



British Women's Heart and Health Study



Name:

Date of birth:

Address:

NHS Number:

Practice ID:

Postcode:

Please attach a photocopy of the hospital letter or discharge summary
Or fill in this whole form, for the event on this date

Heart Failure Validation Form

1.1 Date of diagnosis: «Irr_source_derived_date_event»

2.1 Has an echocardiogram (cardiac ultrasound) been performed? Yes 1
No 2

3.1 If yes, did it show a diminished left ventricular ejection fraction? Yes 1
No 2

4.1 Left ventricular ejection fraction (if available) _____ %

Were any of the following investigations used to make the diagnosis of heart failure, please indicate which by ticking Yes or No:-

		Yes	No
5.1	ECG	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.2	Good response to diuretic treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.3	chest X-ray	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.4	radionuclide scan	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.5	cardiac catheterization	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.6	naturetic peptides	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5.7	other (please give details) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2

6.1 Cause of heart failure: Please write the cause of heart failure below if known - if not known please write 'Not Known'

7.1 Was she admitted to hospital? Yes 1
No 2

8.1 If Yes, which hospital _____

9.1 Do you have a hospital letter confirming a diagnosis of heart failure? Yes 1
No 2

10.1 Comments:

Reviewers Name:Date:/...../.....

Study ID:

Please return to:
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