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OCCLUDED ARTERY TRIAL (OAT)
Hospital Discharge Or Outpatient Contact Form

64825

Please Use Black Pen To Fill Out Form.

Patient's ID Number: ___ - ___ Letter Code: ___ Correction ○

Date of hospital discharge or 48 hour contact after randomization: (whichever is later) fm10dt ___ – ___ – ___
mmm dd yyyy

Discharge time: ○ First 30 days ○ Extended hospitalization seqno

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1. Outcomes during this hospitalization: (Answer each item.)

	First Event Before Study Entry	After Study Entry	No Event
A. Death **If Yes, complete OAT Form 14.**	d_death	○	○
B. Recurrent MI **If Yes, complete OAT Form 17.**	d_mi ○	○	○
C. Stroke and/or coma **If Yes, complete OAT Form 15.**	d_stroke ○	○	○
D. Cardiac arrest **If Yes, complete OAT Form 15.**	d_ca ○	○	○
E. Congestive heart failure If Yes, highest NYHA Class:	d_chf ○	○	○
d_nyhacl ○ I ○ II ○ III ○ IV **If Class III or IV, complete OAT Form 18.**			
F. Recurrent Ischemia	d_ischem ○	○	○
G. Major hemorrhage	d_hem ○	○	○
If Yes, number of units of red blood cells or whole blood transfusions: ○ 1 ○ 2 ○ 3 ○ >3 d_runits			
H. Sustained ventricular arrhythmia **If Yes, complete OAT Form 15.**	○ d_arryth ○		○
I. AICD implantation **If Yes, complete OAT Form 15.**	d_aicd ○	○	○

2. Procedures during this hospitalization: (Answer each item.)

	Yes	No
A. Non-protocol PCI **If Yes, complete OAT Form 16.**	○	○ nonprpci
B. CABG **If Yes, complete OAT Form 19.**	○	○ cabgdone
C. Vascular surgery	○	○ vascsurg

3. Disposition at discharge: (Answer only one.)

dischrg
- ○ Deceased
- ○ Transfer to another acute care hospital
- ○ Nursing home care
- ○ Rehabilitation hospital
- ○ Home or other private residence
- ○ Still in hospital 30 days after randomization
- ○ Other, specify

dichr_rk ___

Signature: _____ ___ - ___
OAT Staff Number

FAX to MMRI (410) 323 - 4729

e-mail to MMRI