



For Internal Use Only

Clinical Event Reference

Marketing Event Reference

## 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?

Yes  No If yes, relationship to patient?

Was CPR performed by bystander prior to AED switch on?

Yes  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?

Yes  No  Unknown

Did the patient have a pulse prior to commencing CPR?

Yes  No  Unknown

Was a shock delivered?

Yes  No

#### Location type for resuscitation attempt

Location type (Check one)

Details

Home

Please indicate the specific type of location (gym, dentist office, restaurant, etc.), providing as much information as possible.

Office

**DO NOT PROVIDE PLACE NAME, ADDRESS OR GEOGRAPHICAL LOCATION.**

Medical facility

Sports center

Public space

Other (Describe location, without name or geographical location)

#### Patient outcome

Outcome (Check one)

Details

Survived to hospital admission

Please provide any additional information on rescue attempt (when did ambulance arrive, actions taken).

Survived to hospital discharge

**DO NOT PROVIDE CITY, OR HOSPITAL NAME OR ADDRESS.**

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](mailto:AEDEvent@Stryker.com). A PDF file will not be accepted.

If you need assistance downloading the file, please contact support at [HeartSineSupport@stryker.com](mailto: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](http://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.