor may indicate either the brand name or its generic equivalent. It is not necessary to record both. Note that in the alphabetic list, the generic equivalent appears in parentheses after each brand name drug, e.g., "#287-Zestril (lisinopril)". Abstractors encountering mention of a stopped or discontinued prescription should make note of the corresponding generic (or trade name) equivalents. For example, if Zestril is prescribed but a later medical note (within the review period) states that lisinopril was discontinued, the abstractor should not list either as a current medication (unless the drug is restarted again at a later date within the review period).

Regarding insulin use, if L, N, R, U, Lente, Regular, NPH, or Ultralente are documented as a current medication but not otherwise specified, code as the appropriate Humulin insulin as noted below:

- L or Lente = code #126 Humulin L
- N = code #127 Humulin N
- NPH = code #128 Humulin NPH
- R or Regular = code #129 Humulin R
- U or Ultralente = code #130 Humulin U (Ultralente).

All drug names listed on the instrument are shown by category, beginning on page 17 of this document. Trade names are capitalized, generics are in lower case, and category headings are capitalized. Please note that the medication list on the chart instrument is sorted alphabetically.

TRIAD Follow-Up Chart Review Medication Categories

ANTIDIABETIC AGENTS

BIGUANIDES
GLUCOSIDASE INHIBITORS
INSULINS
MEGLITINIDES
SULFONYLUREAS
THIAZOLIDINEDIONES
MICELLANEOUS ANTIDIABETIC AGENTS

ANTILIPEMIC AGENTS

BILE ACID SEQUESTRANTS
FIBRIC ACID DERIVATIVES
HMG-CoA REDUCTASE INHIBITORS
NICOTINIC ACID

OTHER CARDIOVASCULAR AGENTS

ADRENERGIC BLOCKERS,
PERIPHERAL & COMBINATIONS

ADRENERGIC STIMULANTS
CENTRAL & COMBINATIONS
ALPHA/BETA ADRENERGIC BLOCKERS
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS WITH CALCIUM CHANNEL BLOCKERS
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS WITH DIURETICS
ANGIOTENSIN II RECEPTOR ANTAGONISTS
ANGIOTENSIN II RECEPTOR ANTAGONISTS WITH DIURETICS
BETA ADRENERGIC BLOCKING AGENTS
BETA ADRENERGIC BLOCKING AGENTS WITH DIURETICS

CALCIUM CHANNEL BLOCKERS
COMBINATION DIURETICS
LOOP DIURETICS
POTASSIUM-SPARING DIURETICS
THIAZIDES & RELATED DIURETICS
RAUWOLFIA DERIVATIVES & COMBINATIONS

ANTIDEPRESSANTS

MICELLANEOUS ANTIDEPRESSANTS
SELECTIVE SEROTONIN REUPTAKE INHIBITORS

ANTIPSYCHOTIC AGENTS

MICELLANEOUS ANTIPSYCHOTIC AGENTS

OTHER

ASPIRIN (or any product containing aspirin)

44. DO THE MEDICAL RECORDS INDICATE THAT ONE OR MORE HOSPITALIZATIONS, EMERGENCY ROOM VISITS, OR URGENT CARE VISITS DURING THE REVIEW PERIOD INCLUDED TREATMENT OR EVALUATION OF TIA, STROKE, OR MI? Check "Yes" or "No". If "No", skip to question 45. If "Yes", notify the project coordinator immediately upon completion of this chart review.

Note: items 45-48 are not limited to the follow-up review period interval.

45. IS IT INDICATED ANYWHERE IN THE MEDICAL RECORDS (BEFORE, DURING, OR AFTER THE REVIEW PERIOD) THAT THIS PATIENT IS DECEASED? Check "Yes" or "No". If "Yes", complete items 46, 47, and 48 and inform the project coordinator immediately upon completion of this chart review. Provide the coordinator with date, cause, and place of death as noted anywhere in the patient's medical record.

46. DATE OF DEATH: date of death as noted in the medical records.

47. CAUSE OF DEATH: cause of death as noted in the medical records.

48. PLACE OF DEATH: location of death as noted in the medical records.

APPENDIX:

All Medications on the Follow-Up Chart Review Instrument, by Category

ANTIDIABETIC

AGENTS

BIGUANIDES
Glucophage
Glucophage XR
Glucovance
metformin
GLUCOSIDASE
INHIBITORS
acarbose
Glyset
miglitol
Precose
INSULIN
(INTERMEDIATE
ACTING INSULINS)
Humulin L
Humulin N
Humulin NPH
Iletin II, L (Lente)
Iletin II, NPH
Novolin L
Novolin N
Purified Pork Lente
Purified Pork NPH
Isophane
(INTERMEDIATE AND
RAPID ACTING INSULIN
COMBINATIONS)
Humalog 25/75
Humalog 75/25
Humulin 50/50
Humulin 70/30
Novolin 70/30
(LONG ACTING
INSULINS)
Humulin U (Ultralente)
insulin glargine
Lantus
(RAPID ACTING
INSULINS)
Humalog
Humulin R
Iletin II Regular
insulin aspart
insulin lispro
Novolin R
Novolog
Purified Pork R
Velosulin BR
MEGLITINIDES
Prandin
repaglinide
SULFONYLUREAS
acetohexamide
Amaryl
chlorpropamide
DiaBeta
Diabinese
Dymelor

glimeperide
glipizide
Glucotrol
Glucotrol XL
Glucovance
glyburide
Glycron
Glynase
Micronase
Orinase
tolazamide
tolbutamide
Tolinase
THIAZOLIDINEDIONES
Actos
Avandia
pioglitazone
Rezulin WITHDRAWN FROM
MARKET
rosiglitazone
troglitazone WITHDRAWN
FROM MARKET
MICELLANEOUS
ANTIDIABETIC AGENTS
nateglinide
Starlix

ANTILIPEMIC

AGENTS

BILE ACID
SEQUESTRANTS
cholestyramine
Cholestyramine Light
colesevelam
Colestid
colestipol
Locholest
Locholest Light
Prevalite
Questran
Questran Light
Welchol
FIBRIC ACID
DERIVATIVES
Atromid-S
clofibrate
fenofibrate
gemfibrozil
Lopid
Tricor
HMG-CoA REDUCTASE
INHIBITORS
atorvastatin
Baycol WITHDRAWN FROM
MARKET
cerivastatin WITHDRAWN
FROM MARKET
fluvastatin
Lescol
Lescol XL

Lipitor
lovastatin
Mevacor
Pravachol
pravastatin
simvastatin
Zocor
NICOTINIC ACID
B-3
Endur-Acin
Nia-bid
Niac
Niacels
niacin
Niacin SR
Niacor
Niaspan
Niaspan ER
Nico-400
Nicobid
Nicolar
Nicotinex
Slo-niacin
Vitamin B-3

OTHER CARDIOVASCULAR AGENTS

ADRENERGIC
BLOCKERS, PERIPHERAL
& COMBINATIONS
Cardura
Demi-Regroton
Dibenzylidine
Diupres
Diotensin-R
doxazosin
guanadrel
Hylorel
Hytrin
Minipress
Minizide
phenoxybenzamine
prazosin
terazosin

ADRENERGIC
STIMULANTS CENTRAL
& COMBINATIONS
Aldoclor
Aldomet
Aldoril
Catapres
Catapres-TTS
clonidine
Clorpres
Combipres
guanabenz
guanfacine
methyldopa
Tenex
Wytenzin
ALPHA/BETA
ANDRENERGIC
BLOCKERS
carvedilol
Coreg
labetalol
Normodyne
Trandate
ANGIOTENSIN
CONVERTING ENZYME
(ACE) INHIBITORS
Accupril
Aceon
Acea
Altace
benazepril
Capoten
captopril
enalapril
fosinopril
lisinopril
Lotensin
Mavik
moexipril
Monopril
perindopril
Prinivil
quinapril
ramipril
trandolapril
Univasc
Vasotec
Zestril
ANGIOTENSIN
COVERTING ENZYME
(ACE) INHIBITORS WITH
CALCIUM CHANNEL
BLOCKERS
Lexxel
Lotrel
Tarka
Teczem
***continued on
next page***

OTHER**CARDIOVASCULAR
AGENTS (continued)****ANGIOTENSIN
CONVERTING ENZYME
(ACE) INHIBITORS WITH
DIURETICS**

Accuretic
Capozide
Lotensin HCT
Monopril HCT
Prinzide
Uniretic
Vaseretic
Zestoretic
**ANGIOTENSIN II
RECEPTOR
ANTAGONISTS**
Atacand
Avapro
candesartan
Cozaar
Diovan
eprosartan
irbesartan
losartan
Micardis
telmisartan
Teveten
valsartan
**ANGIOTENSIN II
RECEPTOR
ANTAGONISTS WITH
DIURETICS**
Atacand HCT
Avalide
Diovan HCT
Hyzaar 100
Hyzaar 50
Micardis HCT
**BETA ADRENERGIC
BLOCKING AGENTS**
acebutolol
atenolol
Betapace
Betapace AF
betaxolol
bisoprolol
Blocardren
Brevibloc
carteolol
Cartrol
Corgard
esmolol
Inderal
Inderal LA
Kerlone
Levatol
Lopressor
metoprolol
nadolol
penbutolol

pindolol
propranolol
Sectral
sotalol
Tenormin
timolol
Toprol-XL
Visken
Zebeta
**BETA ADRENERGIC
BLOCKING AGENTS
WITH DIURETICS**
bendroflumethiazide
Corzide 40/5
Corzide 80/5
Inderide
Inderide LA
Lopressor HCT
Tenoretic
Timolide
Ziac
**CALCIUM CHANNEL
BLOCKERS**
Adalat
Adalat CC
amlodipine
bepridil
Calan
Calan SR
Cardene
Cardene SR
Cardizem CD
Cardizem SR
Cartia XT
Covera-HS
Dilacor XR
Diltia XT
diltiazem
Diltiazem CD
Diltiazem SR
Dynacirc
Dynacirc CR
felodipine
Isoptin
Isoptin SR
isradipine
nicardipine
nifedipine
Nifedipine CC
Nifedipine XL
nimodipine
Nimotop
nisoldipine
Norvasc
Plendil
Procardia
Procardia XL
Sular
Tiamate
Tiazac
Vascor
verapamil

Verapamil SR
Verelan
Verelan PM
**COMBINATION
DIURETICS**
Aldactazide
Apresazide
Dyazide
Hydra-zide
Maxzide
Maxzide 25
Moduretic
Spironolactone Plus
LOOP DIURETICS
bumetanide
Bumex
Demadex
Edecrin
ethacrynic acid
Furocot
Furomide MD
furosemide
Lasix
Lo-Aqua
torsemide
**POTASSIUM-SPARING
DIURETICS**
Aldactone
amiloride
Dyrenium
Midamor
Spironol
spironolactone
triamterene
**THIAZIDES & RELATED
DIURETICS**
Aquatensen
Aquazide H
chlorothiazide
chlorthalidone
Diucardin
Diuril
Diuril Oral Suspension
Enduron
Esidrix
Ezide
Hydro-chlor
hydrochlorothiazide,
(HCTZ)
Hydrocot
Hydro-D
Hydrodiuril
hydroflumethiazide
Hydromox
Hygroton
indapamide
Lozol
Metahydrin
methyclothiazide
metolazone
Microzide
Mykrox

Naqua
Naturetin
Oretic
polythiazide
quinethazone
Renese
Saluron
Thalitone
Trichlorex
trichlormethiazide
Zaroxolyn
**RAUWOLFIA
DERIVATIVES &
COMBINATIONS**
Moderil
rescinamine
reserpine
Serpalan

ANTIDEPRESSANTS

**MICELLANEOUS
ANTIDEPRESSANTS**
bupropion
Effexor
Effexor XR
mirtazapine
nefazodone
Remeron
Serzone
venlafaxine
Wellbutrin
Wellbutrin SR
**SELECTIVE SEROTONIN
REUPTAKE INHIBITORS
(SSRI)**
Celexa
citalopram
fluoxetine
paroxetine
Paxil
Prozac
sertraline
Zoloft

**ANTIPSYCHOTIC
AGENTS**

**MICELLANEOUS
ANTIPSYCHOTIC
AGENTS**
Clozapine
clozaril
Geodon
olanzapine
quetiapine
Risperdal
risperidone
Seroquel
ziprasidone
Zyprexa
Zyprexa ZYDIS

OTHER: ASPIRIN (ASA)

Products containing Aspirin include:

<i>8-Hour Bayer Timed-Release Caplets</i>	<i>Bufferin</i>	<i>Laniroif</i>
<i>Acetasol</i>	<i>Buffets II</i>	<i>Lanorinal</i>
<i>Aceticyl</i>	<i>Buffex</i>	<i>Lortab ASA</i>
<i>Acetol</i>	<i>Butalbitol</i>	<i>Magnaprin</i>
<i>Acetophen</i>	<i>Cama Arthritis Pain Reliever</i>	<i>Maximum Pain Relief</i>
<i>Acetosalin</i>	<i>Carisoprodol</i>	<i>Miacrin Tablets</i>
<i>Acetylin</i>	<i>Cope</i>	<i>Micrainin</i>
<i>Acetysal</i>	<i>Damason-P</i>	<i>Momentum</i>
<i>Acuprin</i>	<i>Darvon Compound</i>	<i>Norgesic</i>
<i>Adprin-B</i>	<i>Easprin</i>	<i>Norgesic Forte</i>
<i>Alka-Seltzer Effervescent Pain</i>	<i>Ecotrin</i>	<i>Norwich Aspirin</i>
<i>Alka-Seltzer with Aspirin</i>	<i>Emagrin</i>	<i>Orphengesic</i>
<i>Alor 5/500</i>	<i>Empirin</i>	<i>P-A-C Analgesic</i>
<i>Anacin</i>	<i>Endodan</i>	<i>Pamprin</i>
<i>Anacin Maximum Strength</i>	<i>Equagesic Tablets</i>	<i>Panasal</i>
<i>Anodynos</i>	<i>Excedrin</i>	<i>PC-CAP</i>
<i>Arthritis Foundation Pain Reliever</i>	<i>Extra Strength Adprin-B</i>	<i>Percodan</i>
<i>Arthritis Pain Ascriptin</i>	<i>Extra Strength Bayer</i>	<i>Percodan-Demi</i>
<i>Arthritis strength BC</i>	<i>Farbital</i>	<i>Propoxyphene</i>
<i>Ascriptin</i>	<i>Fiorinal</i>	<i>Regiprin</i>
<i>Ascriptin A/D</i>	<i>Fiormor</i>	<i>Robaxisal</i>
<i>Aspercine</i>	<i>Fiortal</i>	<i>Roxiprin</i>
<i>Aspergum</i>	<i>Fortabs</i>	<i>Saletin</i>
<i>Aspermin</i>	<i>Gelprin</i>	<i>Saleto</i>
<i>Aspirin</i>	<i>Gemnisyn</i>	<i>Sloprin</i>
<i>Aspirin-B</i>	<i>Genacote</i>	<i>Soma Compound</i>
<i>Asprimox</i>	<i>Genprin</i>	<i>Stanback Original Formula</i>
<i>Axotal</i>	<i>Gensan</i>	<i>Supac</i>
<i>Azdone</i>	<i>Goody's Headache Powders</i>	<i>Synalgos-DC</i>
<i>Back-Quell</i>	<i>Halfprin</i>	<i>Talwin Compound</i>
<i>BC Powder</i>	<i>Halfprin 8.1</i>	<i>Ursinus Inlay-Tabs</i>
<i>Buffaprin</i>	<i>Heartline</i>	<i>Vanquish</i>
<i>Buffasal</i>	<i>Idenal</i>	<i>ZORprin.</i>
	<i>Isollyl Improved</i>	