



Affix Patient I.D. Here

1 Date:    /   /     
          mo  dy  yr

REASON FOR COMPLETION

- 2
- REASON#  1 Baseline
- 2 Open label titration
- 3 Randomization to blinded therapy
- 4 Scheduled followup (specify):
- |   |   |                                  |
|---|---|----------------------------------|
| <input type="checkbox"/> 1 4 mo         | <input type="checkbox"/> 2 8 mo         | <input type="checkbox"/> 3 1 YR  |
| <input type="checkbox"/> 4 1 YR + 4 mo  | <input type="checkbox"/> 5 1 YR + 8 mo  | <input type="checkbox"/> 6 2 YR  |
| <input type="checkbox"/> 7 2 YR + 4 mo  | <input type="checkbox"/> 8 2 YR + 8 mo  | <input type="checkbox"/> 9 3 YR  |
| <input type="checkbox"/> 10 3 YR + 4 mo | <input type="checkbox"/> 11 3 YR + 8 mo | <input type="checkbox"/> 12 4 YR |
| <input type="checkbox"/> 13 4 YR + 4 mo | <input type="checkbox"/> 14 4 YR + 8 mo | <input type="checkbox"/> 15 5 YR |
- 5 Interim visit.
- 6 Unscheduled event.

STUDY DRUG AT TIME OF EVALUATION

- 3
- THERAPY#  1 No drug (before open label titration)
- 2 CAST Therapy
- |                                     |                                      |                                     |
|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> 1 CAST-ENC | <input type="checkbox"/> 2 CAST-FLEC | <input type="checkbox"/> 3 CAST-MOR |
|-------------------------------------|--------------------------------------|-------------------------------------|
- 1 Dose 1     2 Dose 2     3 Other:     mg/day
- 3 Washout
- 4 Individualized Therapy
- IT#  1 No antiarrhythmic therapy
- 2 Non-CAST antiarrhythmic therapy

specify: \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

4 Was patient taking any medication other than CAST drug (including Individualized Antiarrhythmic Therapy)?

<sub>1</sub> yes <sub>2</sub> no MEDSØØ

If yes, complete lines 5 through 25.

- |    | yes                      | no                       |   |                                 |
|----|--------------------------|--------------------------|---|---------------------------------|
| 5  | <input type="checkbox"/> | <input type="checkbox"/> | Beta blocker                            | BETABKØØ                        |
| 6  | <input type="checkbox"/> | <input type="checkbox"/> | Calcium channel blocker                 | CABKØØ                          |
|    |                          |                          | If yes:                                 |                                 |
|    |                          |                          | <input type="checkbox"/>                | <sub>3</sub> Verapamil          |
|    |                          |                          | <input type="checkbox"/>                | <sub>4</sub> Diltiazam CABKTYØØ |
|    |                          |                          | <input type="checkbox"/>                | <sub>5</sub> Nifedipine         |
| 7  | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis preparation                   | DIGØØ                           |
| 8  | <input type="checkbox"/> | <input type="checkbox"/> | Diuretic                                | DIURETØØ                        |
| 9  | <input type="checkbox"/> | <input type="checkbox"/> | Vasodilator or afterload reducing agent | VASOØØ                          |
| 10 | <input type="checkbox"/> | <input type="checkbox"/> | Nitrate                                 | NITRATØØ                        |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | Inotropic agent                         | INOTROØØ                        |
| 12 | <input type="checkbox"/> | <input type="checkbox"/> | Other antihypertensive not listed above | HYPERTØØ                        |
| 13 | <input type="checkbox"/> | <input type="checkbox"/> | Lipid lowering agent                    | LIPLOWØØ                        |
| 14 | <input type="checkbox"/> | <input type="checkbox"/> | Potassium supplement                    | POTASSØØ                        |
| 15 | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemic                            | HYPØGLØØ                        |
| 16 | <input type="checkbox"/> | <input type="checkbox"/> | Anticoagulant                           | ANCOAGØØ                        |
| 17 | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin                                 | ASAØØ                           |
| 18 | <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory agent                 | ANINFLØØ                        |
| 19 | <input type="checkbox"/> | <input type="checkbox"/> | Antiplatelet                            | ANPLATØØ                        |
| 20 | <input type="checkbox"/> | <input type="checkbox"/> | Bronchodilator                          | BRONCHØØ                        |
| 21 | <input type="checkbox"/> | <input type="checkbox"/> | Tricyclic antidepressant                | TRICYCØØ                        |
| 22 | <input type="checkbox"/> | <input type="checkbox"/> | Phenytoin                               |                                 |
| 23 | <input type="checkbox"/> | <input type="checkbox"/> | Cimetidine                              | CIMETØØ                         |
| 24 | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid replacement                     | THYRDØØ                         |
| 25 | <input type="checkbox"/> | <input type="checkbox"/> | Other, specify:                         | OTHMEDØØ (Phenytoin or other)   |

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\_\_\_\_\_

\_\_\_\_\_

ACEØØ (ACE Inhibitor)  
 ACETYØØ (ACE Inhibitor type)  
 OTHVASØØ (Other Vasodilator)