

PATIENT INFORMATION

Patient identifier: (DO NOT USE the patient's name, initials, social security number, date of birth, medical record number or other personal identifiers)

(Please limit your response to 8 characters)

Patient's age at time of event:

Patient's gender:

Male

Female

Not known

Not applicable

Patient's weight: (select unit or "do not know")

Patient's race and ethnic background (check all that apply): [Optional]

American Indian or Alaskan Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or other Pacific Islander

White

Unknown

Not applicable

Did the patient have any of the following preexisting characteristics that may have contributed to the event? (Check all that apply)

Allergies

Alcohol/drug use

COPD

Coronary heart disease

Diabetes

Hepatic/renal dysfunction

Hypertension

Immuno-compromised

Morbidly obese

Pneumonia

Pregnancy

Premature infant

Smoking

Status post total hysterectomy or salpingo-oophorectomy

Stroke

Surgery

Relevant accidents (e.g. Hit head)

Electrophysiology related characteristic (ACC registry)

Other

No preexisting characteristics

Not known

Not applicable

Please provide any other information about the patient that may have influenced the outcome of the event. [limit: 50 lines of text]

Cancel

Save »