SEE INSTRUCTIONS ON BACK

MAGIC: Magnesium in Coronaries
Form 01 – Randomization & Study Drug Administration Form

A. Patient Identification and Randomization Information

A1. Study ID Number: [AFFIX STUDY ID LABEL HERE]

A2. Date of randomization: ___ ___ / ___ ___ / ___ ___ ___ ___ (MONTH / DAY / YEAR)

A3. Date of birth: ___ ___ / ___ ___ / ___ ___ ___ ___ (MONTH / DAY / YEAR)

A4. Gender: ☐ 1. Female ☐ 2. Male

A5. Is the patient Hispanic? ☐ 1. YES ☐ 2. NO

A6. Patient's race (select one): ☐ 1. White ☐ 2. Black ☐ 3. Asian/Pacific Islander ☐ 4. Other, a. specify: _____

B. Pre-Randomization Findings

B1. MI symptom onset: Date: ___ ___ / ___ ___ / ___ ___ ___ ___ (MONTH / DAY / YEAR) a. Time: ☐☐ : ☐☐ 24-hour clock

B2. Blood pressure immediately prior to randomization: ☐☐☐ / ☐☐☐ mm Hg (a. Systolic / b. Diastolic)

B3. Heart rate immediately prior to randomization: ☐☐☐ Beats per minute

B4. Clinical evidence (x-ray or bilateral rales greater than ½ lung fields) of pulmonary congestion on admission? ☐ 1. YES ☐ 2. NO

C. Study Drug Treatment

C1. Was the 15-minute bolus started? ☐ 1. YES ☐ 2. NO

If NO:

Reason not started:
- a. Sustained Hypotension ☐ 1. YES ☐ 2. NO
- b. Bradycardia / heart block ☐ 1. YES ☐ 2. NO
- c. Death ☐ 1. YES ☐ 2. NO
- d. Other reason ☐ 1. YES ☐ 2. NO
  - d1. Specify: _____

C2. Date bolus started: ___ ___ / ___ ___ / ___ ___ ___ ___ (MONTH / DAY / YEAR) C3. Time bolus started: ☐☐ : ☐☐ 24-hour clock

C4. Was ischemic discomfort present when study drug was initiated? ☐ 1. YES ☐ 2. NO ☐ 3. UNKNOWN

C5. Was the 15-minute bolus completed? ☐ 1. YES ☐ 2. NO

If NO:

Discontinued due to:
- a. Sustained Hypotension ☐ 1. YES ☐ 2. NO
- b. Bradycardia / heart block ☐ 1. YES ☐ 2. NO
- c. Death ☐ 1. YES ☐ 2. NO
- d. Other reason ☐ 1. YES ☐ 2. NO
  - d1. Specify: _____

C6. Was the 24-hour infusion started? ☐ 1. YES ☐ 2. NO

If NO:

Reason not started:
- a. Sustained Hypotension ☐ 1. YES ☐ 2. NO
- b. Bradycardia / heart block ☐ 1. YES ☐ 2. NO
- c. Death ☐ 1. YES ☐ 2. NO
- d. Other reason ☐ 1. YES ☐ 2. NO
  - d1. Specify: _____

Person completing form: _____ Date: _____

FAX THIS FORM WITHIN 24 HOURS OF COMPLETION TO THE CLINICAL TRIAL CENTER AT (617) 926-7090