

**MAGIC: Magnesium in Coronaries**
Form 02 – Hospitalization & Discharge Form**A. Patient Information**

A1. Study ID Number:

AFFIX STUDY ID
LABEL HERE

A2. Date of admission to randomizing hospital:

____ / ____ / ____
MONTH DAY YEAR

A3. Date of discharge from randomizing hospital:

____ / ____ / ____
MONTH DAY YEAR**B. Study Drug Treatment**B1. Was the 24-hour infusion completed? 1. YES 2. NO

Discontinued due to:

a. Sustained Hypotension 1. YES 2. NOb. Bradycardia / heart block 1. YES 2. NOc. Death 1. YES 2. NOd. Other reason 1. YES 2. NO

d1. Specify: _____

C. Past Cardiovascular HistoryC1. Does the patient have a history of any of the following conditions? 1. YES 2. NOa. Hypertension requiring treatment 1. YES 2. NOb. Diabetes requiring treatment 1. YES 2. NOc. Hyperlipidemia requiring treatment 1. YES 2. NOd. Current cigarette smoker 1. YES 2. NOe. Prior MI 1. YES 2. NOf. CHF requiring treatment 1. YES 2. NOg. Prior CABG and / or PTCA 1. YES 2. NOh. Permanent pacemaker 1. YES 2. NOi. Stroke (not including TIA) 1. YES 2. NO**D. Non-Study Treatment**D1. Was IV magnesium treatment *other than the study drug* given within 24 hours of randomization? 1. YES 2. NOa. Date first dose of non-study IV magnesium given: ____ / ____ / ____
MONTH DAY YEARb. Time first dose of non-study IV magnesium given: ____ : ____ 24-hour
clockc. Total amount of non-study IV magnesium given: ____ * ____ c1. Unit (check one): g mMolD2. Were concomitant medications given during study infusion? 1. YES 2. NOa. Beta blocker (IV / PO) 1. YES 2. NOb. ACE inhibitor (IV / PO) 1. YES 2. NOc. IV Inotrope / vasopressor
other than digoxin 1. YES 2. NOd. Digoxin (IV / PO) 1. YES 2. NOe. Anticoagulant (IV / PO) 1. YES 2. NOf. Nitrate (IV, PO, or Topical) 1. YES 2. NOg. Diuretic (IV / PO) 1. YES 2. NOh. Calcium channel blocker (IV / PO) 1. YES 2. NOi. Lipid – lowering agent 1. YES 2. NOj. Angiotensin (A II) receptor antagonist 1. YES 2. NOk. Aspirin or other oral anti-platelet agent 1. YES 2. NOl. IV Glycoprotein IIb/IIIa receptor antagonist 1. YES 2. NOm. Amiodarone (IV / PO) 1. YES 2. NOn. Other antiarrhythmic agent (IV / PO) 1. YES 2. NO

D3. Was reperfusion therapy given? 1. YES 2. NO

a. Thrombolytic 1. YES 2. NO

a1. Date lytic started: _____ / _____ / _____ a2. Time lytic therapy started: _____ : _____ 24-hour clock
MONTH DAY YEAR

a3. Type of thrombolytic: 1. SK 2. TPA 3. RPA 4. Other, specify _____

b. Primary or rescue PTCA attempt (even if unsuccessful) 1. YES 2. NO

b1. Date of first procedure: _____ / _____ / _____ b2. Time of first balloon inflation (even if unsuccessful) or last guidewire attempt: _____ : _____ 24-hour clock
MONTH DAY YEAR

E. Qualifying ECG

E1. Location of infarction:

- a. ST elevation: anterior (including lateral and anterolateral) 1. YES 2. NO
- b. ST elevation: inferior (including inferolateral and inferoposterior) 1. YES 2. NO
- c. Complete left bundle branch block (new or presumably new) 1. YES 2. NO

E2. Rhythm:

- a. Sinus rhythm 1. YES 2. NO
- b. Other supraventricular rhythm 1. YES 2. NO
- c. Ventricular rhythm 1. YES 2. NO
- d. Pacemaker rhythm 1. YES 2. NO

F. Events During Hospitalization, After Randomization

- F1. Defibrillation for VF or pulseless VT 1. YES 2. NO
- F2. Bradycardia requiring atropine 1. YES 2. NO
- F3. Stroke (not including TIA) 1. YES 2. NO
- F4. Death 1. YES 2. NO

a. Date of death: _____ / _____ / _____
MONTH DAY YEAR

G. Treatment During Hospitalization, After Randomization

G1. Intensive therapy for CHF 1. YES 2. NO

a. Intra-aortic balloon pump / LVAD 1. YES 2. NO

b. IV pressor / inotrope 1. YES 2. NO

c. IV vasodilator 1. YES 2. NO

G2. Revascularization other than primary or rescue PTCA 1. YES 2. NO

a. Type: 1. CABG 2. PTCA

- G3. Temporary pacemaker (transvenous or transcutaneous) 1. YES 2. NO
- G4. Antiarrhythmic therapy for ventricular arrhythmias
(excluding prophylactic lidocaine) 1. YES 2. NO

H. Assessments

- H1. Was an EF assessment made? 1. YES 2. NO

↓

a. What was the result?

1. Normal (>50%)

2. Mod. depressed (30-50%)

3. Sev. depressed (<30%)

↓

b. Mode of measurement: 1. MUGA / RVG 2. ECHO 3. Angiographic contrast ventriculogram

**COMPLETE THE REMAINING QUESTIONS
ONLY IF THE PATIENT WAS DISCHARGED ALIVE**

- H2. Where was the patient discharged?
1. Home 2. Transferred to another hospital 3. Other, specify _____

- H3. Was the patient in NYHA Classification III or IV at discharge? 1. YES 2. NO

I. Medications

- I1. Were any of the following medications prescribed at discharge? 1. YES 2. NO

<p>a. Beta blocker <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>b. ACE inhibitor <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>c. Digoxin <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>d. Anticoagulant <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>e. Nitrate (PO or Topical) <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>f. Diuretic <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p>	<p style="text-align: center;">↓</p> <p>g. Calcium channel blocker <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>h. Lipid – lowering agent <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>i. Angiotensin (A II) receptor antagonist <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>j. Aspirin or other oral anti-platelet agent <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>k. Amiodarone <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p> <p>l. Other antiarrhythmic agent <input type="checkbox"/> 1. YES <input type="checkbox"/> 2. NO</p>
---	--

Person completing form: _____ Date: _____

**ENTER DATA ON THE MAGIC WEB SITE
AT [HTTPS://STUDY.NERI.ORG/MAGIC](https://study.neri.org/magic)
WITHIN 48 HOURS OF COMPLETION,
OR FAX THIS FORM TO (617) 926-7090**

