Affix Patient I.D. Here

COMPLETE THIS FORM EACH TIME THE PATIENT IS HOSPITALIZED AFTER ENROLLED IN CAST

1 Hospitalization admission date: ___/___/___ (mo dy yr) DATE17

STUDY DRUG AT ADMISSION THERAP17

2 ☐1 No drug (before open label titration)

☐2 CAST Therapy

DRUG17 ☐1 CAST-ENC ☐2 CAST-FLEC ☐3 CAST-MOR

DOSE17 ☐1 Dose 1 ☐2 Dose 2 ☐3 Other: ___ mg/day

☐3 Washout

☐4 Individualized Therapy

IT17 ☐1 No antiarrhythmic therapy

☐2 Non-CAST antiarrhythmic therapy

specify: _____

_____

PRIMARY REASON FOR HOSPITALIZATION

3 ☐1 Non-cardiac REASON17

☐2 Cardiac (check only ONE)

4 ☐1 VT (Complete VT form if disqualifying, CAST 21)

☐2 Recurrent MI (Complete Recurrent MI form, CAST 20)

☐3 New or worsened CHF (Complete New or Worsened CHF, CAST 19)

CARD17 ☐4 Syncope (Complete Adverse Symptoms form, CAST 08)

☐5 Angina

☐6 Cardiac procedure or surgery

☐7 Initiation of CAST study drug

☐8 Other (specify)

_____

EVENTS DURING HOSPITALIZATION

5 Check ANY events that occurred DURING hospitalization:

DEATH17 ☐1 Death (Complete Death or Cardiac Arrest form, CAST 23)

☐1 Resuscitated cardiac arrest (Complete Death or Cardiac Arrest form, CAST 23)

CAVTS17

☐1 VT (Complete VT form if disqualifying, CAST 21)

MI17 ☐1 Recurrent MI (Complete Recurrent MI form, CAST 20)

CHF17 ☐1 New or worsened CHF (Complete New or Worsened CHF, CAST 19)

☐1 Syncope (Complete Adverse Symptoms form, CAST 08)

ANGINA17 ☐1 Angina

CARDP17 ☐1 Cardiac procedure or surgery

If YES, check any procedures that were done:

6 CABGV17 ☐1 CABG or valve replacement

AIPACE17 ☐1 AICD implant or pacemaker insertion

OTHER17 ☐1 Aneurysm resection, thrombolytic therapy or other cardiac procedure

OTHCAR17 ☐1 Other cardiac event (specify)

7 Hospital discharge date: __/__/__ (mo dy yr) DTDIS17

STUDY DRUG AT DISCHARGE

8 ☐1 CAST Therapy

DISDRG17

TXDIS17

☐1 CAST-ENC ☐2 CAST-FLEC ☐3 CAST-MOR

☐1 Dose 1 ☐2 Dose 2 ☐3 Other: ___ mg/day

DISDOS17

☐2 Washout

☐3 Individualized Therapy

DISIT17

☐1 No antiarrhythmic therapy

☐2 Non-CAST antiarrhythmic therapy

specify: _____

Name of person filling out form ____ Code Number