

For Internal Use Only	
<b>Clinical Event Reference</b>	
<b>Marketing Event Reference</b>	

# Customer event report

**FORM MUST NOT CONTAIN INFORMATION THAT COULD IDENTIFY THE PATIENT**

Please do not provide any identifiable information, such as patient name, address or location of hospital.

## Patient information

Male  
  Female  
  Non-binary/ third gender  
 Age in years: \_\_\_\_\_  
 Weight (estimation): \_\_\_\_\_  
 Lb  
 Kg

## Event information

Country: \_\_\_\_\_

Date of use:	Time of use (local):
Was the event witnessed?	<input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, relationship to patient?
Was CPR performed by bystander prior to AED switch on?	<input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, for how many minutes?
What was the rescuer response time from SCA to retrieving AED?	In minutes: _____
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

## Location type for resuscitation attempt

Location type (Check one)	Details
<input type="checkbox"/> Home	Please indicate the specific type of location (gym, dentist office, restaurant, etc.), providing as much information as possible.  <b>DO NOT PROVIDE PLACE NAME, ADDRESS OR GEOGRAPHICAL LOCATION.</b>
<input type="checkbox"/> Office	
<input type="checkbox"/> Medical facility	
<input type="checkbox"/> Sports center	
<input type="checkbox"/> Public space	
<input type="checkbox"/> Other (Describe location, without name or geographical location)	

## Patient outcome

Outcome (Check one)	Details
<input type="checkbox"/> Survived to hospital admission	Please provide any additional information on rescue attempt (when did ambulance arrive, actions taken).  <b>DO NOT PROVIDE CITY, OR HOSPITAL NAME OR ADDRESS.</b>
<input type="checkbox"/> Survived to hospital discharge	
<input type="checkbox"/> Did not survive	

## Patient pre-existing medical condition (if known)

Condition (Check all that apply)

Diabetes mellitus

Hypertension

Hyperlipidaemia

Implanted pacemaker

Please list other known conditions:

## Event file

The event file, downloaded using SAVER EVO software, must be provided with this form. Please use the following filename structure:

**Device serial number\_Date of event (MM-DD-YYYY)**

Please send both the form and the event file (.evo) to AEDEvent@Stryker.com. A PDF file will not be accepted.

If you need assistance downloading the file, please contact support at HeartSineSupport@stryker.com.

## Device information

Device type (Check one)

SAM PAD 300     SAM PAD 360P

SAM PAD 300P     SAM PAD 450P

SAM PAD 350P     SAM PAD 500P

Device serial number

## Pad-Pak™ information

Pad-Pak type (Check one)

Pad-Pak

Pediatric-Pak™

Lot/Serial number

Expiration date

## Reporter information

Event reporter name:

Telephone:

Email:

Distributor name:

## User information

Was user trained? (if known):

Yes     No

Training provider (if known):

## Terms

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

1. Please do not attach any picture, audio and/or video recording related to the reported event.
2. Event must be a sudden cardiac arrest to qualify. (Event is reviewed by Stryker Clinical team whose decision is final.)
3. Please refer to heartsine.com for the complete list of requirements to qualify for Free Pad-Pak and/or Forward Hearts after a Stryker AED has been used during a sudden cardiac arrest resuscitation.

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 of reporter: \_\_\_\_\_ Date: \_\_\_\_\_

**Please detail your experience using this AED.**

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