VITATOPS Follow-up Data Form (1 year)

Please use a black pen & BLOCK PRINT IN CAPITALS

Centre and Patient Details:

Date of Randomisation: _____/_____/_____ Type of Follow-up (eg postal, clinic, GP visit, telephone) _____

Patient initials _____ Randomising Dr/RN _____ VITATOPS number _____ Today's date ____/____/_____
dd mm yyyy

Primary or Secondary Outcome Event or Adverse Event *(since last follow-up)*: Yes (1) No (2)

If Yes, please fill out a blue Major Events Form

Vascular Surgery or Angioplasty / Stent *(since last follow-up)*: Yes (1) No (2)

If Yes, specify type _____

Current Risk Factors *(if deceased the following applies to the period immediately prior to patient's death)*

Current blood pressure *(systolic/diastolic)* _____ /_____ *(seated, right arm, Phase V Korotkov sound)*

Current smoker ? Yes (1) No (2)

Atrial fibrillation ? Yes (1) No (2)

Ischaemic heart disease ? Yes (1) No (2)

Peripheral vascular disease ? Yes (1) No (2)

Current Medications:

Anti-platelet drugs ? Yes (1) No (2)

Anti-coagulants ? Yes (1) No (2)

Anti-hypertensives ? Yes (1) No (2)

Lipid- lowering therapy ? Yes (1) No (2)

Treatment (diet or other) for diabetes mellitus ? Yes (1) No (2)

Anti-depressants ? Yes (1) No (2)

Please specify any other medications _____

_____

VITATOPS Medication Compliance *(Collect returned bottle and label with the patient name, today's date and VITATOPS number)*

On average, since the last follow up how many times per week was the trial medication taken?

(0) times per week
(1-2) times per week
(3-4) times per week
(5-6) times per week
(7) times per week

Did patient **stop** the trial medication at all since the last follow up? Yes, temporarily (1) Yes, permanently (2) No (3)

If Yes, specify dates and reason _____

Is the patient taking vitamins/minerals **other than** the trial medication Yes (1) No (2)

If Yes, please specify: _____

Has the patient been treated for depression since last review? Yes (1) No (2)

Has the patient been diagnosed with dementia since last review? Yes (1) No (2)

Dementia and Depression (optional)

MMSE score _____ (please also fax a copy of the MMSE test sheet to the trial office)

HAD Score A _____ D _____ (please also fax a copy of the HADS test sheet to the trial office)

Blood Test Results (if available)

Homocysteine (fasting) _____ (μmol/L)

Cholesterol (fasting) _____ (mmol/L)

Triglycerides (fasting) _____ (mmol/L)

Creatinine _____ (μmol/L)

Glucose (fasting) _____ (mmol/L)

Please write a prescription for 6 months supply of VITATOPS tablets with the VITATOPS randomisation number and make a follow-up appointment for 6 months from now

Please FAX this form now to: VITATOPS Trial coordinator Fax: 0800 291 523