Data collection tool

Title: ***Anticoagulation in atrial fibrillation for stroke prevention in resource-limited settings: A report from Arsi University Referral Hospital in Ethiopia*.**

Part I: Introduction

My name is _____. I am working with the research team of Arsi University Referral and Teaching Hospital. We would like to assure you your name will not be mentioned in the questionnaire and the information that you will give us will be kept confidential and only used for research purpose. You have full right to refuse to take part or to interrupt the interview at any time. But the information that you will give us is quite useful to achieve the objective of the study and to bring change in atrial fibrillation managements.

Are you willing to participate in the study? 1- Yes 2 - No

If the answer is yes, thanks! Conduct the interview. If the answer is no, Thanks!

Don't force or reinforce an individual to participate in the survey

Interviewer's: name ---------- signature -------

Date of interview ---------- date ----------month/2020 G. C.

Checked on ---------- date----------month/2020 G.C

Complete 1 Incomplete 2 other (specify) ----------

Part II: ***Consent form***

In signing this document, I am giving my consent to participate in the study titled **magnitude of anticoagulation use in patients with AF as primary prophylaxis of stroke in medical follow up clinic**.

I have been informed that the purpose of this study to assess **magnitude and level of anticoagulation use in AF patients as primary prophylaxis of stroke at medical follow up clinic** ARTH. I have understood that participation in this study is entirely voluntarily. I have been told that my answers to the questions will not be given to anyone else and no reports of this study ever identify me in any way. I have also been informed that my participation or non-participation or my refusal to answer questions will have no effect on me. I understood that participation in this study does not involve risks.

I understood that Dr. Diress Molla is the contact person if I have questions about the study or about my rights as a study participant.

Investigator: Dr.Diress Molla

Cell phone: +251 909262342

E-mail:molladiress@gmail.com

Participant's signature and date: _____

Part III: ***Data collection questionnaire***

Patient interview Date _____Card number _____

Section 1 – Socio-demographic and clinical data

1. Age of the patient in years _____
2. Sex A. Male ☐ B.Female ☐
3. Weight(Kg)_____Height(meter)_____BMI_____
4. Occupation - 1.Farmer ☐ 2.Merchant ☐ 3.Employee in governmental institution ☐ 4. Employee in non-governmental institutions ☐
5. Residence -1. Urban ☐ 2. Rural ☐

Section II – Medication history

6. Have you been told to have HTN? 1. Yes ☐ 2. NO ☐
7. Have you been told to have DM? 1. Yes ☐ 2. NO ☐
8. How many years have you been told to have rhythm problem? 1. Yes ☐ 2.NO ☐
9. Have you been told to have renal problem? 1. Yes ☐ 2.NO ☐
10. Are you taking aspirin prevention (show the drug) of first stroke? 1. Yes ☐ 2 .No ☐
11. Are you taking warfarin prevention of first stroke? 1.Yes ☐ 2..NO ☐
12. If you're a nswer is yes for the above question, for how long have you been taking warfarin (Yedem makitegna in Amharic? _____
13. Was there any bleeding tendency while you were taking warfarin? 1.Yes ☐ 2.No ☐
14. If your answer is yes for the above question, what was the type of bleeding?

1. Nasal bleeding ☐ 2. Bloody urine ☐ 3.bleading to brain,

4.Other, ☐ specify _____

15. What was the INR level at the time of bleeding(can be from the chart)_____

Section III – Financial history

16. What is your average monthly income?_____
17. What is the average amount you spend on medication (warfarin) monthly? ----------
18. What is the average amount you spend on laboratory for INR monthly? ----------
19. What is the average amount you spend for transportation for a single visit? ----------
20. What is the type of atrial fibrillation? 1. Valvular ☐ 2. Non-valvular ☐
21. If the answer for the above question is non-valvular what is the CHA2DS2-Vasc score? ------
22. If the answer for the above question is 2 and above, what is the HAS BLED score?.----------
23. Was there any drug discontinuation? 1. YES ☐ 2. NO ☐
24. If the answer for the above question is yes, for how long was the drug discontinued?---------
25. What was the reason for drug discontinuation? 1. Poor adherence ☐ 2. Unavailability of the drug. ☐ 3. Drug side effect ☐ 4.finicial ☐ 5. Other ☐ specify…….
26. Was there a diagnosis of ischemic stroke or transient ischemic attack while the patient was taking prophylaxis for stroke? 1. Yes ☐ 2. NO ☐
27. If the answer for the above question is yes, what was the medication?

1. Aspirin ☐ 2.Warfarin ☐

28. If the patient was taking warfarin, what was the INR result at that time?.....

29. Types of medications the patient is taking currently (please select all the patient takes)?

1 .Aspirin ☐ 2 .Warfarin ☐ 3.ACEI ☐ 3.BB ☐ 4. Digoxin ☐

5. Diuretics ☐ 6. Satins ☐ 7. NSAIDS ☐ 8. Anti acids ☐ 9.others ☐

specify_____

Investigation results

30. Renal function test Creatinine _____ BUN_____

31. Liver function test 1. Normal ☐ 2. Abnormal ☐

32. Complete blood count: Hemoglobin_____ Platelet_____ ☐

Echocardiography

33. Thrombus in left atrium or appendage? 1. Yes ☐ 2.NO ☐

34. If the patient has valvular disease, what is the diagnosis?

1. Rheumatic heart disease ☐ 2.Degenerative disease. ☐ 3. Other ☐

specify_____

35. Final echocardiography conclusion?

1. Rheumatic heart disease ☐ 2. Ischemic heart disease 3. ☐ Dilated cardiomyopathy ☐ 4 .LVH ☐ 6. Degenerative valvular heart disease

7 .pulmonary hypertension ☐ 8. Other, ☐ specify……

Declarations:

Declaration of Investigator

I, the undersigned student of Internal Medicine, declare that this proposal is my original work in partial fulfillment of the requirement for the Specialty in Internal Medicine to my best knowledge.

Name of investigator: _____

Signature: _____ Date_____

Declaration of Advisors

We, the undersigned Advisors, declare that this proposal is our original work in partial fulfillment of the requirement for the Specialty in Internal Medicine for the stated student

above to our best knowledge. We confirmed that this proposal is ready for defense with our approval as the university advisor(s).

Date of Submission: _____

Name of primary Advisors:	**Signatures**	**Date**
_____	_____	_____
Name of secondary Advisors:	**Signatures**	**Date**
_____	_____	_____