



Complete this form for each clinical event (from the list below). For multiple events (e.g. fatal stroke), complete one form to document each event.

Fax this form to the CTC within 24 hours of learning about a patient's death or within one week of learning about other events.

1. Date of event:

Month / Day / Year

Days07

Affix Patient ID # Here

Patient ID # grid

Print Acrostic Here

Acrostic grid

2. Type of event: (Specify one event type only; use multiple forms if needed.)

Event07

- 1 Death => Complete all of the following items:

a. Briefly describe presumed cause:

Cause description grid

Cardio07

- b. Was this death presumably: 1 Cardiovascular 2 Noncardiovascular

c. Complete Death form and submit materials.

- 2 Torsades de pointes VT => Submit required materials.
2 Sustained ventricular tachycardia => Submit required materials.
2 Resuscitated cardiac arrest: VF, VT => Submit required materials.
2 Resuscitated cardiac arrest: EMD, brady, other => Submit required materials.
5 Disabling anoxic encephalopathy => Complete CNS Disability form.
3 Ischemic stroke => Complete CNS Disability form.
4 Major bleeding => Specify:
o Intracranial bleeding => Complete CNS Disability form.
o Non-CNS hemorrhage
5 Systemic embolism => Submit required materials.
5 Pulmonary embolism => Submit required materials.
5 Myocardial infarction

1 = Death
2 = Arrhythmia
3 = Ischemic Stroke
4 = Major Bleeding
5 = Other

For CTC use only:

CTC use grid



48233



Event Notification

Fax to: (800) 547-0463

Date of event:

		/			/		
Month			Day			Year	

Affix Patient ID # Here

					-				-	
--	--	--	--	--	---	--	--	--	---	--

Specify type of event:

<input type="radio"/> Death	<input type="radio"/> Ischemic stroke
<input type="radio"/> Torsades de pointes VT	<input type="radio"/> Major bleeding
<input type="radio"/> Sustained ventricular tachycardia	<input type="radio"/> Systemic embolism
<input type="radio"/> Resuscitated cardiac arrest: VF, VT	<input type="radio"/> Pulmonary embolism
<input type="radio"/> Resuscitated cardiac arrest: EMD, brady, other	<input type="radio"/> Myocardial infarction
<input type="radio"/> Disabling anoxic encephalopathy	

3. Antiarrhythmic drugs patient was taking at time of event:

No ₀ Yes ₁

- Amiod07* Amiodarone ⇒ Specify dose:

--	--	--	--

 mg/day
- BetaBl07* Beta blocker
- Digox07* Digoxin
- Calc07* Diltiazem *or Verapamil*
- Disopyramide
- Flecainide
- Moricizine
- Procainamide
- Propafenone
- Quinidine
- Sotalol
- Verapamil

AntiAO07 Other antiarrhythmics ⇒ Specify:

(including Disopyramide or Flecainide or Moricizine or Procainamide or Propafenone or Quinidine or Sotalol)

For CTC use only:

--	--



Event Notification

Fax to: (800) 547-0463

Date of event:

		/			/		
Month			Day			Year	

Affix Patient ID # Here

				-				-	
--	--	--	--	---	--	--	--	---	--

Specify type of event:

<input type="radio"/> Death <input type="radio"/> Torsades de pointes VT <input type="radio"/> Sustained ventricular tachycardia <input type="radio"/> Resuscitated cardiac arrest: VF, VT <input type="radio"/> Resuscitated cardiac arrest: EMD, brady, other <input type="radio"/> Disabling anoxic encephalopathy	<input type="radio"/> Ischemic stroke <input type="radio"/> Major bleeding <input type="radio"/> Systemic embolism <input type="radio"/> Pulmonary embolism <input type="radio"/> Myocardial infarction
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

5. Has atrial fibrillation or flutter been documented by ECG since last follow-up?

AFLast07 No
 Yes ⇒ Specify:
 Atrial fibrillation ⇒ Continuous Intermittent
 Atrial flutter

6. Was patient in atrial fibrillation or flutter at time of event?

AFEvnt07 No
 Yes ⇒ Specify:
 Atrial fibrillation
 Atrial flutter
 Unknown

Name of person completing this form _____

Date _____

Please print

mm/dd/yy

For CTC use only:

--	--