

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 (**DICOM format**) 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	Sonographer (for this exam)	
Name: _____	Name: _____	
Phone: _____	Training (select one):	
Email: _____	<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		A vel:	m/sec	<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.			

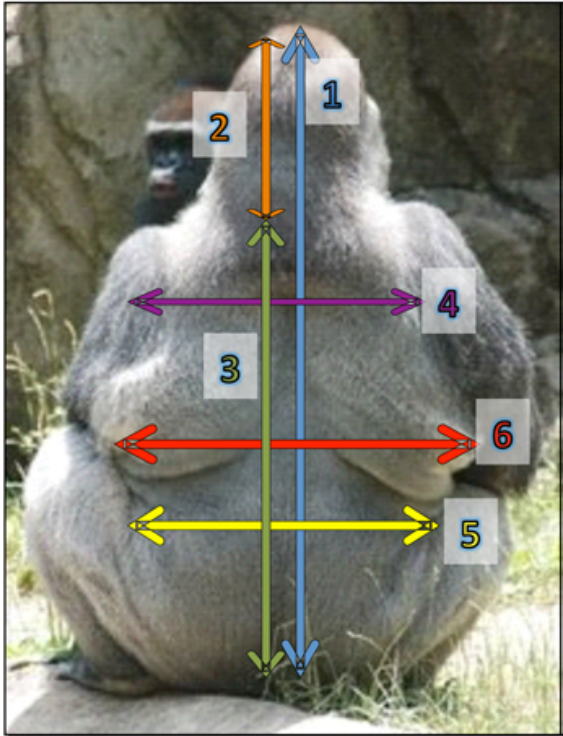
PLEASE LIST ANY MEDICATIONS AND TREATMENTS:			
Product Name (Generic or Brand)	Start date – End date	Dose and units	Frequency and Route
1.			
2.			
3.			
4.			
5.			

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)

PLEASE 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

- AWAKE BLOOD PRESSURE MEASUREMENT** (within 1 week of echocardiogram and without sedation/induction or inhalant anesthesia)
 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: _____