

VALIDATION FORM: HEART ATTACK / MI / ACUTE CORONARY SYNDROME

Study No:	
Name:	
Address:	
DOB:	
NHS:	

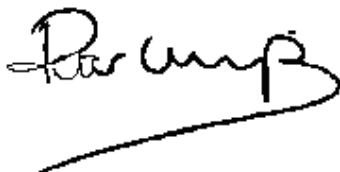
Dear Doctor,

Thank you for supplying information on the above patient who took part in the British Regional Heart Study. We note that he has had a major IHD event recently and would be most grateful if you could complete the following brief enquiry to provide documentation for our record, **OR send us a photocopy of the hospital letter or discharge summary.** This information is critical for the validation of our case criteria.

Re: Myocardial Infarction	Date of event: _____
	Yes No
1. Did he have prolonged chest pain lasting at least half an hour? If not, how did he present?	<input type="checkbox"/> <input type="checkbox"/>
2. Did he have an ECG? If yes, what was the result?	<input type="checkbox"/> <input type="checkbox"/>
3. Did he have cardiac enzyme levels measured? If yes - what were these results?	<input type="checkbox"/> <input type="checkbox"/>
4. Did he have troponin levels measured? If yes - what were the results?	<input type="checkbox"/> <input type="checkbox"/>

We are extremely grateful for the co-operation we have received from so many GPs and hope to provide valuable information for the treatment and prevention of IHD in the future.

Yours sincerely



Prof Peter H Whincup
Professor of Cardiovascular Epidemiology

VALIDATION FORM: STROKE

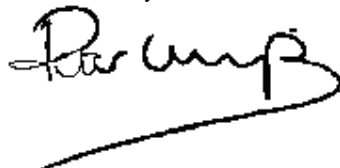
Study No:	
Name:	
Address:	
DOB:	
NHS:	

Dear Doctor,
 Thank you for supplying information on the above patient who took part in the British Regional Heart Study. We note that he has had a major CVA event recently and would be most grateful if you could complete the following brief enquiry to provide documentation for our record, **OR send us a photocopy of the hospital letter or discharge summary.** This information is critical for the validation of our case criteria.

RE: STROKE	Date of Event _____
1. Did signs/symptoms last for longer than 24 hours?	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't Know <input type="checkbox"/> 3
2. Did he have definite hemiparesis or hemiplegia? (weakness affecting one side on the body)	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Don't Know <input type="checkbox"/> 3
2.1 If No, how did he present? _____	
3. Did he have a CT/MRI scan?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/>
3.1 If Yes, what was the CT/MRI Scan result?	
Ischaemic stroke	<input type="checkbox"/> 1
Haemorrhagic stroke	<input type="checkbox"/> 2
Normal scan	<input type="checkbox"/> 3
Other pathology, not a stroke	<input type="checkbox"/> 4
Results unavailable / Not known	<input type="checkbox"/> 5
4. What was the final diagnosis?	
Ischaemic stroke	<input type="checkbox"/> 1
Haemorrhagic stroke	<input type="checkbox"/> 2
Subarachnoid haemorrhage	<input type="checkbox"/> 3
Stroke of uncertain pathological type	<input type="checkbox"/> 4
Not a stroke at all	<input type="checkbox"/> 5
Possible stroke	<input type="checkbox"/> 6
Transient Ischaemic Attack	<input type="checkbox"/> 7
Aneurysm/ Arteriovenous malformation	<input type="checkbox"/> 8
Vascular Dementia	<input type="checkbox"/> 9
Chronic Cerebrovascular Disease	<input type="checkbox"/> 10
Subdural Haematoma	<input type="checkbox"/> 11
5. Was he admitted to hospital?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/>

We are extremely grateful for the co-operation we have received from so many GPs and hope to provide valuable information for the treatment and prevention of strokes in the future.

Yours sincerely



Prof Peter H Whincup
 Professor of cardiovascular Epidemiology

VALIDATION FORM: HEART FAILURE

Study No:	
Name:	
Address:	
DOB:	
NHS:	

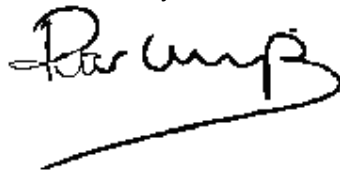
Dear Doctor,
Thank you for supplying information on the above patient who took part in the British Regional Heart Study. We are seeking further information about diagnoses of heart failure, particularly to take account of the results of investigations (particularly echocardiograms) performed. We note from our records that this patient has had a diagnosis of heart failure and would be most grateful if you could complete the enclosed brief enquiry to provide documentation for our records, **or send us a photocopy of the hospital letter or discharge summary.** This information is critical for the validation of our case criteria.

RE: Heart Failure	Date of Diagnosis: _____
	Yes No
1. Was an echocardiogram (cardiac ultrasound) performed?	<input type="checkbox"/> <input type="checkbox"/>
2. If yes, did it show a diminished left ventricular ejection fraction?	<input type="checkbox"/> <input type="checkbox"/>
3. Left ventricular ejection fraction (if available) _____ %	
4. If other factors were important in making the diagnosis of heart failure, please indicate which:- (please tick if important)	
Good response to diuretic treatment	<input type="checkbox"/>
Chest X-ray result	<input type="checkbox"/>
Radionuclide scan result	<input type="checkbox"/>
Cardiac catheterisation result	<input type="checkbox"/>
Other (please give details) _____	
5. Cause of heart failure Please write the cause of heart failure below if known - if not known please write 'not known'	

	Yes No
6. Is there a hospital diagnosis of heart failure?	<input type="checkbox"/> <input type="checkbox"/>

We are extremely grateful for the co-operation we have received from so many GPs and hope to provide valuable information for the treatment and prevention of cardiovascular disease in the future.

Yours sincerely



Prof Peter H Whincup
Professor of cardiovascular Epidemiology

VALIDATION FORM: DEEP VEIN THROMBOSIS and / or PULMONARY EMBOLISM

Study No:	
Name:	
Address:	
DOB:	
NHS:	

Dear Doctor,

Thank you for supplying information on the above patient who took part in the British Regional Heart Study. We are seeking further information about diagnoses of a Deep Vein Thrombosis and / or Pulmonary Embolism that have occurred since the re-examination 1998-2000, particularly to take account of the results of investigations performed.

We note from our records that this patient has had a diagnosis of Deep Vein Thrombosis and / or Pulmonary Embolism and would be most grateful if you could complete the enclosed brief enquiry to provide documentation for our records, **or send us a photocopy of the hospital letter or discharge summary.**

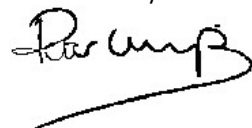
This information is will be very helpful for the validation of our case criteria.

RE: DEEP VEIN THROMBOSIS	Date of Diagnosis: _____
1 Was the deep venous thrombosis investigated by	Yes No
Duplex ultrasound scan	<input type="checkbox"/> <input type="checkbox"/>
Venogram	<input type="checkbox"/> <input type="checkbox"/>
D-dimer test	<input type="checkbox"/> <input type="checkbox"/>
2 Did the results of the test show evidence of DVT?	
Duplex ultrasound scan	<input type="checkbox"/> <input type="checkbox"/>
Venogram	<input type="checkbox"/> <input type="checkbox"/>
D-dimer test	<input type="checkbox"/> <input type="checkbox"/>
3 What was the D dimer result (if available) _____	

RE: PULMONARY EMBOLISM	Date of Diagnosis: _____
1 Was the Pulmonary Embolism investigated by	Yes No
Ventilation-perfusion scan	<input type="checkbox"/> <input type="checkbox"/>
CT scan	<input type="checkbox"/> <input type="checkbox"/>
Pulmonary angiogram	<input type="checkbox"/> <input type="checkbox"/>
D-dimer test	<input type="checkbox"/> <input type="checkbox"/>
2 Did the results of the test show evidence of PE?	
Ventilation-perfusion scan	<input type="checkbox"/> <input type="checkbox"/>
CT scan	<input type="checkbox"/> <input type="checkbox"/>
Pulmonary angiogram	<input type="checkbox"/> <input type="checkbox"/>
D-dimer test	<input type="checkbox"/> <input type="checkbox"/>
3. What was the D dimer result (if available) _____	

We are extremely grateful for the co-operation we have received from so many GPs and hope to provide valuable information for the treatment and prevention of cardiovascular disease in the future.

Yours sincerely



Prof Peter H Whincup
Professor of cardiovascular Epidemiology