open-label-meds

AFRICAN AMERICAN STUDY OF KIDNEY DISEASE AND HYPERTENSION
AASK STUDY
STATUS OF PATIENTS ON UNAPPROVED OPEN LABEL ANTIHYPERTENSIVES FORM # 37

This form is to be completed every calendar quarter thereafter, in February, May, August, and November for randomized AASK patients who have not had an approved stop point but are currently taking open label ACE, beta blockers, Calcium Channel Blockers, or an Angiotensin II receptor blocker (ARB) such as Cozaar or Hyzaar.

1. Identification Number.....	2. Name Code.....	3. Date: mm/dd/yyyy med_dt

Which of the following antihypertensives is this patient taking? (0=no, 1=yes)
(This should match the most current Form 5 for this patient)

4. AASK Blinded Meds ..... aask_med ___
5. ACE ..... ace ___
6. Beta Blockers ..... bb ___
7. Calcium Channel Blockers ..... ccb ___
8. ARB ..... arb ___
9. Who is the main person who wants this patient on an unapproved antihypertensive? (1=the Patient or Patient's family, 2=AASK Physician/Team member, 3=Outside physician) ..... who ___
10. What is the main reason cited? (1=Effective blood pressure control, 2=Side effects, 3=Cardiologic medical condition, 4=Non cardiologic medical condition, 5=Other) ..... rsn_code ___
11. What does the AASK team plan to do? (code) ..... plan_code ___
    - 1 = Rechallenge the patient with blinded meds
    - 2 = Declare a stop point (or wait for the results of a stop point which was already submitted, or re-apply with more details if a past stop point was rejected)
    - 3 = Nothing for now
    - 4 = Other

12. Why is the patient on an unapproved antihypertensive? **Whatever your response to items 9 and 10**, please write (and key enter) a text explanation. Use the back of the page if necessary - you will be able to enter as much text as you wish. Description of team plan. **Also, if item 11 = Other,** please write (and key enter) a brief text explanation of the team plan.

plan_text

(Certification)

200. Date this form completed (mm/dd/yyyy) ..... compl_dt _ _/_ _/_ _ _ _

201. Certification ID of person completing this form ..... compl_by _ _ _ _ _ _ _

202. Certification ID of person entering this form ..... enter_by _ _ _ _ _ _ _

For Clinical Center Use Only
Date Entered _ _/_ _/_ _ _ _ **Verified?** _____