63487

AVID

Initiation of Antiarrhythmic Drug

Fax to: (206) 685-7569
or (800) 253-6404

Complete this form for administration of antiarrhythmic drug during baseline hospitalization only.

1 Date first drug started: days09 ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

☐☐-☐☐☐-☐ ☐☐☐☐ Affix Patient ID # Here seqnum09

2 Drug assigned at randomization

Amiodarone - complete the following

Result of dosing:

asgami09

1 ○ Started, patient discharged on amiodarone

Cumulative dose (mg) given during in-hospital loading phase: ☐☐☐☐☐ asgtam09 mg

2 ○ Started but discontinued prior to discharge

Specify the reason which best describes why:

stpami09

1 ○ Intolerable adverse symptoms *(complete the Adverse Symptoms form)*
2 ○ Patient died
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

0 ○ Never started

Specify reason:

nvrami09

1 ○ Patient refused
2 ○ Patient died
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sotalol - complete the following

Result of dosing:

asgsot09

1 ○ Started, patient discharged on sotalol

Daily dose (mg) at discharge: ☐☐☐ asgsmg09 mg

2 ○ Started but discontinued prior to discharge

Specify the reason which best describes why:

stpsot09

4 ○ Inefficacy
1 ○ Intolerable adverse symptoms *(complete the Adverse Symptoms form)*
2 ○ Patient died
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

0 ○ Never started

Specify reason:

nvrsot09

4 ○ Insufficient ectopy/ noninducible
1 ○ Patient refused
2 ○ Patient died
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Initiation of Antiarrhythmic Drug

Date first drug started:

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Month Day Year

[ ][ ]-[ ][ ][ ]-[ ] [ ][ ][ ][ ]

Affix Patient ID # Here

3. If the patient was discharged on something other than (or in addition to) the assigned drug therapy, please specify what the therapy was at discharge (check all applicable).

dscnon09 O No antiarrhythmic therapy

dscami09 O Amiodarone

For amiodarone, cumulative dose (mg) given during in-hospital loading phase: [ ][ ][ ][ ][ ] mg dsctam09

dscsot09 O Sotalol dose: [ ][ ][ ] mg/day dscsmg09

droth09 O Other anitarrhythmic drugs:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] dose: [ ][ ][ ][ ][ ][ ] mg/day

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] dose: [ ][ ][ ][ ][ ][ ] mg/day

dscicd09 O ICD *(Notify CTC prior to implantation - This is a crossover. Complete Change of Therapy and ICD Implantation forms)*

Signature of person filling out this form

[ ][ ][ ][ ]

code number

For Clinical Trial Center Use Only: rtnum09

[ ][ ]	Yes O	No O	2	0	9	0	3	0	0
CTC Code			DRUGINIT page 2 of 2 07/15/94						