British Women's Heart and Health Study

Name:

Address:

Date of birth:

NHS Number:

Postcode:

Practice ID:

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

Unstable Angina Validation Form

1.1 Date of event ☐ «w1rr_source_derived_date_event»

1.2 Did she have prolonged chest pain lasting at least half an hour?
Yes ☐1
No ☐2
Uncertain ☐3

1.3 If not, how did she present?

.....

2.1 Did she have an ECG:
Yes, evidence of ST segment changes ☐1
Yes, no evidence of ST segment changes ☐2
No ECG done ☐3

3.1 Did she have routine cardiac enzyme levels measured?
Yes, raised ☐1
Yes, normal ☐2
Not done ☐3

4.1 Did she have troponin enzyme levels measured?
Yes, raised ☐1
Yes, normal ☐2
Not done ☐3

5.1 Was she admitted to hospital?
Yes ☐1
No ☐2

6.1 If yes, which hospital .....

7.1 Do you have a hospital letter confirming a diagnosis of unstable angina?
Yes ☐1
No ☐2

8.1 Comments:

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

For Office Use Only:
BWHHS Record Review Round 6
Version 1

Study ID:

Please return to:
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