Area where the event took place: [Optional] OR OR OR OR OR OR OR OR	FOLLOW-UP QUESTIONS
Critical Care EX	Area where the event took place: [Optional] [2]
Stellice Nursing Unit	○ Critical Care ○ OR
Other Other On the applicable If you selected "Other" from the above menu, please specify where the event took place in the hospital. [2] FOLLOW-UP QUESTIONS Other location of event: [Optional] [2] FOLLOW-UP QUESTIONS Date of death: (mm/dd/yyyy) [2] Outcomes attributed to serious injury: (Check all that apply) [2] Outcomes attributed to serious injury: (Check all that apply) [2] Outcomes attributed to serious injury: (Check all that apply) [2] Outcomes attributed above, please describe the outcome. [2] FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) [2] Outcomes attributed to serious injury: (Check all that apply) [2] Outcomes attributed to serious injury: (Check all that apply) [2] Outcomes attributed to serious injury: (Check all that apply) [2] FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [2] Douter was hard to use Device was hard to was Device was Dev	
If you selected "other" from the above menu, please specify where the event took place in the hospital. 2 FOLLOW-UP QUESTIONS Date of death: (mm/dd/yyyy) FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes No Not applicable Outcomes attributed to serious injury: (Check all that apply) Outcomes attributed to serious injury: (Check all that apply) Outcomes attributed to serious injury: (Check all that apply) Outcomes attributed to serious injury: (Check all that apply) Outcomes attributed to serious injury: (Check all that apply) Outcomes attributed to serious injury: (Check all that apply) FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) Device sailed (e.g. broke, couldin't get it to work or stopped working) Device was hard to use Not Applicable FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] Device was hard to use Not Applicable If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name. If the provider Patient Not Applicable FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that apply) [Optional] Outcomes attributed to serious injury: (Check all that ap	Other Not known
FOLLOW-UP QUESTIONS Other location of event: [Optional] 2 FOLLOW-UP QUESTIONS Date of death: (mm/dd/yyyyy) 2 Yes	○ Not applicable
Distributed to serious injury: (Check all that apply) Contents	If you selected "Other" from the above menu, please specify where the event took place in the hospital. 2
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes	FOLLOW-UP QUESTIONS
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes	Other location of event: [Optional]
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes	
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes	Date of death: (mm/dd/yyyy)
Was intervention required to prevent permanent impairment or damage? Yes	(I) Culendar
Outcomes attributed to serious injury: (Check all that apply) Use	
Outcomes attributed to serious injury; (Check all that apply) Congenital anomaby Disability	Was intervention required to prevent permanent impairment or damage?
Outcomes attributed to serious injury: (Check all that apply)	
Congenital anomaly Disability Disabili	
Congenital anomaly Disability Other Not known Not applicable	Outcomes attributed to serious injury: (Check all that apply)
Not applicable	Congenital anomaly Disability
What problem did the user have (check all that apply) [Optional] 2 Device failed (e.g. broke, couldn't yet it to work or legice did not do what it was supposed to do Device was hard to use Other	
What problem did the user have (check all that apply) [Optional] 2 Device failed (e.g. broke, couldn't yet it to work or legice did not do what it was supposed to do Device was hard to use Other	
What problem did the user have (Check all that apply) [Optional] [2] Device failed (e.g. broke, couldn't get it to work or stopped working) Device was hard to use Device working) Device malfunction - that is, the device? (Check all that apply) [Optional] [2] Device failed (e.g. broke, Device failed (e.g. broke, Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Devi	If you checked "Other" above, please describe the outcome.
What problem did the user have (Check all that apply) [Optional] [2] Device failed (e.g. broke, couldn't get it to work or stopped working) Device was hard to use Device working) Device malfunction - that is, the device? (Check all that apply) [Optional] [2] Device failed (e.g. broke, Device failed (e.g. broke, Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it to work or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Device failed (e.g. broke, Couldn't get it ow ork or stopped working) Devi	
Device halled (e.g.), broke, couldn't get it to work or stopped working)	
couldn't get it to work or stopped working) Device was hard to use Other	What problem did the user have (Check all that apply) [Optional] [7] □ Device failed (e.g. broke, □ Device malfunction - that is, the
Not known Not Applicable	couldn't get it to work or device did not do what it was stopped working) supposed to do
Who was operating the device? (Check all that apply) [Optional] [2] Patient	
Who was operating the device? (Check all that apply) [Optional] [2] Patient	FOLLOW-UP OUESTIONS
Miled Health Provider Patient Other Not known Not applicable	Secretary and Agents was an account.
Patient	Doctor Nurse
Not known Not applicable	
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? POLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? POLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? POLLOW-UP QUESTIONS Who was a particular with the user have (Check all that apply) FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) [Optional] Device was hard to use with the device did not do what it was supposed to do what it was supposed to do what it was supposed to do there was hard to use with the device did not do what it was supposed to do there was hard to use with the device did not do what it was supposed to do there was hard to use with the device did not do what it was supposed to do the was operating the device? (Check all that apply) [Optional] POLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] Allied Health Provider patient of the was operating the device. Do not give the person's name. FOLLOW-UP QUESTIONS Date of dialysis: (mm/dd/yyyy) Date of dialysis: (mm/dd/yyyy) Date of chemotherapy: (mm/dd/yyyy) Collow-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) Lisamular FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	
FOLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? POLLOW-UP QUESTIONS Was intervention required to prevent permanent impairment or damage? Yes	If you calected "Other" above, please describe the type of person who was
Date of dialysis: (mm/dd/yyyy) 2 Calculated Calculate	operating the device. Do not give the person's name. $\sqrt{2}$
Date of dialysis: (mm/dd/yyyy) 2 Calculus Calculus	FOLLOW-UP OUESTIONS
Was intervention required to prevent permanent impairment or damage? Yes	Date of dialysis: (mm/dd/yyyy)
Was intervention required to prevent permanent impairment or damage? Pes	1 Carandar
Outcomes attributed to serious injury: (check all that apply) Ife-threatening	Charles and particular the particular and the
Outcomes attributed to serious injury: (Check all that apply) 2 Life-threatening	
Outcomes attributed to serious injury: (Check all that apply) Ife-threatening	
Life-threatening	
Congenital anomaly Obsability Other Not known Not applicable If you checked "Other" above, please describe the outcome. FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) [Optional] [2] Device failed (e.g., broke, couldn't get it to work or stopped working) Device was hard to use Other Not known Not known Not Applicable FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] [2] Doctor Nurse Family Member / Visitor Patient Other Not known Not applicable If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name. [7] FOLLOW-UP QUESTIONS Date of dialysis: (mm/dd/yyyy) [2] The calculated of the device of the type of person who was operating the device. Do not give the person's name. [8] FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) [2] The calculated of the event that may be of the event that the tim	Outcomes attributed to serious injury: (Check all that apply)
Not applicable	Congenital anomaly Disability
FOLLOW-UP QUESTIONS What problem did the user have (check all that apply) [Optional] [2]	
FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) [Optional] 2 Device failed (e.g. broke, couldn't get it to work or stopped working) Device was hard to use Not known FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] 2 Doctor Solve	_ not applicable
FOLLOW-UP QUESTIONS What problem did the user have (Check all that apply) [Optional] 2 Device failed (e.g. broke, couldn't get it to work or stopped working) Device was hard to use Not known FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] 2 Doctor Solve	If you checked "Other" above, please describe the outcome.
What problem did the user have (Check all that apply) [Optional] 2 Device failed (e.g. broke, couldn't get it to work or stopped working) Device malfunction - that is, the device did not do what it was supposed to do Other Not Known	
Device hald (e.g., broke, couldn't get it to work or stopped working) Device was hard to use Not known Not Applicable POLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] Dector	ANALOGO PARTO DE CONTROLO PORTO DE CONTROLO PORT
couldn't get it to work or stopped working) Device was hard to use Other Not Applicable FOLLOW-UP QUESTIONS Who was operating the device? (Check all that apply) [Optional] Other Not Applicable Misse Allied Health Provider Family Member / Visitor Other Not known Not applicable If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name. Other Ot	What problem did the user have (Check all that apply) [Optional]
Device was hard to use	couldn't get it to work or device did not do what it was stopped working) supposed to do
Who was operating the device? (Check all that apply) [Optional] 2	Device was hard to use Other
Who was operating the device? (Check all that apply) [Optional] 2 Doctor	
Doctor Nurse Nur	Taken of the state
Allied Health Provider Family Member / Visitor Other Other Not known Not applicable If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name.	Who was operating the device? (Check all that apply) [Optional] [?] Doctor Nurse
Not known Not applicable If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name. Pollow-up QUESTIONS Date of dialysis: (mm/dd/yyyy) (Calendar) FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) (Calendar) To calendar FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	☐ Allied Health Provider ☐ Family Member / Visitor
perating the device. Do not give the person's name. [?] FOLLOW-UP QUESTIONS Date of dialysis: (mm/dd/yyyy) [?] FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) [?] [1] calendar FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	
perating the device. Do not give the person's name. [?] FOLLOW-UP QUESTIONS Date of dialysis: (mm/dd/yyyy) [?] FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) [?] [1] calendar FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	
FOLLOW-UP QUESTIONS Date of dialysis: (mm/dd/yyyy) 2 FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyyy) 2 FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	If you selected "Other" above, please describe the type of person who was operating the device. Do not give the person's name.
Date of dialysis: (mm/dd/yyyy) 2 1 Calendar FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyy) 2 1 Calendar FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	
FOLLOW-UP QUESTIONS Date of chemotherapy: (mm/dd/yyyyy) [2] FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	Section of the Agency Section of the
Date of chemotherapy: (mm/dd/yyyy) [2] [1] calendar FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	Date of dialysis: (mm/dd/yyyy)
FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	A CONTRACTOR OF THE CONTRACTOR
FOLLOW-UP QUESTIONS List other therapies used on the patient at the time of the event that may	Date of chemotherapy: (mm/dd/yyyy)
List other therapies used on the patient at the time of the event that may	I Carettar
have caused or contributed to the event: [limit: 50 lines of text]	List other therapies used on the patient at the time of the event that may
	have caused or contributed to the event: [limit: 50 lines of text]