

aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

Form Approved OMB No. 0920-XXXX Exp. Date XX/XX/2016

Patient chair #:	Shift:	on regular dialysis schedule
Patient chair #:	_ Shift:	on the event date (if different)
NATE A L	ı	
What do you reme	mber occu	urred during the event?
Did you notice any	thing unus	sual about patient X during several days before the event?
Did you notice any	thing unus	sual about patient X on that day before the event?
Did you notice any	recent ch	anges at the facility?
Ask the foll	•	
-New medi		
-New equip		
<del>-</del>	_	hings before or during dialysis?
-new staff	lany staif,	including service and house keeping)

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

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What did they do when the event happened?
Did you have any symptoms on that day during dialysis, such as shortness of breath, faint anxious, itching, rash)? Yes/No
If Yes, what were they and when did they occur?

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