Appendix 1

**Emergency Physician ACR Survey**

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**Site:** □ UH □ VH

**Was the ACR available when you first assessed your patient?**

 □ NO □ YES

**Was the ACR available at any time while the patient was under your care in the ED?**

□ NO □ YES

**Do you believe that information contained in the ACR changed or altered your treatment plan for this patient?**

□ NO □ YES

 **If yes, how so?**

□ Medical therapy □ Lab investigations □ Imaging investigation

□ Outpatient referral □ Inpatient referral □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you believe that information contained in the ACR provided information to support your diagnosis or disposition for this patient?**

□ NO □ YES

 **If yes, please check:**

□ Abnormal vitals

□ Abnormal cardiac rhythm

□ Pertinent patient history

□ Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was a rhythm strip or 12-lead ECG available?** □ NO □ YES

**If no, would one have been useful for this patient?** □ NO □ YES

**If the ACR was NOT available, do you believe that having the ACR would have provided valuable information relevant to the care of this patient?**

□ NO □ YES

 **If yes, please check:**

□ Vital signs □ Patient history □ Prehospital interventions/treatment

□ Prehospital rhythm analysis □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you believe that having access to the ACR would have allowed you to provide BETTER care to this patient?** □ NO □ YES

**Do you believe that having access to the ACR would have allowed you to provide EXPEDITED care to this patient?** □ NO □ YES

**Was a rhythm strip or 12-lead ECG available?** □ NO □ YES

**If no, would one have been useful for this patient?** □ NO □ YES

**Did you receive verbal handover for this patient?** □ NO □ YES

***If YES to above, please answer the following questions:***

**Did you receive verbal handover from an RN or a paramedic?** □ RN □ Paramedic

**Did the verbal handover include information that was not contained in the written ACR?** □ No □ YES

**Did the ACR include information that was not relayed in the verbal handover?**  □ NO □ YES

**If yes, please check all that apply:**

□ Pertinent patient history □ Vital signs before treatment □ Vital signs during care

□ Scene characteristics □ Prehospital interventions

□ Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes to above, did this information impact/change your management?** □ NO □ YES

□ Medical therapy □ Lab investigations □ Imaging investigation

□ Outpatient referral □ Inpatient referral □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 2

Please stamp blue card here

**Emergency Physician ACR Survey**

**Site:** □ UH □ VH

**Was the ACR available when you FIRST assessed your patient?** □ NO □ YES

**Was the ACR available at ANY time while the patient was under your care in the ED?**

 **YES** **NO**

**Do you believe information contained in the ACR changed or altered your treatment plan for this patient?**

□ NO □ YES ***If yes, please check all that apply:***

□ Medical therapy □ Imaging investigation

□ Lab investigations □ Outpatient referral

□ Inpatient referral □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you believe information contained in the ACR provided information to support your diagnosis**

**or disposition for this patient?**

□ NO □ YES ***If yes, please check all that apply:***

□ Abnormal vitals

□ Abnormal cardiac rhythm

□ Pertinent patient history

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you believe having access to the ACR would have allowed you to provide BETTER care to this patient?**

□ NO □ YES

**Do you believe having access to the ACR would have allowed you to provide EXPEDITED care to this patient?**

□ NO □ YES

**Do you believe having the ACR would have provided valuable information relevant to the care of this patient?**

□ NO □ YES

***If yes, please check all that apply:***

□ Vital signs □ Patient history

□ Prehospital interventions/treatment

 □ Prehospital rhythm analysis

 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you receive verbal handover for this patient?** □ NO □ YES

**Clerks: Please leave this form in the RESEARCH STUDY box NEAR REGISTRATION.**