

CUSTOMER EVENT REPORT

Reporter Information

Event Reporter Name:	
Telephone:	
Email:	
Distributor Name:	

User Information

Country:	
Was user trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Training Provider (if known):	

Device Information

Device Type (Check one.)	Device Serial Number	Device Software Version
<input type="checkbox"/> SAM PAD 300		
<input type="checkbox"/> SAM PAD 300P		
<input type="checkbox"/> SAM PAD 350P		
<input type="checkbox"/> SAM PAD 360P		
<input type="checkbox"/> SAM PAD 450P		
<input type="checkbox"/> SAM PAD 500P		
<input type="checkbox"/> PDU 400		

Pad-Pak™ Information

Pad-Pak Type (Check one.)	Lot/Serial Number	Expiration Date
<input type="checkbox"/> Pad-Pak		
<input type="checkbox"/> Pediatric-Pak™		

Patient Information*

<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/ third gender	
Age in Years:	
Weight in Kgs (Estimation):	
Time of Use (Local):	
Date of Use:	

Pre-Existing Medical Conditions (if known)

Medical Condition (Check all that apply.)

<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hyperlipidaemia
<input type="checkbox"/> Implanted Pacemaker
Please list other known conditions:

Event Information

Was the event witnessed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, by whom?
Was CPR performed by bystander prior to AED switch on?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for how long?
What was the rescuer response time (from SCA to retrieving AED)?		
Was patient breathing prior to commencing CPR?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Did the patient have a pulse prior to commencing CPR?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was a shock delivered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

* Only information requested on the Customer Event Form should be provided. All other patient information should remain anonymous.

Type of Location of Resuscitation Attempt

Location (Check one.)	Details (For instance, a gym, dentist office, restaurant, park) Please do not provide identifiable information such as place names or addresses.
<input type="checkbox"/> Home	
<input type="checkbox"/> Office	
<input type="checkbox"/> Medical Facility	
<input type="checkbox"/> Sports Center	
<input type="checkbox"/> Public Space	
<input type="checkbox"/> Other	
<input type="checkbox"/> Unknown	

Patient Outcome

Outcome (Check one.)	Details, such as extra information on resuscitation attempt (For instance, when did ambulance arrive, what actions were taken, survival beyond hospital admission etc.) Please do not provide identifiable information such as city names, hospital names or addresses.
<input type="checkbox"/> Survived to hospital admission	
<input type="checkbox"/> Survived to hospital discharge	
<input type="checkbox"/> Did not survive	
<input type="checkbox"/> Unknown	

Is the device used available for investigation, if required?

Yes No

Was the event downloaded using Saver EVO™ software?

Yes No

If yes, please upload event file to:

<http://heartsine.com/support/upload-saver-evo/>

If no, should HeartSine provide a printed or download version of the event?

Printed Downloaded Neither

Forward Hearts

Has the survivor been informed of the HeartSine Forward Hearts program? (http://heartsine.com/forward-hearts)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the survivor wish to participate in the Forward Hearts program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

TERMS Following are the terms for the Free Pad-Pak and Forward Hearts programs.

1. The event must be an actual sudden cardiac arrest to qualify.
2. The event is verified by the HeartSine Clinical Team, whose decision is final.
3. Exclusions apply. Please contact your sales representative for details.
4. Please do not attach any picture, audio and/or video recording related to the reported event.
5. The person completing this form will ensure compliance with local privacy regulations, and agrees to ensure no identifiable information is contained in this form.

Signature: _____ **Date:** _____

Please detail your experience using this AED

Please do not provide any identifiable information on individuals and places involved

EMEA/APAC

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