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NHLBI-VA Study #995
Revised FEB 1992

DIGITALIS INVESTIGATION GROUP

EVENT FORM

Local Center Name _____

PRINT Patient Name _____
Last First M.I.

Randomization Number
___ ___ ___ / ___ ___ ___ ___

Date of Event Mo __ __ Day __ __ Yr __ __

PLEASE COMPLETE A SEPARATE EVENT FORM FOR EACH HOSPITALIZATION OR EPISODE OF SUSPECTED DIGOXIN TOXICITY. CODE DISCHARGE DIAGNOSES FOR EACH HOSPITALIZATION.

A. HOSPITALIZATION (Defined as admission to hospital for at least 24 hours.)

CODE: 1=YES 0=NO

01. WAS PATIENT HOSPITALIZED? (If No, Go to Section B) Q1
IF YES, COMPLETE QUESTIONS 02 THROUGH 17 AND QUESTIONS 27a AND 27b.
02. WORSENING HEART FAILURE Q2
03. DIGOXIN TOXICITY (If YES, complete Section B below) Q3
04. MYOCARDIAL INFARCTION Q4
05. UNSTABLE ANGINA Q5
06. STROKE Q6
07. ARRHYTHMIA - SUPRAVENTRICULAR Q7
08. ARRHYTHMIA - VENTRICULAR Q8
09. CORONARY ARTERY BYPASS GRAFT SURGERY (CABG) Q9
10. PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) Q10
11. CARDIAC TRANSPLANTATION Q11
12. VALVE OPERATION Q12
13. OTHER CARDIAC SURGERY, SPECIFY _____Q13_SPEC_____ Q13
14. OTHER CARDIOVASCULAR REASON, SPECIFY _____Q14_SPEC_____ Q14
15. RESPIRATORY INFECTION Q15
16. OTHER NONCARDIAC, NONVASCULAR REASON, SPECIFY _____Q16_SPEC_____ Q16
17. ENTER NUMBER OF PRIMARY REASON FOR HOSPITALIZATION (USE QUESTIONS 02-16 TO CODE) Q17

B. SUSPECTED/CONFIRMED SYMPTOMS AND SIGNS OF DIGOXIN TOXICITY

18. DID PATIENT HAVE AN EPISODE OF SUSPECTED/CONFIRMED DIGOXIN TOXICITY? Q18
IF YES, COMPLETE QUESTIONS 19-27b. IF NO, COMPLETE QUESTIONS 27a AND 27b.
19. VENTRICULAR TACHYCARDIA Q19
20. VENTRICULAR FIBRILLATION Q20
21. SUPRAVENTRICULAR ARRHYTHMIA Q21
22. AV-BLOCK Q22
23. NAUSEA OR VOMITING Q23
24. VISUAL DISTURBANCES Q24
25. DIARRHEA Q25
26. OTHER, SPECIFY _____Q26_SPEC_____ Q26
27. SERUM DIGOXIN CONCENTRATION (IF KNOWN) (ng/ml) Q27

C. PLEASE PROVIDE THE FOLLOWING BLOOD LEVELS ON THE FIRST DAY OF HOSPITALIZATION OR AT DIAGNOSIS OF SUSPECTED DIGOXIN TOXICITY

27a. SERUM POTASSIUM LEVEL ..... Q27A mEq/l OR Q27A mmol/l

27b. SERUM CREATININE LEVEL ..... Q27B mg/dl OR Q27B μ mol/l

*REMINDER: If knowledge of digoxin blood levels is **essential** for the **immediate** management of the patient, obtain digoxin blood levels from the most convenient and quick source. Please report the level to the Pharmacy Coordinating Center at (505) 265-1711, ext. 2580. In other situations where digoxin toxicity is suspected but the situation is not urgent, please reduce or stop trial medication and send the blood sample to SmithKline Beecham Clinical Laboratories, Inc. by calling 800-877-7004. You will receive results within 4 working days. In such circumstances, **PLEASE AVOID OBTAINING DIGOXIN BLOOD LEVELS LOCALLY.***

28. LAST NAME AND FIRST INITIAL OF INDIVIDUAL COMPLETING THIS FORM (IN CAPITALS) ..... _____
Last First Initial

Signature _____

PLEASE RETURN FORM TO THE DATA COORDINATING CENTER AT PERRY POINT.

VA Form 10-20914c(NR)
JAN 1991