4388

AFFIRM

Electrocardiogram

Fax to: (800) 547-0463

Complete this form:
- At baseline, for the qualifying episode of atrial fibrillation, prior to randomization.
- At baseline, after conversion to normal sinus rhythm, for patients in rhythm control arm.
- At baseline, after completion of drug titration.
- At 4 month follow-up.
- At 1 year follow-up.

1. Date of recording:

Month / Day / Year

Days03

Affix Patient ID # Here

Print Acrostic Here

2. Reason for recording: *Reason03*

○ *1* Baseline, during qualifying episode of atrial fibrillation

○ *2* Baseline, after conversion to sinus rhythm ⇒ Specify: *(Mark one only.)* *BARand03*

- ○ *1* Before randomization
- ○ *2* After randomization

○ *3* Baseline, after completion of drug titration

○ *4* 4 month follow-up

○ *5* 1 year follow-up

3. Source of tracing: *(Mark one only.)*

Source03 ○ *1* 12-lead ECG ○ *2* Rhythm strip

4. Rhythm(s) at time of recording:

	No 0	*Yes 1*	
Sinus03	○	○	Sinus rhythm (normal, tachycardia, or bradycardia)
AF03	○	○	Atrial fibrillation
	○	○	Atrial flutter
Paced03	○	○	Paced ⇒ ○ Atrial pacing only; ○ Ventricular pacing only; ○ Dual chamber pacing
RhythO03	○	○	Other ⇒ Specify:

For CTC use only:

166

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Date of recording:

Month / Day / Year

Affix Patient ID # Here

Specify reason for recording:

- ○ Baseline, during atrial fibrillation
- ○ Baseline, after conversion to sinus rhythm
- ○ Baseline, after completion of drug titration
- ○ 4 month follow-up
- ○ 1 year follow-up

5. Heart rate: *Rate03* ___ beats/min

6. Intervals:

PR interval *PRInt03* ___ msec ○ PR not measurable

QRS duration *QRS03* ___ msec

QT interval *QT03* ___ msec *(Do not record QTc)*

7. Drugs taken by the patient at the time of the ECG:

	No 0	Yes 1			No 0	Yes 1	
Amiod03	○	○	Amiodarone		○	○	Moricizine
BetaBl03	○	○	Beta blocker		○	○	Procainamide
Digox03	○	○	Digoxin		○	○	Propafenone
Dilt03	○	○	Diltiazem		○	○	Quinidine
	○	○	Disopyramide	*Sotal03*	○	○	Sotalol
	○	○	Flecainide	*Verap03*	○	○	Verapamil
	○	○	Ibutilide	*CalcBl03*	○	○	Calcium channel blocker (other than diltiazem and verapamil)

ClassI - Class I Drug (Disopyramide or Flecainide or Moricizine or Procainamide or Propafenone or Quininide)

Name of person completing this form _____ **Date** _____

Please print mm/dd/yy

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