CONFIDENTIAL**

SINGAPORE MYOCARDIAL INFARCTION REGISTRY
National Registry of Diseases Office
Health Promotion Board
Level 5, 3 Second Hospital Avenue
Singapore 168937
Tel: (65) 64353089 / 3327 or E-mail: hpb_servicenrdo@hpb.gov.sg

ACUTE MYOCARDIAL INFARCTION NOTIFICATION FORM

Reg. No. ☐☐☐☐☐☐☐☐☐☐
Registry Use

E-Notification: www.moh.gov.sg

Sections coloured in red are NOT APPLICABLE for cases seen/died at EMD

SECTION 1: PATIENT'S PARTICULARS

Name of Patient (required if NRIC is not available): _____ | Residential Postal code: _____

NRIC/Passport No. / Foreign Identification No. (FIN)*_____ | Hospital Account Number : _____

Resident Status	**Gender**	**Date of Birth**	**Ethnic Group**
☐ Singapore Citizen ☐ Singapore PR ☐ Others _____	☐ Male ☐ Female	_____DD_____MM_____YYYY ☐ Estimated	☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian ☐ Others _____

SECTION 2: ADMISSION DATA

Date of admission:	_____	Transferred to:	_____
Date of Discharge:	_____	☐AOR _____	☐Non AOR

Admitting Hospital

☐ AH ☐ CGH ☐ KKH ☐ KTPH ☐ NHC ☐ NUH ☐ NTFGH
☐ SGH ☐ TTSH ☐ MEHN ☐ SKGH ☐ MAH ☐ RH ☐ Others: _____
☐ MEH ☐ GEH ☐ PEH

Transferred from other acute care or specialist hospital

☐ Yes, Specify Name of Hospital: _____
☐No

If Yes:
☐ Urgent Transfer Without Admission
☐ Urgent Transfer After Admission

Arrival at EMD Date: _____ ☐ N.A

☐ Reg Time:_____ ☐AFT 12MN ☐N.A	☐ Triage Time:_____ ☐AFT 12MN ☐N.A	☐ Amb Time:_____ ☐AFT 12MN ☐N.A	ECG TRANS: ☐Yes ☐No ☐N.A

Onset of Symptoms: Date:_____ Time: _____ ☐ Unknown

Presenting Symptoms/Signs:

☐ Chest Pain ☐ Breathlessness ☐ Diaphoresis ☐ Syncope ☐ Back Pain ☐ Epigastric Pain
☐ Jaw Pain ☐ Shoulder Pain ☐ ECG Changes ☐ Elevated Cardiac Enzymes ☐ Others:_____

Symptoms:
☐ Typical
☐ Atypical
☐ Others
☐ None
☐ Typical (Inadequately Described)
☐ Insufficient Data

CPR in Ambulance: ☐ Yes ☐ No DC Shock : ☐ Yes
CPR in EMD: ☐ Yes ☐ No ☐ No

Only for EMD cases:
Brought in Dead: ☐ Yes ☐ No Died in EMD: ☐ Yes ☐ No

Heart Failure on EMD/Admission

☐ Killip Class 1
☐ Killip Class 2
☐ Killip Class 3
☐ Killip Class 4
☐ Unknown

Vital Signs on EMD/Admission

First HR : _____bpm ☐ Unknown

First Systolic / Diastolic BP :
_____/_____mmHg
☐ Unknown

Management of Patient after Onset of Event

☐ In Hospital
☐In Hospital/ On Clinical Trial:_____
☐ Medically Unattended
☐ In Nursing Home
☐ Other Medical Consultation, excluding hospitalisation, Home-care
☐ At Home by a doctor
☐ Insufficient Data

** THE INFORMATION IN THE FORM NEEDS TO BE KEPT CONFIDENTIAL AFTER THE FORM HAS BEEN FILLED.

SECTION 3: RISK FACTOR PROFILE

Smoking:

☐ Current smoker
☐ Ex-smoker
☐ Never
☐ Missing

If Smoker, Cessation advice given during this index admission:
☐ Yes
☐ No
☐ Unknown

Obesity

Height: ____m ☐ Unknown BMI: _____
Weight: ____ kg ☐ Unknown

Past History of :	**Hypertension:** ☐ Yes, not on treatment ☐ Yes, on non-pharmacological control ☐ Yes, on oral medication ☐ Yes, Unknown	☐ No	☐ Unknown
	Diabetes Mellitus: ☐ Yes, not on treatment ☐ Yes, on diet control ☐ Yes, on oral medication ☐ Yes, on Insulin ☐ Yes, on oral medication and insulin ☐ Yes, Unknown	☐ No	☐ Unknown
	Hyperlipidaemia: ☐ Yes, not on treatment ☐ Yes, on diet control ☐ Yes, on oral medication ☐ Yes, Unknown	☐ No	☐ Unknown
	AMI event: ☐ Yes, documented	☐ Yes, undocumented	☐ No
	CABG: ☐ Yes	☐ No	☐ Unknown
	PTCA/PCI: ☐ Yes	☐ No	☐ Unknown

Diagnosed during this Admission:	**Hypertension:**	**Diabetes Mellitus:**	**Hyperlipidaemia:**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 4: INVESTIGATION

Enzyme Tests Findings: ☐ Not Done

Date	CPK (U/L)	CKMB (MASS) (µg/L)	TropT T (µg/L)	TropT I (µg/L)

Enzyme Assessment

☐ Abnormal ☐ CPK (U/L) ☐ CKMB (MASS) (µg/L) ☐ Trop T (µg/L) ☐ Trop I (µg/L)
☐ Equivocal ☐ CPK (U/L) ☐ CKMB (MASS) (µg/L) ☐ Trop T (µg/L) ☐ Trop I (µg/L)
☐ Non-Specific
☐ Normal
☐ Incomplete
☐ Insufficient Data

	Random	Fasting				Not Done
Blood Sugar: _____mmol/L	☐	☐				☐
Total Cholesterol: _____mmol/L	☐	☐				☐
HDL Cholesterol: _____mmol/L	☐	☐				☐
LDL Cholesterol: _____mmol/L	☐	☐				☐
Triglyceride: _____mmol/L	☐	☐				☐
HbA1c: _____%						☐
Haemoglobin: _____ g/dL						☐
First Creatinine: _____ µmol/L Date : _____						☐
Highest Creatinine _____ µmol/L Date : _____						☐

Renal Impairment ☐ Pre-existing ☐ No ☐Unknown

SECTION 5: TREATMENT ☐ Yes ☐ No

☐ **STEMI:** **Reperfusion Therapy**: ☐ Yes

If Yes, Immediate:

Thrombolysis		
☐ Fibrinolytic Therapy: : _____		
Date: _____(dd/mm/yyyy) Time: _____ (hh/mm) Mins : _____	☐ Yes ☐No ☐ Unknown	
☐ Primary PTCA, First Device Date : _____ (dd/mm/yyyy)		
First Device Time : _____(hh/mm) Mins : _____	☐ Yes ☐No ☐ Unknown	
☐ Rescue PTCA (Failed Thrombolysis followed by PTCA)		
☐ Facilitated PTCA (Thrombolysis followed by immediate PTCA)	☐ No	
☐ Urgent CABG	☐ No	
Treatment Administrated: _____	☐ No	

If No Reperfusion Therapy, Reasons:

- ☐ Late Presentation
- ☐ Declined
- ☐ Contraindication
  - ☐ Previous Cerebrovascular Event, Intracranial Neoplasm, AVM Or Aneurysm
  - ☐ Active Bleeding
  - ☐ Conditions That Increase Bleeding Risk:

☐ Haemorrhagic Diasthesis	☐ Puncture Of Non-Compressible Vessel (<10 Days)
☐ Known Thrombocytopenia	☐ Systolic BP > 200mmhg Not Responding To Treatment
☐ Oral Anticoagulants (INR > 2)	☐ Organ Biopsy Or Major Surgery Or Trauma Within The Past 6 Weeks
☐ Prolonged CPR	☐ Peptic Ulcer Within Past 3 Months

☐ Reasons unknown _____

Subsequent (12 Hours)

CATH		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

PTCA		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

CABG		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

☐ **NSTEMI** ☐ **MI:** ☐**AMI** ☐**Type 1** ☐**Type 2** ☐**Type 3** ☐**Type 4A** ☐**Type 4 B** ☐**Type 5**

CATH		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

PTCA		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

CABG		
(Inp)	☐	Yes
	☐	No
(Plan)	☐	Yes
	☐	No

Stent Thrombosis ☐ Thrombosis of prior stent ☐ Acute stent thrombosis ☐ NA

SECTION 6: DRUG USED

Stat Dose On Admission/ Inpatient event onset within 24 hrs:	Aspirin:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Other Anti-Platelet Agents:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
Current Hospitalisation:	Aspirin:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Beta-Blockers:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	ACE Inhibitors/ ARB:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Lipid Lowering Therapy/ Statin:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Other Anti-Platelet Agents:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
At Discharge:	Aspirin:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Beta-Blockers:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	ACE Inhibitors/ ARB:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Lipid Lowering Therapy/ Statin:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown
	Other Anti-Platelet Agents:	☐ Yes	☐ No	If No, Contraindication:	☐ Yes	☐ No	☐ Unknown

SECTION 7: COMPLICATIONS (IN-HOSPITAL)

Complication of AMI:		☐ Yes	☐ No				
If Yes,	Cardiogenic Shock:	☐ Yes	☐ No				
	Heart Failure:	☐ Killip Class 1	☐ Killip Class 2	☐ Killip Class 3			
		☐ Killip Class 4	☐ Unknown				
	Arrhythmic complications:	☐ Yes	☐ No				
	If Yes Supraventricular Arrhythmia	☐ Yes	☐ No				
	If Yes	☐ Atrial Fibrillation	☐ Atrial Flutter				
	Ventricular Arrhythmia:	☐ Yes	☐ No				
	If Yes	☐ VF	☐ Sustained VT	☐ NSVT			
	Complete Heart Block:	☐ Yes	☐No				

	In-Patient Events:						
	Acute Renal Failure:	☐ Yes	☐ No				
	CVA: If Yes, LVSD:	☐ Yes ☐ Ischaemic ☐ Yes LVEF _____ %	☐ No ☐ Haemorrhagic ☐ No Date _____	 ☐ Unknown ☐ Unknown			

SECTION 8: DEATH				
Death:	☐ Yes	☐ No		
If yes,	Date of Death: _____		Time of Death: _____	
Place of Death:	☐ Residence	☐ Hospital (at EMD)	☐ Hospital (not at EMD)	
	☐ Nursing Home	☐ Others	☐ Unknown	
Cause of Death:	☐ AMI	☐ Non-AMI	☐ Unknown	
MHA Cause of Death 1:	_____			
MHA Cause of Death 2:	_____			
MHA Cause of Death 3	_____			
MHA Cause of Death (Others)	_____			
Remarks	_____			

SECTION 9: ADMITTING ELECTROCARDIOGRAM ASSESSMENT			
If MI, Admitting Electrocardiographic (ECG) Diagnosis:	☐ Yes ☐ No		
Site of AMI:			
☐ Anterior	☐ Inferior	☐ Lateral	☐ Right Ventricular
☐ Posterior	☐ NSTEMI	☐ LBBB	☐ Unspecified (AMI/STEMI/Evolved MI)
Admitting ECG Bundle Branch Block: ☐ Yes ☐ No ☐ Complete RBBB ☐ Complete LBBB ☐New ☐Old			
Discharge Diagnosis (AMI)			
☐ Primary Diagnosis	☐ Secondary Diagnosis	☐ Others	

DETAILS OF NOTIFYING HEALTHCARE INSTITUTION

Name of Notifying Healthcare Institution*: _____

Name of Person who made the notification: _____

Date of Notification: _____/_____/_____(dd/mm/yyyy)

EXPLANATORY NOTES

CASES TO BE NOTIFIED

1. Please notify cases within than 3 months after patient has been diagnosed with Acute Myocardial Infarction.

PROCEDURE FOR SUBMISSION

2. Submission may be made in the following manner:
   a) E-services – available at www.hpb.moh.gov.sg;
      or
   b) Hardcopy form - by hand (including courier services) or registered mail;
      or
   c) by using such secured electronic notification system as may be approved by the Registrar.

   N.B. Please DO NOT submit the notification form via email or fax.

NATIONAL REGISTRY OF DISEASES ACT (Chapter 201B)

(ACUTE MYOCARDIAL INFARCTION NOTIFICATION) REGULATIONS 2012

Notification of Acute Myocardial Infarction is mandatory in accordance to Section 6(1) of the National Registry of Diseases Act.

Please duly fill in the minimum (mandatory) data items (in asterisk) – as follow:

1. Identification number of patient (NRIC number, passport number, Foreign Identification number or hospital registration number).
2. Name of patient.
3. Date of birth or age of patient (if date of birth is unknown).

In pursuant to Section 7(2) of the NRD Act, you may also choose to submit information on the other items in the form or alternatively the Registry Coordinator will visit your premise to collect the additional data.

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