

# SOLVD

## HOSPITALIZATION FORM

VERSION B / 9-1-1986

RAND ID:

FORM:  S  H  F

VERSION:  B

VISIT:

SEQUENCE NUMBER:

**INSTRUCTIONS:**

This form is to be used each time a randomized participant has been hospitalized. If the form is used between SOLVD visits, the visit number entered should be the last SOLVD visit attended by the participant. The sequence number is needed to indicate the number of times this form has been used between any two visits. Sequence number should start with 01 the first time the form is used for the participant for a specific visit number. Print clearly when entering a response in the appropriate boxes. For multiple choice questions, circle the one appropriate letter corresponding to the response chosen. Specific instructions for various questions are enclosed in boxes directly below the question. See the SOLVD General Instructions for Completing Forms for details.

SOLVD HOSPITALIZATION FORM (screen 1 of 6) (SHF page 1 of 4)

**A. IDENTIFYING INFORMATION**

1. Today's Date:   /   /

Month      Day      Year

2.1. Last Name:

2.2. First Name:

2.3. Middle Name:

3. Hospital Name:

4.1. Date of Admission:   /   /

Month      Day      Year

4.2. Date of Discharge:   /   /

Month      Day      Year

**B. PRIMARY REASON FOR HOSPITALIZATION**

5. Hospitalization.....

Cardiovascular      C

Noncardiovascular      N

If Cardiovascular (C), go to Question 7. on page 2.

6. If Noncardiovascular (N), specify:

Go to section C. SECONDARY REASONS FOR HOSPITALIZATION, Question 11. on page 3.



C. SECONDARY REASONS FOR HOSPITALIZATION

11. Hospitalization.....

Cardiovascular	C
Noncardiovascular	N
None	O

If Cardiovascular (C), go to Question 13.

If None (O), go to section D. INITIALS OF PERSON COMPLETING THIS FORM, Question 2B. on page 4.

12. If Noncardiovascular (N), specify:

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Go to section D. INITIALS OF PERSON COMPLETING THIS FORM, Question 2B. on page 4.

Indicate SECONDARY REASONS:

Yes	No
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13. Worsening CHF.....	Y	N
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Yes	No
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14. New CHF.....	Y	N
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15. Worsening or new angina.....	Y	N
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16.1. Myocardial Infarction (MI).....	Y	N
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If No (Myocardial Infarction), go to Question 17.

16.1a. Date of MI:

		/			/		
Month			Day			Year	

16.1b. Time of MI:

		:		
Hours			Minutes	

16.1c. (Circle one)

a.m. ....	A
p.m. ....	P

Yes	No
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16.2. Pain.....	Y	N
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16.3. Elevated enzymes.....	Y	N
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Yes	No
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16.4. Changes in ECG.....	Y	N
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17. Nonfatal cardiac arrest or ventricular tachycardia that required defibrillation...	Y	N
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18. Supraventricular tachycardia or fibrillation that required DC conversion or pacing.....	Y	N
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19. Uncertain tachycardia that required DC conversion or pacing.....	Y	N
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20. Other arrhythmias.....	Y	N
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21. Stroke.....	Y	N
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22.1. Cardiac surgery.....	Y	N
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If No (Cardiac surgery), go to Question 23.

22.2. If Yes (cardiac surgery), indicate the type.....

Graft	G
Valve	V
Transplantation	T
Graft & Valve	B
Other	O

If Graft (G), Valve (V), Transplantation (T) or Graft & Transplant, go to Question 23.

22.3. If Other (O), specify:

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Yes	No
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23. Pulmonary embolism.....	Y	N
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24. Peripheral embolism.....	Y	N
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25. Hypotension.....	Y	N
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Yes No

26. Azotemia..... Y N

27.1. Any other major event..... Y N

If No (major event), go to Question 28.

27.2. If Yes, specify other major event:

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D. INITIALS OF PERSON  
COMPLETING THIS FORM

28. Initials..... 

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