

Cardiovascular Examination Form

Great Ape Heart Project

Please complete the following sections and submit **with a copy of the echocardiogram by mail or email:**

Great Ape Heart Project, Zoo Atlanta, 800 Cherokee Ave. SE, Atlanta, GA 30315

gahpinfo@gmail.com

1. **General Information** – complete this first page for all submissions.
2. **Echocardiogram Form** – please provide this form to the person performing the echo so that they are aware of the measurements we are requesting. Ask for a copy of the echo performed (video or DICOM) so that the measurements can be confirmed. We need both measurements as well as the echo in order to provide you with report feedback.
3. **Health Conditions/Medications** – please list any conditions and medications for this ape.
4. **Body Assessment Form** – please print this form and have someone collect the measurements during an anesthetized exam.
5. **Anesthesia / Electrocardiogram / CBC Chem** – these may be submitted as attachments from your institution's record keeping system.
6. **Blood Pressure Form** – if blood pressure was recorded please fill out this form.

GENERAL INFORMATION			
Taxon: <input type="checkbox"/> Bonobo <input type="checkbox"/> Chimpanzee <input type="checkbox"/> Gorilla <input type="checkbox"/> Orangutan <input type="checkbox"/> Other:			
Exam Date:	Exam Institution:		
Supervising Veterinarian Name: _____ Phone: _____ Email: _____	Sonographer (for this exam) Name: _____ Training (select one): <input type="checkbox"/> Zoo Technician <input type="checkbox"/> Zoo Veterinarian <input type="checkbox"/> Professional Sonographer <input type="checkbox"/> MD Cardiologist <input type="checkbox"/> DVM Cardiologist <input type="checkbox"/> Other _____		
Reason for Exam (select one): <input type="checkbox"/> Routine Physical <input type="checkbox"/> Pre-shipment to: _____ <input type="checkbox"/> Quarantine exam <input type="checkbox"/> Suspected heart disease <input type="checkbox"/> Previously diagnosed heart disease* <input type="checkbox"/> Clinical Problem, reason: _____ <input type="checkbox"/> Other: _____			
*Please include current medications and conditions on page 3.			
Ape Name:	DOB:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Institutional ID#:		Studbook#:	
Weight (kg):		Weight: <input type="checkbox"/> Actual or <input type="checkbox"/> Estimated	

APE NAME / NUMBER: _____

Echocardiogram

RELEVANT EXAM INFORMATION			
<input type="checkbox"/> Anesthetized	<input type="checkbox"/> Awake	EXAM START TIME:	
<input type="checkbox"/> Transthoracic	<input type="checkbox"/> Transesophageal	ECHO START TIME:	

MEASUREMENTS & CALCULATIONS									
IVS(d):	cm	LVID(d):	cm	LVPW(d):	cm	LA:	cm	Ao:	cm
IVS(s):	cm	LVID(s):	cm	LVPW(s):	cm	RVID(d):	cm	RA:	cm
1	Method of EF determination: <input type="checkbox"/> M-mode/Teichholz <input type="checkbox"/> Simpson's <input type="checkbox"/> Visually Estimated							%	
2	If 2 nd Method of EF determination: <input type="checkbox"/> M-mode/Teichholz <input type="checkbox"/> Simpson's <input type="checkbox"/> Visually Estimated							%	
3	If 3 rd Method of EF determination: <input type="checkbox"/> M-mode/Teichholz <input type="checkbox"/> Simpson's <input type="checkbox"/> Visually Estimated							%	
FS:		%		Other Measurements:					

DOPPLER ASSESSMENT						
		VALVULAR REGURGITATION			MITRAL INFLOW	
MV	<input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Sev	E vel:		m/sec		E/A:
	Peak vel: m/sec	Max grad:		mmHg		<input type="checkbox"/> N/A - Summated
TV	<input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Sev	LV OUTFLOW				
	Peak vel: m/sec	Max grad: mmHg		Peak vel: m/sec	<input type="checkbox"/> Laminar flow	
AV	<input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Sev	Max grad: mmHg		<input type="checkbox"/> Turbulent flow		
	Peak vel: m/sec	Max grad: mmHg		RV OUTFLOW		
PV	<input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Sev	Peak vel: m/sec		<input type="checkbox"/> Laminar flow		
	Peak vel: m/sec	Max grad: mmHg		Max grad: mmHg	<input type="checkbox"/> Turbulent flow	

EXAMING INSTITUTIONS COMMENTS

PERFORMING SONOGRAPHER OR CARDIOLOGISTS COMMENTS:
Please attach a copy of any cardiac reports received and include a copy of the echo to confirm measurements. To be considered a complete exam submission, we request the following cardiac measurements: IVS(d), IVS(s), LVID(d), LVID(s), LVPW(d), LVPW(s), LA size, RVID(d) and one EF measurement. Without these measurements we cannot guarantee diagnostic feedback.

APE NAME / NUMBER: _____

Health Conditions / Medications

PLEASE LIST ANY CONCURRENT HEALTH PROBLEMS:			
Description of Event/Condition	Body System: [select one]	Date First Observed - End date	Outcome: [select one]
	Neurologic Dermatologic Cardiovascular Respiratory Gastrointestinal Endocrine Reproductive Musculoskeletal Urogenital Dental Ophthalmic Other:		Resolved Ongoing Alive with sequelae Dead Euthanized Unknown
1.			
2.			
3.			
4.			
5.			

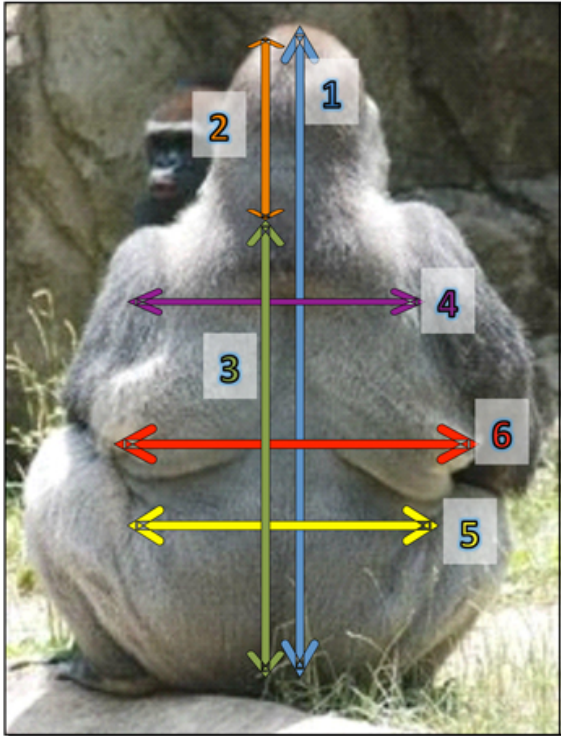
PLEASE LIST ANY MEDICATIONS AND TREATMENTS:			
Product Name (Generic or Brand)	Start date – End date	Dose and units	Frequency and Route
1.			
2.			
3.			
4.			
5.			

APE NAME / NUMBER: _____

Body Assessment (BMI)

[FOR ALL SPECIES PLEASE AT LEAST ATTEMPT TO COLLECT THE FIRST MEASUREMENT REQUESTED DURING ANESTHETIZED EXAMS – Disregard this form for awake submissions]

The reason we ask for all 6 measurements is in order to calculate a more accurate BMI assessment. This is based on research by Dr. Elena Less at Cleveland Metroparks Zoo.

BODY MEASUREMENTS	
	
1. Bottom of back to crown of head:	Circle one: cm - inches
2. Bottom of neck (even with height of shoulders) to top of crown:	Circle one: cm - inches
3. Bottom of back to bottom of neck (even with height of shoulders):	Circle one: cm - inches
4. Underneath right armpit to underneath left armpit:	Circle one: cm - inches
5. Hips – Right above where the right leg meets the back when in a seated posture:	Circle one: cm - inches
6. Width of the back measurement at 2/3 the way down from the crown (1/3 above the rump):	Circle one: cm - inches

APE NAME / NUMBER: _____

Anesthesia / Electrocardiogram / CBC Chem

(check here if awake exam – you do not need to complete this form)

[ALTERNATIVELY, YOU MAY SUBMIT YOUR INSTITUTION'S ANESTHESIA REPORT]

ANESTHETIC PROTOCOL			
MAINTENANCE			
<input type="checkbox"/> None <input type="checkbox"/> Isoflurane <input type="checkbox"/> Sevoflurane <input type="checkbox"/> Other:			
Agent(s) ----- PREMEDICATION ----- Dosage/Method Administered & Route-----Timestamp			
Agent(s) ----- INDUCTION ----- Dosage Dosage/Method Administered & Route----- Timestamp			
Agent(s) ----- PRE-ECHO REVERSAL ----- Dosage Dosage/Method Administered & Route----- Timestamp			
SUPPLEMENTAL AGENTS/DOSES (e.g., if additional drugs/doses were necessary)			

ELECTROCARDIOGRAM (check here <input type="checkbox"/> if ECG not performed)		
Was a telemetry strip recorded: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Interpretation from: <input type="checkbox"/> ECG observed during echocardiogram (on monitor) <input type="checkbox"/> Documented ECG (attached)		
<input type="checkbox"/> Normal sinus rhythm (if not, use remaining lines to describe abnormal ECG findings)		
QRS Duration: msec	PR Duration: msec	QT Duration: msec
Please attach a copy of the ECG if available		

CBC Chem (check here <input type="checkbox"/> if CBC Chem report is attached)
Were any blood values abnormal/of concern: <input type="checkbox"/> Yes <input type="checkbox"/> No

APE NAME / NUMBER: _____

GAHP Blood Pressure Form

<input type="checkbox"/> AWAKE BLOOD PRESSURE MEASUREMENT (within 1 week of echocardiogram and without sedation/induction or inhalant anesthesia) <input type="checkbox"/> ANESTHETIZED BLOOD PRESSURE MEASUREMENT				
Device Model & Cuff Size Used:				
Session Notes:				
Date:				
1	METHOD: <input type="checkbox"/> Direct <input type="checkbox"/> Indirect Oscillometric <input type="checkbox"/> Indirect Doppler <input type="checkbox"/> Indirect Stethoscope/Manometer	CUFF SITE: <input type="checkbox"/> Antebrachium <input type="checkbox"/> Brachium <input type="checkbox"/> Thigh <input type="checkbox"/> Lower Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other:	TIME: (HR:MIN AM/PM) _____:_____	SYSTOLIC/DIASTOLIC
				/
				MEAN
				PULSE
2	METHOD: <input type="checkbox"/> Direct <input type="checkbox"/> Indirect Oscillometric <input type="checkbox"/> Indirect Doppler <input type="checkbox"/> Indirect Stethoscope/Manometer	CUFF SITE: <input type="checkbox"/> Antebrachium <input type="checkbox"/> Brachium <input type="checkbox"/> Thigh <input type="checkbox"/> Lower Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other:	TIME: (HR:MIN AM/PM) _____:_____	SYSTOLIC/DIASTOLIC
				/
				MEAN
				PULSE
3	METHOD: <input type="checkbox"/> Direct <input type="checkbox"/> Indirect Oscillometric <input type="checkbox"/> Indirect Doppler <input type="checkbox"/> Indirect Stethoscope/Manometer	CUFF SITE: <input type="checkbox"/> Antebrachium <input type="checkbox"/> Brachium <input type="checkbox"/> Thigh <input type="checkbox"/> Lower Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other:	TIME: (HR:MIN AM/PM) _____:_____	SYSTOLIC/DIASTOLIC
				/
				MEAN
				PULSE
4 Nominal Session Value	METHOD: <input type="checkbox"/> Direct <input type="checkbox"/> Indirect Oscillometric <input type="checkbox"/> Indirect Doppler <input type="checkbox"/> Indirect Stethoscope/Manometer	CUFF SITE: <input type="checkbox"/> Antebrachium <input type="checkbox"/> Brachium <input type="checkbox"/> Thigh <input type="checkbox"/> Lower Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other:	TIME: (HR:MIN AM/PM) _____:_____	SYSTOLIC/DIASTOLIC
				/
				MEAN
				PULSE

APE NAME / NUMBER: _____