Persons using assistive technology may not be able to fully access information in this file. For assistance, e-mail biolincc@imsweb.com. Include the Web site and filename in your message.

9679

AVID

Notification of Death

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

Affix Patient ID # Here

This form should be FAXed to the Clinical Trial Center within 24 hours of discovery of death.

1 Date of death:

Month / Day / Year

2 Preliminary assessment of cause of death:

The following should not delay the faxing of this form. If unsure, mark "Don't know".

autpsy17
inRT18

3 Was an autopsy performed? *(If yes, submit results with records documenting death)*

O Yes (1) O No (0) O Don't know (2)

icdint17
inRT18

4 Was the ICD interrogated after death? *(If yes, submit results with records documenting death)*

O Yes (1) O No (0) O Don't know (2) O No ICD (3)

explnt17
inRT18

5 Was the ICD explanted after death? *(If yes, submit to manufacturer for evaluation)*

O Yes (1) O No (0) O Don't know (2) O No ICD (3)

Signature of person filling out this form

code number

For Clinical Trial Center Use Only:

CTC Code

Yes O No O

2 1 7 0 2 0 0

DTHNOTE page 1 of 1 01/31/95