39240

AFFIRM

Change of Treatment Strategy

Fax to: (800) 547-0463

Complete this form whenever a patient on:
- rate control therapy begins antiarrhythmic drug therapy.
- rhythm control therapy discontinues all antiarrhythmic drug therapy on an anticipated long-term basis.

If a patient changes treatment ***strategy*** multiple times, complete this form for **EACH** change. Do **NOT** complete this form for changes in antiarrhythmic drug type (e.g., quinidine changed to amiodarone) or for changes in the dosage.

Fax this form to the CTC within 14 days of change in therapy. The AFFIRM Principal Investigator must also submit a letter within 14 days describing the situation that led to the change in treatment strategy.

1. Date treatment strategy changed:

☐☐ / ☐☐ / ☐☐
Month Day Year

Days06

Affix Patient ID # Here

☐☐☐☐ - ☐☐☐ - ☐

Print Acrostic Here

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2. New treatment strategy (after change):

Treat06
○ *1* Rate control
○ *2* Rhythm control ⇒ Specify which antiarrhythmic drugs patient began:

	No *0*	Yes *1*		No *0*	Yes *1*	
Amiod06	○	○	Amiodarone	○	○	Procainamide
	○	○	Disopyramide	○	○	Propafenone
	○	○	Flecainide	○	○	Quinidine
	○	○	Moricizine	○	○	Sotalol *Sotal06*
	○	○	Other ⇒ Specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			

Class I = Disopyramide or Flecainide or Moricizine or Procainamide or Propafenone or Quinidine (0=No, 1=Yes)

3. Primary reason for change of therapy: *(Mark one only.)*

Reason06
1 ○ Intolerable adverse effect ⇒ Specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
5 ○ New or worsened CHF
5 ○ Proarrhythmic effects
4 ○ Atrial fibrillation with unacceptable symptoms in the rate control arm
6 ○ Failure to achieve and/or maintain sinus rhythm in the rhythm control arm
5 ○ Other ⇒ Specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of person completing this form ________________________ **Date** __________

Please print mm/dd/yy

For CTC use only: ☐☐

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