# British Women's Heart and Health Study

Name:

Date of birth: Address:

NHS Number:

Practice ID: Postcode:

Please attach a photocopy of the hospital letter or discharge summary
**Or** fill in this whole form, for the event on this date

## Atrial Fibrillation Validation Form

1.0 Date of Diagnosis: ☐ «w1rr_source_derived_date_event»

2.0 Were any of the following investigations used to make the diagnosis of atrial fibrillation, please indicate which by ticking Yes or No, If Yes please attach a copy:-

| | | Yes | No |
|---|---|---|---|
| 2.1 | ECG | ☐1 | ☐2 |
| 2.2 | Holter Monitor (other ambulatory ECG) | ☐1 | ☐2 |
| 2.3 | other (please give details)_____ | ☐1 | ☐2 |

3.0 Has the patient been prescribed medications to control the heart rate/rhythm?

| | Yes | No |
|---|---|---|
| Beta blocker | ☐1 | ☐2 |
| Calcium | ☐1 | ☐2 |
| Channel blocker | ☐1 | ☐2 |
| Digoxin | ☐1 | ☐2 |
| Quinidine | ☐1 | ☐2 |
| Propafenone | ☐1 | ☐2 |
| Flecainide | ☐1 | ☐2 |
| Amiodarone | ☐1 | ☐2 |

4.0 Has the patient been prescribed medication to reduce atrial fibrillation associated stroke risk?

| | Yes | No |
|---|---|---|
| Warfarin | ☐1 | ☐2 |
| Dabigatran | ☐1 | ☐2 |
| Rivaroxiban | ☐1 | ☐2 |
| Apixaban | ☐1 | ☐2 |
| Aspirin | ☐1 | ☐2 |
| Clopidogrel | ☐1 | ☐2 |
| Dipyridamole | ☐1 | ☐2 |

5.0 Has the patient been treated with any of the following procedure?

| | Yes | No |
|---|---|---|
| Electrical (DC) cardioversion | ☐1 | ☐2 |
| Invasion ablation | ☐1 | ☐2 |

6.0 Was she admitted to hospital? Yes ☐1
No ☐2

7.0 If Yes, which hospital _____

8.0 Do you have a hospital letter confirming a diagnosis of atrial Fibrillation/flutter? Yes ☐1
No ☐2

9.0 Comments:

Reviewers Name: ……..Date: ..…../…..…/……..

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Please return to:
British Women's Heart and Health Study
UCL The Farr Institute of Health Informatics Research
222 Euston Road
London
NW1 2DA

For Office Use Only:
BWHHS Record Review Round 6
Version 1

Study ID: