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28411

OCCLUDED ARTERY TRIAL (OAT)
Long-Term Outcome Follow-Up Form

Please Use Black Pen To Fill Out Form.

Patient's ID Number: ___ - ___ Letter Code: ___ Correction ○

Date of Contact: ___ - ___ - ___ (mmm dd yyyy) *fm71dt*

○ Not Done *form71nd*

Period in months: 18 ○ 24 ○ 30 ○ 36 ○ 42 ○ 48 ○ 54 ○ 60 ○ 66 ○ 72 ○ 78 ○ 84 ○ 90 ○ 96 ○ 102 ○ *visit*

Instructions: At each 6 month contact, record the first event and date for each event since the last completed Outcome Follow-Up Form.

	Yes	No	Unknown	Date (mmm dd yyyy)	Date Unknown
1. Death If Yes, complete OAT Form 14. Complete Form 15 if hospitalized.	○ *odeath*	○	○	*odthdt*	○ *odth_uk*
2. Recurrent MI If Yes, complete OAT Form 17. Complete Form 15 if hospitalized.	○ *omi*	○	○	*omidt*	○ *omi_uk*
3. Hospitalization or outpatient therapy for CHF If Yes, complete OAT Form 18. Complete Form 15 if hospitalized.	○ *ochf*	○	○	*ochfdt*	○ *ochf_uk*
4. Other CV hospitalization If Yes, complete Form 15.	○ *ohosp*	○	○	*ohospdt*	○ *ohosp_uk*
5. Stroke If Yes, complete Form 15.	○ *ostroke*	○	○	*ostrkdt*	○ *ostrk_uk*
6. Placement of AICD If Yes, complete Form 15.	○ *oaicd*	○	○	*oaicddt*	○ *oaicd_uk*
7. Percutaneous Coronary Intervention If Yes, complete Forms 15 and 16.	○ *opci*	○	○	*opcidt*	○ *opci_uk*
8. CABG If Yes, complete Form 15.	○ *ocabg*	○	○	*ocabgdt*	○ *ocabg_uk*

Signature: _____ ___ - ___
OAT Staff Number

FAX to MMRI (410) 323 - 4729

e-mail to MMRI