



**This form is used to record CAD Performance Measures  
for the Quality Improvement and Incentive Program**

Physician Name:		CHS ID:	
Patient Name:		DOB:	
Insurance:		Member ID:	Patient inappropriate <input type="checkbox"/>

	<b>Most Recent</b>	<b>Ongoing Measurements to be recorded at each patient visit (2006 and Forward)</b>	
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**LDL: fasting performed at least on an annual basis Goal < 100, High risk pts with established CVD plus major risk such as diabetes, smoking, metabolic syndrome and acute coronary syndrome LDL ideal goal is < 70 \* very high risk HDL men ≥40mg/dL, women ≥ 50, Triglycerides < 150 mg/dL**

Most recent performed	_/_/_/____	_/_/_/____	_/_/_/____
Results			
Next most recent	_/_/_/____	_/_/_/____	_/_/_/____
Results			

**BP management : recommended at each visit: Treatment goal < 130/80**

Date Performed	_/_/_/____	_/_/_/____	_/_/_/____
Results			

**Smoking counseling: Recommended at each visit ( NS = nonsmoker)**

Date Performed	_/_/_/____	_/_/_/____	_/_/_/____
Results			

**Nutritional assessment and counseling: Recommended at each visit - Sodium restriction, Fluid restriction, limit alcohol consumption, decrease cholesterol, saturated and trans fats, increase fiber and omega 3 fatty acids**

Date Performed	_/_/_/____	_/_/_/____	_/_/_/____
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**Activity level assessment and counseling : recommended at each visit walking , jogging 3-4 times a week for 30-60 minutes plus increase in daily lifestyle ( gardening)**

Date Performed	_/_/_/____	_/_/_/____	_/_/_/____
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**Statin Therapy: recommended for patients with established CAD**

**ASA therapy : one daily ( 81-162mg) unless contraindicated ( ie. allergy, GI disorders, intracranial bleed)- may be on other anti-platelet therapy that will negate use of ASA. On ASA therapy, \_\_\_yes\_\_\_no, contraindicated reason \_\_\_\_\_ or on other form of anti platelet therapy \_\_\_\_\_**

**Beta Blocker Therapy: Recommended for all patients with previous MI or relief from angina ( for angina , if beta blocker is contraindicated, order Nitrate) On beta blocker \_\_\_yes\_\_\_no, contraindicated reason \_\_\_\_\_**

Pt. and Clinician Jointly Set Goals	_/_/_/____	_/_/_/____	_/_/_/____
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- ❖ Please rate patient compliance with treatment plan (circle):    Excellent    Very Good    Good    Fair    Poor
- ❖ Would this patient benefit from a Disease Management program for CAD::     Yes     No

*Reference: 13th edition, ICSI stable coronary artery disease guidelines web accessed 8/27/09*  
 • 10<sup>th</sup> edition, ICSI Lipid Management in Adults guidelines web accessed 1/27/09