

# VITATOPS Follow-up Data Form (6 months)

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)

Anti-depressant Trial Medication? 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: \_\_\_\_\_

**Oxford Handicap Score** (0) (1) (2) (3) (4) (5) (see back of this sheet for categories)

**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)

Post ML homocysteine \_\_\_\_\_ (µmol/L)

Cholesterol (fasting) \_\_\_\_\_ (mmol/L)

Triglycerides (fasting) \_\_\_\_\_ (mmol/L)

Creatinine \_\_\_\_\_ (µmol/L)

Glucose (fasting) \_\_\_\_\_ (mmol/L)

HISS sub-study samples collected ? (RPH only) Yes (1) No (2)

**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: 1800 000 225**