



PVDOMICS STUDY

Sleep Study Core Incidental Finding(s) Form #154

Data on this form is collected by the Sleep Core when an incidental finding(s) has been identified on a participant's sleep study recording(s). This form will be entered in the PVDOMICS database by the Sleep Core personnel and an email message will automatically be sent to the Clinical Center PI and Study Coordinator. A Form 138 will need to be completed by the local site to acknowledge receipt of these findings.

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1. Identification Number

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2. Alphacode

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3. Date sleep study started (mm/dd/yyyy)

4. Date file received at Sleep Core (mm/dd/yyyy) ____ / ____ / ____
5. Date sleep study scored at Sleep Core (mm/dd/yyyy) ____ / ____ / ____
6. Username of polysomnologist who identified findings _____

Findings:

7. Abnormal apnea hypopnea index (AHI) > 50? (0=No, 1=Yes) ____
8. Oxyhemoglobin saturation during sleep <85% for greater than 10% of the estimated sleep time? (0=No, 1=Yes)..... ____
9. Other urgent specific heart rate or ECG finding? (0=No, 1=Yes)..... ____
- a. Supraventricular tachycardia sustained for 30 seconds or greater with heart rate > 150 bpm? (0=No, 1=Yes) ____
- b. Marked bradycardia? (30 bpm for 6 seconds or greater) (0=No, 1=Yes) ____
- c. Wide QRS tachycardia? (>4 beats with rate >100 bpm) (0=No, 1=Yes) ____
- d. Second degree AV block Mobitz Type II, high grade AV block? (0=No, 1=Yes) ____
- e. Third degree atrioventricular block? ____
- f. Atrial fibrillation/atrial flutter with rate >150 bpm? (0=No, 1=Yes) ____
- g. Sinus pauses >3 seconds? (0=No, 1=Yes) ____

10. Comments:

11. a. Date of review with Sleep Core PI (mm/dd/yyyy)..... ____/____/____
b. Username of Sleep Core PI _____
12. Has someone at the Sleep Core spoken to someone at the center?
(0=No, not necessary, 1=Yes) ____
- a. Date contacted (mm/dd/yyyy)..... ____/____/____
- b. Sleep Core personnel spoke to? ____
1=PVDOMICS PI
2=PVDOMICS Co-PI
3=Other Physician
4=PVDOMICS Study Coordinator
5=Other clinical center person

Name of person contacted: (not entered into database):

200. Date form completed (mm/dd/yyyy)..... ____/____/____
201. Username of person completing/reviewing completeness of this form _____

Clinical Center Use Only

Date form entered (mm/dd/yyyy) ____/____/____

Username of person entering this form _____