



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:

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:

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

0 Never started
Specify reason:

1 Patient refused
2 Patient died
3 Other:

Sotalol - complete the following

Result of dosing:

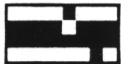
1 Started, patient discharged on sotalol
Daily dose (mg) at discharge: **asgsmg09** mg

2 Started but discontinued prior to discharge
Specify the reason which best describes why:

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

0 Never started
Specify reason:

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



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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 No antiarrhythmic therapy

dscami09 Amiodarone

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

						mg dsctam09
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dscsot09 Sotalol

dose:

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 mg/day **dscsmg09**

droth09 Other anitarrhythmic drugs:

												dose: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> mg/day						

												dose: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> mg/day						

dscicd09 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

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code number

For Clinical Trial Center Use Only: **rtnum09**

		Yes <input type="radio"/>	No <input type="radio"/>	2	0	9	0	3	0	0
CTC Code				DRUGINIT page 2 of 2 07/15/94						