61885

AVID

Lab Data

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

Affix Patient ID # Here seqnum06

Complete this form (only for patients receiving amiodarone) at:

- Baseline.
- Follow-up visits (testing recommended every 3 - 6 months).
- Event where lab data was obtained.

1 Date of lab test:

days06 Month / Day / Year

2 Reason for completion:

reason06

1 ○ Baseline

follow06 Closest to scheduled follow-up:

2 ○ 3 mo	3 ○ 6 mo	4 ○ 9 mo	5 ○ 1 yr
6 ○ 1 yr 3 mo	7 ○ 1 yr 6 mo	8 ○ 1 yr 9 mo	9 ○ 2 yr
10 ○ 2 yr 3 mo	11 ○ 2 yr 6 mo	12 ○ 2 yr 9 mo	13 ○ 3 yr
14 ○ 3 yr 3 mo	15 ○ 3 yr 6 mo	16 ○ 3 yr 9 mo	17 ○ 4 yr

3 ○ Event

Note: Reason = 2 when a follow-up bubble is checked.

3 Current antiarrhythmic therapy:

txnone06 ○ No Therapy txicd06 ○ ICD txanti06 ○ Antiarrhythmic drug

If antiarrhythmic drug, specify:

dramio06 ○ Amiodarone dose: amiomg06 mg/day

droth06 ○ Other:

dose: mg/day

dose: mg/day

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LABDATA

Date: ___ / ___ / ___
Month / Day / Year

Affix Patient ID # Here

4 Test results:

TEST		RESULT		Test Not Done (2)	Outside Normal Range Yes (1)	Outside Normal Range No (0)	If Yes, Specify Possible Cause of Abnormality *
Clinical Chemistry:							
AST (SGOT)	sgot06	___	IU/L	absgot06			cssgot06
ALT (SGPT)	sgpt06	___	IU/L	absgpt06			cssgpt06
Alk Phos (ALK PHOS)	alp06	___	IU/L	abalp06			csalp06
Bilirubin (Total)	bilt06	___.___	mg/dL	abbilt06			csbilt06
OR Bilirubin (Direct)	bild06	___.___	mg/dL	abbild06			csbild06
TSH	tsh06	___.___	ulU/mL	abtsh06			cstsh06
Thyroxine (T4)	thy406	___.___	ug/dL or mcg/dL	abthy406			csthy406
OR Thyroxine (Free)	thyf06	___.___	ng/dL	abthyf06			csthyf06

Pulmonary Function Evaluation:			Test Not Done (2)	Outside Normal Range Yes (1)	Outside Normal Range No (0)	If Yes, Specify Possible Cause of abnormality *
Diffusion capacity, hemoglobin corrected (DLCO)						
dlcpre06 predicted	___.___	ml/min/ mmHg				
dlcact06 actual	___.___	ml/min/mmHg	abdlco06			csdlco06
AND/OR Chest X-ray			abxray06			csxray06

* **Possible Cause of Abnormality:**

1 = Amiodarone
2 = Concurrent drug therapy *(provide explanation)*
3 = Concurrent illness *(provide explanation)*
4 = Other known cause *(provide explanation)*
5 = Uncertain, not clinically significant
6 = Uncertain, clinically significant

If possible causes coded as 1, 2, 3, or 4 provide an explanation:

___

Signature of person filling out this form

___ code number

For Clinical Trial Center Use Only: rtnum06

CTC Code ___ | Yes ○ | No ○ | 2 0 6 0 4 0 1