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| **Intake** | |  |
| \* | **Consent to the personal data processing** | **By submitting this questionnaire to Stryker LLC (address of location - 125167, Moscow, Leningradskiy Avenue, 39, bldg. 80, floor 3), I guarantee that all the data provided will be anonymized and will not contain my personal data, personal data of the patient(s) or personal data of the medical worker(s). This data is collected, processed, stored in order to control undesirable events associated with Stryker products. Actions with the provided data include recording, systematization, accumulation, storage, clarification (update, change), extraction, use, access of the organization's personnel, cross-border transfer, blocking, deletion, destruction of personal data.**  **I provide the consent for personal data processing** |
| \* | **Country Of Event** |  |
| \* | Product Family |  |
| \* | **Stryker Personnel** |  |
| \* | CIC | Complaint Intake Center |
| \* | Awareness Date | When Stryker Employee first becomes aware of this issue event or complaint. |

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| **Event Details** | |  |
| \* | **Event Date** | **What date did the issue occur?** |
|  | **Approx** | **Pick Yes, if exact event date is unknown.** |
| \* | **Event description** | **What was experienced? What happened? Was any replacement device used?** |
| \* | **How was the issue Noticed?** | **Was this identified during, prior or after medical procedure/installation/in coming inspection/service, out of box failure?** |
| \* | **Procedure completed successfully?** |  |
| \* | **Patient Involvement?** | **Was the patient affected as a result of the event?** |
| \* | **Medical Intervention?** | **Any unanticipated medical procedures/treatments/therapy administered in relation to the alleged event or device malfunction.** |
| \* | **Surgical Delay** | **Any unanticipated delay or prolongation to any medical procedures/treatments/therapy?** |
| \* | **Adverse Consequences** | **Any patient or user impact/affect** |
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|  | **Death Date** |  |
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| \* | **User/Distribution Reported** | **Did the Initial Reporter Report this to a Regulatory Authority?** |

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| **Contact Information** | |  |
| \* | **Initial Reporter Facility**  **(Stryker /third part distribution site)** | **If known, Enter Initial Reporter Facility name.** |
| \* | **Initial Reporter Type** |  |
| \* | **Initial Reporter Address** |  |
| \* | **Initial Reporter City** |  |
|  | **Initial Reporter Postal Code** |  |
| \* | **Initial Reporter Country** |  |
| \* | **Initial Reporter Email:** |  |
| \* | **Initial Reporter Phone** |  |
|  | **Contact Reporting Incident / Hospital name**  **(when Incident was reported by a Stryker third part distribution site)** |  |
|  | **Hospital Address**  **(when Incident was reported by a Stryker third part distribution site)** |  |
|  | **Health Professional Occupation** | **If health profession, list occupation.** |
|  | **Contact Information:Tel.#, Fax # , e-mail address**  **(when Incident was reported by a Stryker third part distribution site)** |  |

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| **Product Details** | |  |
| 1. **Product – long description:\*** | | |
| **Catalogue #** | | |
| **Lot/Serial #** | | |
| **Quantity** | | |
| 1. **Product – long description:\*** | | |
| **Catalogue #** | | |
| **Lot/Serial #** | | |
| \* | **Complainant Require Results** | **Does complainant require investigation results?** |
| \* | **Product Available To Stryker** |  |
| \* | **Product Not Available, Why Not** |  |
|  | **Medical Records Available** | **Photos, X-Rays, Medical Files** |
|  | **Product to be Returned** | **Is Product to be returned to complainant?** |
| Products to be Returned List  Products to be returned to the complainant following investigation. | | |

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| **Patient/Physician Info** |  |
| **Patient Identifier** | **For confidentiality purposes, list initials or other similar patient identifier.** |
| **Anatomy Position** | **Body part affected by event.** |
| **Gender** |  |
| **Age at time of event** |  |
| **Age Units (Patient)** |  |
| **Height** |  |
| **Height Units** |  |
| **Weight** |  |
| **Weight Units** |  |
| **Date of Birth** |  |
| **Date of Implant** |  |
| **Date of Explant** |  |
| **Activity – Post Implant** | **Describe patient activity post-surgery.** |
| **Revision** | **Indicate if implant event is about (or revision of) primary product, if not primary, what revision number.** |
| **Clinical Study Type** |  |
| **Clinical Study Description** |  |