HeartSine®

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. **DO NOT PROVIDE PLACE NAME, ADDRESS OR GEOGRAPHICAL LOCATION.**
☐ Office	
☐ 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). **DO NOT PROVIDE CITY, OR HOSPITAL NAME OR ADDRESS.**
☐ Survived to hospital discharge	
☐ Did not survive	

Patient pre-existing medical condition (if known)

Condition (Check all that apply)	Please list other known conditions:
☐ Diabetes mellitus	
☐ Hypertension	
☐ Hyperlipidaemia	
☐ Implanted pacemaker	

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)	**Device serial number**
☐ SAM PAD 300 ☐ SAM PAD 360P	
☐ SAM PAD 300P ☐ SAM PAD 450P	
☐ SAM PAD 350P ☐ SAM PAD 500P	

Pad-Pak™ information

Pad-Pak type (Check one)	**Lot/Serial number**	**Expiration date**
☐ Pad-Pak		
☐ Pediatric-Pak™		

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.