33208

AVID Screen

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

Initial Screening:

dyscrn01

Month / Day / Year

Site

norsou01
1=North
0=South

Patient Acrostic
First letter of first name and first 3 letters of last name.

1 Index Arrhythmia:

arrtyp01 PRIMARY means there is no evidence (even weak) that the event was due to transient or correctable cause

(check only one)

1 O (A) PRIMARY cardiac arrest due to VF
2 O (B) Documented sustained PRIMARY VT with syncope
3 O (C) Documented sustained PRIMARY VT, systolic BP < 80 mmHg or chest pain or near-syncope AND EF ≤ 0.40
4 O (D) Documented sustained PRIMARY VT, systolic BP < 80 mmHg or chest pain or near-syncope BUT EF > 0.40
5 O (E) Documented sustained PRIMARY VT, hemodynamically stable
6 O (F) Out-of-hospital documented sustained VT or cardiac arrest due to VF associated with transient or correctable cause

arrcs01 If (F) checked, indicate the most probable cause:

1 O (F.1) New Q wave MI
2 O (F.2) New non-Q wave MI
3 O (F.3) Antiarrhythmic drug reaction
4 O (F.4) Electrolyte imbalance
5 O (F.5) Cocaine or other illicit drug
6 O (F.6) Other

7 O (G) Out-of-hospital syncope with structural heart disease and EP inducible VT/VF with symptoms

2 Registry Exclusion Checklist:

Screen patient for all readily available information. Exclusions are not prioritized.
Check yes for EACH exclusion noted in the chart.

1 Yes	0 No		
O	O	(1)	Event occurred in-hospital within 5 days after myocardial infarction
O	O	(2)	Event occurred within 5 days after cardiac surgery or PTCA
O	O	(3)	Prior ICD implant or attempted implant
O	O	(4)	Intra-aortic balloon pump or other device or inotropic drug (not digitalis) necessary for hemodynamic support
O	O	(5)	NYHA Class IV heart failure
O	O	(6)	Currently on a heart transplant waiting list
O	O	(7)	Life expectancy < 1 year
O	O	(8)	Chronic serious bacterial infection
O	O	(9)	Inability to give verbal assent due to severe neurologic impairment
O	O	(10)	Died during screening

If ANY exclusion is checked YES, FAX only this form to the CTC. DO NOT complete a Registry form.

If ALL exclusions are checked NO, enter registry ID below, FAX this form to the CTC, and complete a Registry form for this patient. seqnum01

_____
Signature of person filling out this form

code number

For Clinical Trial Center Use Only:

CTC Code | Yes O | No O | 1 0 1 0 4 0 0 | Screen page 1 of 1 1/31/95