1650

Drug Discontinuation

Fax to: (800) 547-0463

Complete this form whenever a drug is permanently discontinued. Submit a separate form for each drug that is stopped. Do not submit for dose changes only.

1. Date drug discontinued:

☐☐ / ☐☐ / ☐☐
Month Day Year

Days14

Affix Patient ID # Here

☐☐☐☐ - ☐☐☐ - ☐

Print Acrostic Here

☐☐☐☐

2. Discontinued drug: *(Mark one only.)*

1 ○ Amiodarone ⇒ Specify dose: ☐☐☐☐ mg/day *Drug14*

2 ○ Beta blocker

3 ○ Digoxin

4 ○ Diltiazem

5 ○ Disopyramide

5 ○ Flecainide

5 ○ Moricizine

5 ○ Procainamide

5 ○ Propafenone

5 ○ Quinidine

6 ○ Sotalol

4 ○ Verapamil

○ Other antiarrhythmic ⇒ Specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4 = Calcium-Channel Blocker 5 = Class I Antiarrhythmic Drug 6 = Sotalol

3. Reason(s) for discontinuation:

No *0*	Yes *1*		
○	○	Symptomatic bradycardia	*Brady14*
○	○	Torsades de pointes VT	
○	○	Other proarrhythmia	
○	○	Prolonged QT interval	
○	○	CHF	*Chf14*
○	○	Syncope	
○	○	Pulmonary ⇒ If yes, specify: *(Mark one only.)*	*Pulmon14*

Aptox 14
1 ○ Amiodarone pulmonary toxicity
0 ○ Not amiodarone pulmonary toxicity

No *0*	Yes *1*	
○	○	GI *GI 14*
○	○	GU
○	○	CNS *CNS 14*
○	○	Endocrine
○	○	Inefficacy *Ineff14*
○	○	No longer needed *NoNeed14*

○ ○ Other ⇒ Specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

OthRsn14 (Torsades de pointes VT or other proarrhymithia or Prolonged QT interval or Syncope or GU or Endocrine or other) (0=No, 1=Yes)

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

Please print mm/dd/yy

For CTC use only: ☐☐

0 = No, 1 = Yes)