



TRICUSPID ATRESIA (TA) STUDY



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PATIENT ENROLLMENT FORM

Unique Subject Screening Number: _____

OVERALL GOALS & OBJECTIVES

- To assemble a multi-institutional inception cohort of patients with Tricuspid Atresia and normally related great arteries
- To determine the impact of patient characteristics and management algorithms on outcomes for infants with Tricuspid Atresia and normally related great arteries
- To determine the overall Functional Health Status (FHS) and Quality of Life (QOL) of patients with Tricuspid Atresia and normally related great arteries

INCLUSION CRITERIA

Check as applicable:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diagnosis of tricuspid atresia with normally related great arteries |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Age < 3 months at time of diagnosis |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Admitted to a CHSS institution on or after January 1, 1999; i.e. Date of Birth on or after October 1, 1998 |

Must **MEET** all inclusion criteria (must all be **YES**)

EXCLUSION CRITERIA

Check as applicable:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Patients with atrioventricular (AV) or ventriculoarterial (VA) discordance |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | First intervention at non-CHSS institution |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Age > 3 months at time of diagnosis; i.e. Date of Birth before October 1, 1998 |

Must **NOT** meet any exclusion criteria (must all be **NO**)

REQUIRED DOCUMENTS

Please check off all documents attached:

- | | |
|---|--|
| <input type="checkbox"/> Copy of signed consent and authorization (as applicable)
(otherwise explain: _____) | <input type="checkbox"/> ALL Cardiac operative report(s) |
| <input type="checkbox"/> Admission slip or equivalent for demographic information | <input type="checkbox"/> ALL Discharge summaries |
| <input type="checkbox"/> Admission history and physical (to include height, weight,
oxygen saturation, signs and symptoms) | <input type="checkbox"/> ALL Cardiac clinic letters |
| <input type="checkbox"/> ALL Cath report(s) (diagnostic and/or interventional) | <input type="checkbox"/> MRI (if performed) |
| <input type="checkbox"/> ALL Echo report(s) (include any TEE) | <input type="checkbox"/> Holter, exercise test |
| <input type="checkbox"/> Any subsequent hospital admission (admit history and reports) | <input type="checkbox"/> Nuclear Medicine (MUGA, lung perfusion scans) |
| | <input type="checkbox"/> Autopsy report / Death report (if applicable) |

Completed by: _____

Signature: _____

Date: _____