GWTG-Afib
Post-Ablation Follow-up Case Review Form
December 2020

Legend: Elements in bold are required

Patient ID:

Follow_Up

Ablation procedure date: ___/____/_____

Discharge date: ___/____/_____

Date of most recent clinical follow-up (EP clinic or discharge date)	(MM/DD/YYYY):___/____/_____

Patient alive? O Yes O No	If no, Patient Date of Death: _____/_____/_____

Adverse events: O Yes O No	(if yes, check all that apply): ❑ Air embolus ❑ Atrioesophageal Fistula ❑ AV Fistula ❑ Death ❑ Deep Venous Thrombosis ❑ Gastroporesis ❑ Hematoma ❑ Hemopericardium O Tamponade O Pericardiocentesis ❑ Hypotension ❑ Myocardial Infarction	❑ Phrenic Nerve Injury ❑ Pseudoaneurysm ❑ PV stenosis ❑ Retroperitoneal Bleed ❑ Still LA Syndrome ❑ Stroke ❑ Transfusion ❑ Transient Ischemic Attack ❑ Volume overload/ Pullmonary Edema ❑ Other (specify) ____________________

Rehospitalization for adverse event(s): O Yes O No

Arrhythmia-related hospitalizations: O Yes O No	If yes, enter date (MM/DD/YYYY): _____/____/_____

Cardioversion: O Yes O No	If yes, enter cardioversion date (MM/DD/YYYY): _____/____/_____

Recurrence of Clinical Arrhythmia (Electrocardiographically/EGM confirmed): O Yes O No

If Clinical Atrial Arrhythmia recurred, select type: O Paroxysmal A-fib O Persistent A-Fib O A-Flutter

Change in medical therapy? O Yes O No

Antiarrhythmic Discontinuation: O Yes O No	If yes, enter Antiarrhytmic Discontinuation date (MM/DD/YYYY): ___/____/_____

Is the patient currently taking any of the following cardiac medications? O Yes O No	(if yes is selected, check all that apply): ❑ ACE-I ❑ Aldosterone Antagonist ❑ Angiotensin Receptor Blocker ❑ Beta Blockers	❑ Digoxin ❑ Diuretic ❑ Nondihydropyridine (CCB) ❑ Statin

Is the patient currently on antiarrhythmic drug therapy? O Yes O No	(if yes is selected, check all that apply): ❑ amiodarone (Cordarone) ❑ disopyramide (Norpace, Norpace CR) ❑ dofetilide (Tikosyn) ❑ dronedarone (Multaq)	❑ flecainide (Tamborcor) ❑ propafenone (Rythmol, Rythmol SR) ❑ quinidine ❑ sotalol (Betapace, Betapace AF)

NOT FOR USE WITHOUT PERMISSION. ©2017 American Heart Association and Quintiles. For questions, call 888-526-6700

Is the patient currently on anticoagulation therapy?	If yes, select all anticoagulation therapies that apply:	If no:
O Yes O No	❑ apixaban (Elliquis) ❑ dabigatran ❑ edoxaban (Savaysa) ❑ rivaroxaban (Xarelto) ❑ warfarin (Coumadin, Jantoven)	Date of discontinuation: ____________ Reason for discontinuation (check all that apply) ❑ Major bleeding event ❑ Minor bleeding event ❑ Risk of bleeding ❑ CHA_2DS_2-VASc Score < 2 ❑ Patient preference

Repeat Ablation (Clinical Arrhythmia): O Yes O No	More than one repeat ablation ❑
If yes, enter date (MM/DD/YYYY): ____/____/_____	
Sinus rhythm maintained after ablation: O Yes O No	Estimated time patient was in sinus rhythm post ablation (days) _______
How was maintenance of sinus rhythm determined	❑ 24-hour monitoring ❑ 7-day monitoring ❑ 14-day monitoring ❑ 21- day monitoring ❑ 30-day monitoring ❑ AliveCor/Kardia ❑ Implanted loop recorder ❑ Intracardiac lead ❑ Resting office ECG ❑ Smartwatch ❑ Symptoms ❑ UTD/ND
Symptoms of Recurrent Arrhythmia: O Yes O No	

NOT FOR USE WITHOUT PERMISSION. ©2017 American Heart Association and Quintiles. For questions, call 888-526-6700