

ROC PRIMED ANNOTATION

Changes as of 02-24-2009

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Complete this form:

- for any episode where ROC EMS CPR (any compressions)/defibrillation was performed or ITD opened (even if not used)

Main data resource: PCR

Other data resources: Dispatch



Patient Enrollment

Version 1.04.01

Date: 09/16/2008

Page 1 of 2

Episode Information:

Date (mm/dd/yyyy)
/ /

Time call received at dispatch (hh:mm:ss; 24hr clock)
: : DPINTMCAT

From PCR/other From dispatch

DPINSR obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID:
- -

Incident Number (optional)

Site Linking ID (optional)

1. EMS response: (List vehicles in the order that they arrived at the scene)

Agency name	Vehicle name	# of personnel	Service level				Time of arrival (24 hours) hh:mm:ss	Source			ITD Opened*		ITD Used		ITD # nn- <u>nnn</u> -n
			BLS	BLS-D	BLS+	ALS		1 Watch	2 Dispatch	0 No Tim	1 Yes	0 No	1 Yes	0 No	
1: _____	_____	RIG1NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RIG1TM : _____	ARTMSR1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ITD1OPN	ITD1USE	- - -	
2: _____	_____	RIG2NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RIG2TM : _____	ARTMSR2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ITD2OPN	ITD2USE	- - -	
3: _____	_____	RIG3NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RIG3TM : _____	ARTMSR3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ITD3OPN	ITD3USE	- - -	
4: _____	_____	RIG4NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RIG4TM : _____	ARTMSR4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ITD4OPN	ITD4USE	- - -	

* If more than one ITD opened or any ITD opened and not used, complete Alert CTC form

2. Exclusion Criteria:

a. Both protocols specific:

Yes No

- XAGE Age < age of consent
- XDNR Pre-existing "Do Not Resuscitate" orders
- XTRAUM Arrest due to traumatic cause (blunt, penetrating, burns)
- XSANG Arrest due to exsanguination
- XPRISN Known prisoner
- XPREG Known pregnancy
- XNRSUS No EMS CPR or EMS defibrillation

If ITD opened must still complete all forms (except for "Known prisoner")

b. ITD specific:

Yes No

- XTRACH Tracheostomy present
- XMECH Mechanical CPR/ventilator device used
- XNRVTX Non-ROC vehicle applied pads or began CPR AND no agreement in place to get time call received data

c. Analyze Late vs. Early specific:

Yes No

- XNERHY Non-fire/EMS rhythm analysis (e.g. AED/defib. use by lay person)
- XNRATX Non ROC EMS agency on scene and placed pads or began CPR or EMS directed bystander to continue CPR
- XWITNS ROC EMS witnessed arrest → Complete forms through hospital discharge

3. If all exclusion criteria answered "No" in Item 2a & 2b AND "No" ITD Opened in Item 1, why not?

- Sustained ROSC prior to ITD
- Forgot YNOITD
- Other _____

(60)

continue to next page



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)**

Site Linking ID (optional)

4. CPR Assignment:

a. What agency and vehicle (either ROC or non-ROC) was FIRST to direct the initial chest compressions?

Agency name: } **NOCOMP** or No EMS compressions

Vehicle name:

b. If randomized by defibrillator, note the AED/defibrillator study number:

-

c. Intended ROC EMS CPR assignment: (of the first arriving ROC vehicle who directed the initial chest compressions)

Analyze early } Approximate seconds of CPR prior to analysis: or Not noted/Unknown

Analyze late }

N/A- exclusion noted above in **Item 2a and 2c (first 2 only)**

Not noted

5. Any indication that the patient was enrolled in another clinical trial?

No

Yes, non-ROC clinical trial → Specify:

No further forms required if "No" ITD opened in **Item 1**, and any exclusion criteria checked "Yes" in **Items 2a or 2c (first 2 only)**.

If EMS gives CPR or defibrillates a patient prior to receiving the DNR order and no ITD opened, **STOP HERE**

Person responsible for data on this form:

Complete this form:
 -for any episode where patient met enrollment or safety criteria or ITD opened
 Main data resource: PCR
 Other data resources: Dispatch



Pre-hospital Time Record

Version 1.00.01
 Date: 08/14/2007
 Page 1 of 1

Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : :

From PCR/other From dispatch
 Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

Time Record:

-Fill in Event Order, Watch time, and/or Dispatch/Defib time for all events that occurred. If an event did not occur, enter "0" for Event Order.
 -If the time of event in "Dispatch/Defib" is from Dispatch, enter "0" in the "Source Disp/Defib" box; otherwise enter "1", "2", ... where "1" is the 1st defibrillator used, "2" is the second defibrillator used and so on.
 -If the time of event in "Dispatch/Defib" is from a defibrillator and if that defibrillator appeared to be synched to the atomic clock, check the "Synched to Atomic Clock" box. If the defibrillator was *not* synched to the atomic clock (e.g. time seems off), enter the probable time in the "Aligned Time" field.
 -If no documented time exists (from Watch, Dispatch, or defib) for an event that occurred, fill in event order, leave the time fields blank and check the "No Doc Time" box. The exception is "911 call received at primary PSAP" (enter the event order as "0" if you do not know the time).

-Additional Instructions/Documentation

Event	Event Order 1-19 0=NA	Time of Event		Source Disp Defib	Defib Appears Synched to Atomic Clock	No Doc Time	Computer to generate (you may adjust)	
		Watch hh:mm:ss	Dispatch/Defib hh:mm:ss				Aligned Time hh:mm:ss	Adj ↓
<input type="text"/> 911 911 call received at primary PSAP	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> RCV 1st 911 call received at dispatch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> DSP 1st vehicle dispatch time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> BSK 1st non-EMS shock	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> ARR 1st vehicle arrival at scene	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> AED 1st EMS AED/defib turned on	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> ALS 1st ALS arrival at scene	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> WAR Time of arrest if EMS witnessed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> RHY 1st CA EMS rhythm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> CPR 1st EMS CPR	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> ITD 1st ITD CPR	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> SAS 1st EMS shock assessment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> SHK 1st EMS shock	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> AIR Advanced airway established	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> RSC 1st ROSC	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> RMV First time ITD removed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> TRM Resus. stopped due to death	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> LFT Patient transported from scene	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> EDA ED or EMS destination arrival	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Sort Event Order Align Times Turn Align Off Original Order Reset Form

Note: Time Intervals will be computed at data entry time.

Person responsible for data on this form:



Episode Information:

Date (mm/dd/yyyy) / /
Time call received at dispatch (hh:mm:ss; 24hr clock) : :
ROC PRIMED ID: - -
Incident Number (optional)
Site Linking ID (optional)

From PCR/other From dispatch
 Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

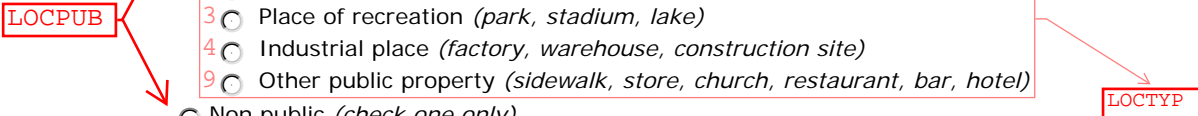
1. Location of Episode:

a. Location (check one only)

- Census tract:
US: State County Tract Link <http://www.ffiec.gov/Geocode/default.aspx>
Toronto: CTName/CTUID (nnnn.nn/nnnnnnn.nn)
- Lat/long:
Latitude → Decimal degrees DMS DM
Longitude → Decimal degrees DMS DM
Datum → NAD83 NAD27 WGS84
- UTM:
Easting → Meters Kilometers
Northing → Meters Kilometers
Zone
- Unknown/not noted

b. Public or non public?

- Public (check one only)
 - 1 Street/highway
 - 2 Public building (schools, government office)
 - 3 Place of recreation (park, stadium, lake)
 - 4 Industrial place (factory, warehouse, construction site)
 - 9 Other public property (sidewalk, store, church, restaurant, bar, hotel)
- Non public (check one only)
 - 5 Home residence (inside or immediately surrounding)
 - 6 Farm/ranch
 - 7 Healthcare facility
 - 8 Residential institution (assisted living, nursing home)
 - 10 Other private



2. Demographics:

- a. Age:** ^{AGE} (years)
 Calculated from DOB
 Estimated by EMS
If no age available use categories below:
 - Child (1 - 11 years)
 - Adolescent (12 - 19 years)
 - Adult (20 - 39 years)
 - Middle age (40 - 60 years)
 - Older (61 - 75 years)
 - Elderly (> 75 years)
- b. Gender:**
 1 Male 2 Female → ^{SEX}
- c. Race/Ethnicity:** (check all that apply)
 Hispanic or Latino Asian
 White Native Hawaiian/Pacific Islander
 African-American/Black Other
 American-Indian/Alaska Native Unknown/not noted

Episode Information:

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ROC PRIMED ID: - - **Incident Number** (optional) **Site Linking ID** (optional)

3. Cardiac arrest occurred:

After EMS (includes fire) arrival/witnessed by EMS → skip **Item 4**

Before EMS arrival

Witnessed (seen or heard) by someone (other than EMS personnel)

Not witnessed (seen or heard)

Unknown/not noted

Patient did not have a cardiac arrest

4. Was resuscitation attempted by bystanders?

Unknown/not noted

No

Yes → Was CPR attempted? Yes No

→ Was AED/defib applied?

No

Yes → Were shocks delivered? No Unknown/not noted Yes → # of shocks: Or Unknown

→ AED/defib applied by: Lay person Police Healthcare Other Unknown/not noted

5. EMS Chest compressions:

Manual

Mechanical compression/ventilation

→ Was ITD used during mechanical compression/ventilation? No Yes → Complete **Alert CTC** form

No EMS chest compressions

6. ITD information:

No ITD used → skip to **Item 7**

a. Emesis noted-

Prior to ITD placement? Yes No

During ITD use? Yes No

b. ITD attached to: (check all)

Mask

ETT

Other advanced airway: LMA Combitube King LT PLA Other: (20)

c. Filter used?

No Yes → Types: 1) 2)

d. Timing light failed?

No Yes Light not used

e. Mask & ITD: Any indication that there were problems maintaining a tight seal (e.g. facial hair, height of equipment, etc.)?

No

Yes → Why: (30)

Mask not used

f. Was there any indication that a tight seal was not maintained during COMPRESSIONS and ventilations?

Yes

No

continue to next page

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ROC PRIMED ID: - - **Incident Number** (optional) **Site Linking ID** (optional)

7. Pre-hospital intervention:

No EMS Pre-hospital interventions from the list below were recorded PNOINT

NA/NR Done

PBAG Airway, bag-mask
 Continuation of non-EMS advanced airway
PADAIR EMS Airway, advanced - Check all attempted/used:

PETTO Oral ET OETNAT OETNNN
 # of attempts OR Not noted
 Was it successful? No Yes OETSUC

PSGA Combitube, LMA, etc. SGANAT
 # of attempts OR Not noted SGANNN
 Was it successful? No Yes SGASUC

Nasal ET
 # of attempts OR Not noted
 Was it successful? No Yes

OTHERADVAIR
 1=Yes; 0=No

RSI
 Cricothyrotomy
 CPAP
 Ventilator

PCPR CPR
PHYPTX Hypothermia therapy
PFLUID IV/IO line -

Check all attempted:
PIO IO → Was it successful? Yes No PIOSUC
PIV Initiation and/or continuation of an IV → Was it successful? Yes No PIVSUC

Was fluid given?
PFLDLV 0 No
 3 Unknown/not noted
 2 TKO (To Keep Open)
 1 Yes (Check all given)

Fluid type	Total volume infused (optional)
PD5W <input type="checkbox"/> D5W <input type="text"/> mls PD5WML	
PNS <input type="checkbox"/> Normal Saline <input type="text"/> mls PNSML	
PLR <input type="checkbox"/> Lactated Ringers <input type="text"/> mls PLRML	
<input type="checkbox"/> Other <input type="text"/> mls	
<input type="checkbox"/> Unknown/not noted	

PMON Monitor, advanced - Check all attempted:
PECG 12-lead
PETCO2 EtCO₂
PPACE Pacing

continue to next page



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8. Drug therapies noted:

Drug Given		Total Dose	Route (check all attempted)			
NA/NR	Yes Name		IV	ETT	IO	Drip
I. REQUIRED:						
<input type="radio"/>	PEPI Epinephrine	PEPING mg	PEPIIV	PEPIET	PEPIIO	PEPIDP
II. TOTAL DOSE/ROUTE ARE OPTIONAL FOR THE FOLLOWING:						
<input type="radio"/>	PAMIO Amiodarone	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	PATRO Atropine	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	PBIC Bicarb	<input type="text"/> mEq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	PLIDO Lidocaine	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. DRUG NAME/TOTAL DOSE/ROUTE ARE OPTIONAL FOR THE FOLLOWING:						
<input type="radio"/>	<input type="radio"/> Calcium	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	<input type="radio"/> Dextrose	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	<input type="radio"/> Magnesium	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	<input type="radio"/> Naloxone	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	<input type="radio"/> Procainamide	<input type="text"/> mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/>	<input type="radio"/> Vasopressin	<input type="text"/> IU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRUG CLASS GIVEN IS OPTIONAL FOR THE FOLLOWING:						
<input type="radio"/>	<input type="radio"/> Inotropes					
<input type="radio"/>	<input type="radio"/> Paralytics					

9. Past History: (from PCR - do not use ED/Hospital records)

- None noted → skip to **Item 10**
- | | |
|---------------------------------------|---|
| <input type="checkbox"/> MI | <input type="checkbox"/> Cardiac medications |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> HTN | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> CHF | <input type="checkbox"/> CABG |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> ICD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Syncope | <input type="checkbox"/> Other surgery |
| <input type="checkbox"/> Afib/flutter | <input type="checkbox"/> Other: <input type="text"/> (30) |

10. Etiology of arrest:

a. Field Classification (from field data) (required)

FCLASS 2 No field classification

0 No obvious cause identified (includes NEMSIS 2250 presumed cardiac) } Do Not complete Column A below

1 Obvious cause → (check one cause in Column A below)

continue to next page

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Continued from page 4 - **Item 10**

b. Site Classification (from field data) (required)

SCLASS 0 No obvious cause identified (includes NEMSIS 2250 presumed cardiac) → Do Not complete Column B below
 1 Obvious cause → (check one cause in Column B below)

c. Were there contributing factors directly related to this cardiac arrest? (from field data; site abstracts information) (required)

— See Manual of Operations for expanded definitions

PCONTR 0 None noted → Do Not complete Column C below
 1 Yes → (check all that apply in Column C below)

Obvious Cause	A Field Classification	B Site Classification	C Contributing Factors
Anaphylaxis	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Chemical poisoning (intentional or unintentional, includes carbon monoxide, toxic gases)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Dialysis	-	-	<input type="checkbox"/>
Drowning	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Drug poisoning (intentional or unintentional, includes alcohol)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Electrocution (non-lightning)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Excessive cold	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Excessive heat	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Foreign body obstruction	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Hanging	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Lightning	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Mechanical suffocation	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Non-traumatic exsanguination	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Radiation exposure	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Respiratory	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
SIDS (sudden infant death syndrome)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Smoke inhalation	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Strangulation	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Terminal illness (includes end-stage diseases such as cancer)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Trauma (includes blunt, penetrating or burns)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Venomous stings	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
* Other obvious cause	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

* Other cause (A - Field classification): (60)
 * Other cause (B - Site classification): (60)
 * Other cause (C - Contributing Factors): (60)

continue to next page



Episode Information:

Date (mm/dd/yyyy) **Time call received at dispatch** (hh:mm:ss; 24hr clock)

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: **Incident Number** (optional) **Site Linking ID** (optional)

11. Disposition:

Died at scene or en route
Why was treatment halted? (check one)

- PDISP** →
- 1 Considered futile
 - 2 DNR (written or verbal)
 - 3 Obviously dead

Transported by EMS to ED/hospital with ROSC or ongoing resuscitation → Complete the **ED Admit** form
Transported method:

- PTRANS**
- 1 By land
 - 2 By air

Patient status at ED arrival:

- PROSC**
- 1 ROSC present
 - 2 Ongoing resuscitation

12. Did the implementation of the ITD or Analyze Late vs. Early protocol result in a safety issue (e.g., delay in treatment) or other potential adverse situation?

- ADVERS**
- No
 - Yes → Complete **Alert CTC** form.
 - Delay in treatment
 - Suspected mechanical failure of ITD
 - ITD filled with fluid
 - Airway bleeding
 - Failure to immediately remove the ITD following ROSC
 - Other, describe: _____ (30)

Person responsible for data on this form: _____



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : :
 From PCR/other From dispatch
 Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)
ROC PRIMED ID: -- **Incident Number (optional)** **Site Linking ID (optional)**

1. Does a continuous ECG recording exist for the EMS (includes fire) resuscitation?

No **CONECG** Yes → For the entire resuscitation or only part? Entire Part of the resuscitation **TOTECEG**
 → How many EMS recordings are there? **NUMECG**

2. Device used:

Order ECG Placed	Manufacturer				If Other; specify	(Required)				Reviewed by site		Attach Recording
	Medtronic	Philips	Zoll	Other		Feedback		Recording Exists		Yes	No	
						Turned on	Muted	Yes	No			Yes
1	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Upload
2	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Upload
3	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Upload

3. Were any shocks delivered by EMS responders?

No **EMSSHK** Yes → Number of shocks: **NUMSHK**

4. Sequence of events:

Rhythm/Shock Event	NA	Time of Rhythm/Shock (hh:mm:ss)	Rhythm (check one)						Source (check one)			Pause -Pre (time)	Pause -Post (time)	
			1 VFWT (includes AED shock)	2 PEA	3 Asystole	4 Perfusing	5 AED-No shock, No st	6 Cannot Determine	1 Continuous ECG	2 Snapshot ECG	3 PCR			
BRHY 1) 1st CA rhythm with non-EMS AED/defib	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ER10 2) 1st CA EMS rhythm within 10 secs of pad placement	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ERCD CA EMS rhythm if the line 2 'rhythm = Cannot Determine'	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ERAN 4) 1st EMS shock assessment	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ESHK1 5) EMS 1st shock	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ESHK1PR	ESHK1PO
ERPS1 6) Rhythm post shock (90-150 secs*)	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ERNA1 7) Rhythm at next analysis after 1st shock	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ESHK2PR	ESHK2PO
ESHK2 8) EMS 2nd shock	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ESHK2PR	ESHK2PO
ERPS2 9) Rhythm post 2nd shock (90-150 secs*)	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-
ERNA2 10) Rhythm at next analysis after 2nd shock	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ESHK3PR	ESHK3PO
ESHK3 11) EMS 3rd shock	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ESHK3PR	ESHK3PO
ERPS3 12) Rhythm post 3rd shock (90-150 secs*)	<input type="checkbox"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	-	-

* If unable to determine @ 90 - 150 seconds, note first evaluable rhythm at least 30 seconds after shock

continue to next page

Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : : From PCR/other From dispatch

ROC PRIMED ID: - - **Incident Number** (optional) Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial) **Site Linking ID** (optional)

5. ECG Analysis:

(hh:mm:ss)

Time first EMS machine turned on: : : OR Not available → **STOP HERE IF ONLY 1 DEVICE USED**

Time first EMS pads placed: : : **PADSTM**

Time of arrest if EMS witnessed: : :

Time of advanced airway placement: : : OR Unable to determine No advanced airway **YNTMAA**

Time resuscitation stopped due to death: : : OR Not applicable

Time of ED arrival: : : OR Not applicable

6. Did the ECG provide CPR process measurements?

CPRPRC No → **STOP HERE**

Yes → Complete the following section for the resuscitative effort
(for optional Ventilation study, complete for entire resuscitation effort)

Options for # seconds with No measures

1 - ROSC 2 - Unanalyzable

Device order	Start time (Auto fill) hh:mm:ss	No ECG	# Vent	# Comp	Comp rate	CPR fraction	# secs with No measures → Why	--(Optional)--						
								Comp depth	Comp release	Peak ET CO ₂	Capnography Vents	# secs missing	# audio vents	
<input type="checkbox"/>	1. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	2. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	3. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	4. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	5. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	6. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	7. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	8. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	9. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	10. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	11. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	12. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	13. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	14. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	15. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	16. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	17. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	18. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	19. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	20. <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> → <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Person responsible for data on this form:

Complete this form:

- episode qualifying for the Pre-hospital Form and the patient was admitted to the ED or the Hospital

- one for each ED patient admitted to

Main data resource: ED records



Episode Information:

Date (mm/dd/yyyy) Time call received at dispatch (hh:mm:ss; 24hr clock)

- From PCR/other From dispatch
Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: Incident Number (optional) Site Linking ID (optional)

1. ED admit information:

Patient bypassed ED and admitted directly to hospital -> Complete Item 3 only, then complete Hospital Admit form.

ED name:

2. Date/time of ED arrival/admit:

Date: Time: 24 hr clock (hh:mm)

3. Demographics (obtained from either ED or hospital information):

- a. Birth year: (yyyy)
b. Race (check all that apply)
American-Indian/Alaska Native
Asian
Black/African-American
Native Hawaiian/Pacific Islander
White
Unknown/not noted

c. Ethnicity: (check one only)

- Hispanic or Latino
Not hispanic or Latino
Unknown/not noted

4. Major procedures while in the ED:

No major procedures from the list below were noted ENOPRC

NA/NR Done

Form section for NA/NR Done with checkboxes for CPRMNE, CPRMCE, CXRE, ALVEOE, INTSTE, FIBRNE, HYPTEXE, LTEMPE, OPROCE, BILATE, VENCNE, NCXRRE, CMEGE, PULEDE, HYPETM, TMPUNE.

5. Possible pre-hospital complications related to study protocol or ITD use diagnosed in ED or autopsy: (check all that apply)

- NOCMPE None Noted
PUCMPE Evidence of Pulmonary Edema found on CXR within 48 hours of arrest
EAIRBL Airway bleeding not reported on the Pre-hosp form
OCMPE Other, describe: (30)
Complete Alert CTC form

6. ED discharge status: (check one only)

- Admitted to hospital -> Complete Hospital Admit form
Transferred directly to another hospital (bypassing other EDs) -> Complete the Hospital Admit form.
Died in ED EDISP
Transferred to another ED
Discharged alive (or left AMA) from ED



Episode Information:

Date (mm/dd/yyyy) / / Time call received at dispatch (hh:mm:ss; 24hr clock) : : From PCR/other From dispatch Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - Incident Number (optional) Site Linking ID (optional)

7. Date and time of ED discharge, admit to hospital, transfer to another ED, or death:

Date: / / (mm/dd/yyyy) Time: : 24 hr clock (hh:mm)

If patient admitted to hospital or transferred to another ED, skip Item 8.

8. Etiology of Arrest:

a. Site Classification (based on all available information including ED notes and public records)

ECLASS No obvious cause identified (Ut stein"presumed cardiac")
 Obvious cause → (check one cause in Column A below)

b. Were there contributing factors directly related to this cardiac arrest?

(based on all available information including ED notes and public records)

— See Manual of Operations for expanded definitions

ECONTR None noted → Do Not complete Column B below
 Yes → (check all that apply in Column B below)

Obvious Cause	A Site Classification	B Contributing Factors
Anaphylaxis	<input type="radio"/>	<input type="checkbox"/>
Chemical poisoning (intentional or unintentional, includes carbon monoxide, toxic gases)	<input type="radio"/>	<input type="checkbox"/>
Dialysis	-	<input type="checkbox"/>
Drowning	<input type="radio"/>	<input type="checkbox"/>
Drug poisoning (intentional or unintentional, includes alcohol)	<input type="radio"/>	<input type="checkbox"/>
Electrocution (non-lightning)	<input type="radio"/>	<input type="checkbox"/>
Excessive cold	<input type="radio"/>	<input type="checkbox"/>
Excessive heat	<input type="radio"/>	<input type="checkbox"/>
Foreign body obstruction	<input type="radio"/>	<input type="checkbox"/>
Hanging	<input type="radio"/>	<input type="checkbox"/>
Lightning	<input type="radio"/>	<input type="checkbox"/>
Mechanical suffocation	<input type="radio"/>	<input type="checkbox"/>
Non-traumatic exsanguination	<input type="radio"/>	<input type="checkbox"/>
Radiation exposure	<input type="radio"/>	<input type="checkbox"/>
Respiratory	<input type="radio"/>	<input type="checkbox"/>
SIDS (sudden infant death syndrome)	<input type="radio"/>	<input type="checkbox"/>
Smoke inhalation	<input type="radio"/>	<input type="checkbox"/>
Strangulation	<input type="radio"/>	<input type="checkbox"/>
Terminal illness (includes end-stage diseases such as cancer)	<input type="radio"/>	<input type="checkbox"/>
Trauma (includes blunt, penetrating or burns)	<input type="radio"/>	<input type="checkbox"/>
Venomous stings	<input type="radio"/>	<input type="checkbox"/>
* Other obvious cause	<input type="radio"/>	<input type="checkbox"/>

* Other cause (A - Site classification): (60)
 * Other cause (B - Contributing Factors): (60)

Complete this form:

- for episode qualifying for the Pre-hospital Form and the patient was admitted to a hospital

Main data resource: Hospital records



Hospital Admit

Version 1.06.01

Date: 02/24/2009

Page 1 of 4

Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

1. Hospital admit information (1st hospital):

Hospital admittance date: / / (mm/dd/yyyy) HADMDT

Hospital name:

2. Was the patient transferred to another acute care hospital before discharge?

No PTXFER

Yes →

Name of next acute hospital	Date of transfer (mm/dd/yyyy)
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

3. Major procedures while in the hospital:

No major procedures from the list below noted HNOPRC

NA/NR Done

CPRH CPR

CXRH Chest X-ray within 48 hours of arrest (complete only if no CXR done in ED)
Date / / (mm/dd/yyyy) Time : (hh:mm) CXRDT CXRTM
Chest X-ray results ALVEOH Alveolar pulmonary edema BILATH Bilateral pleural effusion VENCNH Pulmonary venous congestion
 INTSTH Interstitial pulmonary edema Cardiomegaly CMEGH None of these noted NCXRRH
b) Was pulmonary edema noted? 1 Yes 0 No PULEDH

FIBRNH Fibrinolytics

HYPHXH Hypothermia therapy HYPHTM HYPCON
a) Time started : 24hr clock (hh:mm) Or Continued from ED
b) Date/Time hypothermia therapy was stopped in the hospital HYPDTT Date / / (mm/dd/yyyy) Time : 24hr clock (hh:mm) HYPPTM
c) Lowest temperature degrees → 1 Centigrade 2 Fahrenheit TMPUNH

CATHDH Cath, diagnostic → Within 24 hours of arrival at ED After 24 hours of arrival at ED

CATHIH Cath, interventional (PCI, Stent, etc.) → Within 24 hours of arrival at ED After 24 hours of arrival at ED

CABGH CABG

PACERH Pacemaker implant

ICDH ICD implant → BiV Other

OPROCH Other major cardiac procedure: (30)

4. Possible pre-hospital complications related to study protocol or ITD use diagnosed in ED or autopsy : (check all that apply)

NOCMPH None Noted

PUCMPH Evidence of Pulmonary Edema found on 1st CXR within 48 hours of arrest (complete only if no CXR done in ED).

AIRBLH Airway bleeding not reported on Pre-hosp or ED Admit forms

OCMPH Other, describe: (30)

Complete Alert CTC form



Episode Information:

Date
(mm/dd/yyyy)
 / /

Time call received at dispatch
(hh:mm:ss; 24hr clock)
 : :

- From PCR/other From dispatch
 Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID:
 - -

Incident Number (optional)

Site Linking ID (optional)

5. Residential status prior to arrest:

- Home → ₁ Independent ₂ With assistance ₃ Unknown/not noted
 ₂ Rehabilitation **PREHOM**
PRERES ₃ Assisted living
 ₄ Nursing home
 ₅ Unknown

6. Etiology of Arrest:

a. Site Classification (based on all available information including ED/hospital records/notes and public records)

- HCLASS** ₀ No obvious cause identified (Utstein "presumed cardiac")
 ₁ Obvious cause → (check one cause in **Column A** below)

b. Were there contributing factors directly related to this cardiac arrest?

(based on all available information including ED/hospital records/notes and public records)
 — See Manual of Operations for expanded definitions

- HCONTR** ₀ None noted → Do Not complete Column B below
 ₁ Yes → (check all that apply in **Column B** below)

Obvious Cause	A Site Classification	B Contributing Factors
Anaphylaxis	<input type="radio"/>	<input type="checkbox"/>
Chemical poisoning (intentional or unintentional, includes carbon monoxide, toxic gases)	<input type="radio"/>	<input type="checkbox"/>
Dialysis	-	<input type="checkbox"/>
Drowning	<input type="radio"/>	<input type="checkbox"/>
Drug poisoning (intentional or unintentional, includes alcohol)	<input type="radio"/>	<input type="checkbox"/>
Electrocution (non-lightning)	<input type="radio"/>	<input type="checkbox"/>
Excessive cold	<input type="radio"/>	<input type="checkbox"/>
Excessive heat	<input type="radio"/>	<input type="checkbox"/>
Foreign body obstruction	<input type="radio"/>	<input type="checkbox"/>
Hanging	<input type="radio"/>	<input type="checkbox"/>
Lightning	<input type="radio"/>	<input type="checkbox"/>
Mechanical suffocation	<input type="radio"/>	<input type="checkbox"/>
Non-traumatic exsanguination	<input type="radio"/>	<input type="checkbox"/>
Radiation exposure	<input type="radio"/>	<input type="checkbox"/>
Respiratory	<input type="radio"/>	<input type="checkbox"/>
SIDS (sudden infant death syndrome)	<input type="radio"/>	<input type="checkbox"/>
Smoke inhalation	<input type="radio"/>	<input type="checkbox"/>
Strangulation	<input type="radio"/>	<input type="checkbox"/>
Terminal illness (includes end-stage diseases such as cancer)	<input type="radio"/>	<input type="checkbox"/>
Trauma (includes blunt, penetrating or burns)	<input type="radio"/>	<input type="checkbox"/>
Venomous stings	<input type="radio"/>	<input type="checkbox"/>
* Other obvious cause	<input type="radio"/>	<input type="checkbox"/>

* Other cause (A - Site classification): (60)

* Other cause (B - Contributing Factors): (60)



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss; 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

7. Vital Status at discharge:

VSHOSP 1 Dead → skip to **Item 10** **DCHOME**

0 Alive → complete disposition:

1 Home → 1 Independent 2 With assistance 3 Unknown/not noted

2 **DCRES** Rehabilitation

3 Assisted living

4 Nursing home

5 Remain in acute care hospital, reclassified as non-acute patient awaiting placement or chronic care

8. Structured Chart Review Tool for Assessment of Cerebral Performance Category at discharge:

a. Is the patient able to follow any simple commands or say any words?

0 **FOLCMD** No → skip to **Item 9**

1 Yes

b. Is the assistance of someone essential for all or part of the day for activities of daily living (dressing, preparing meals, local travel, shopping)?

0 **ASSIST** No

1 Yes → skip to **Item 9**

c. Is the patient able to return to work or social activities in any capacity (even limited)?

0 **RETWRK** No → skip to **Item 9**

1 Yes

d. Does the patient have any problems that are more than mild i.e. problems that prevent him/her from doing things that he/she would like to do or have to do (dysphasia, hemiplegia, ataxia, dysarthria, memory, cognition, personality)?

0 **MODPRB** No

1 Yes

9. Modified Rankin Scale at hospital discharge:

0 MRS0 - No symptoms at all

1 MRS1 - No significant disability despite symptoms: *able to carry out all usual duties and activities*

2 **MRS** MRS2 - Slight disability: *unable to carry out all previous activities but able to look after own affairs without assistance*

3 MRS3 - Moderate disability: *requiring some help, but able to walk without assistance*

4 MRS4 - Moderately severe disability: *unable to walk without assistance, and unable to attend to own bodily needs without assistance*

5 MRS5 - Severe disability: *bedridden, incontinent and requiring constant nursing care and attention*

10. Date and time of acute care hospital discharge, re-classification, or death:

Date: / / (mm/dd/yyyy) **HDSPDT**

Time: : (hh:mm) **HDSPTM**

Was patient made DNR or care limited/withdrawn during hospitalization?

Yes → Date: / / (mm/dd/yyyy) **DNRHDT**

No

11. Total days in the ICU/CCU: **DAYICU**

Number of days in hospital: (prefill)

DAYHSP

continue to next page



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss: 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

12. If death occurred, check one main category and one subcategory (where applicable):

- Subject is unstable, and continued life support is impossible or futile
Date of death: / / (mm/dd/yyyy) **FUTLDT**
- PREDTH** **YFUTIL** 1 Multi-system organ failure
- 2 Recurrent cardiac arrest with unsuccessful resuscitation
- 3 Intractable shock
- Subject has brain-death criteria, resulting in withdrawal of care and cardiovascular death
Date of decision: / / (mm/dd/yyyy) **BDTHDT**
- Subject is stable or continued life-support is possible. Because of other non-neurological considerations, care is withdrawn or limited resulting in death
Date of DNR decision: / / (mm/dd/yyyy) **DNR1DT**
- YDNR1** 1 Underlying terminal illness (metastatic cancer, for example)
- 2 Pre-existing advanced directives or living will
- 3 Family or surrogate representation of subject's wishes
- Subject is deemed to have poor neurological prognosis, and care is withdrawn or limited resulting in death
Date of DNR decision: / / (mm/dd/yyyy) **DNR2DT**

13. Were any of the following listed on the hospital discharge summary? (check all that apply)

- HDSNON** None noted
- HCVA** Cerebral bleeding/CVA Sternal fractures **HSTRFR**
- HSEIZ** Seizures ARDS **HARDS**
- HBLEED** Bleeding requiring transfusion or surgical intervention Liver failure **HLIVFL**
- HRECA** Rearrest (and resuscitated with intervention) Renal failure **HRENFL**
- HPULED** Pulmonary edema Sepsis **HSEPSS**
- HINTIN** Internal thoracic or abdominal injuries Pneumonia **HPNEU**
- HRIBFR** Rib fractures MI **HMI**

Interim vital status: Complete this if patient still hospitalized at the time of hospital form completion or DSMB vital status sweep
Patient still hospitalized as of this date: / / (mm/dd/yyyy)

14. Was a troponin level obtained within 48 hours of ED/hospital arrival?

- No
- Yes → What was the highest concentration during the 1st 48 hours after arrival: (ng/ml) → Within normal limits Out of normal limits

15. Did the patient have an ST elevation MI, defined as: ST elevation MI on the 1st ECG in the first 48 hours after arrival at the ED/hospital as defined by the ECG report/overreading MD?

- No
- Yes

Person responsible for data on this form:

Complete this form:

- For each potential Adverse Situation where implementation of study protocol resulted in a potential safety issue to the patient, EMS staff, or bystander
- For public objection to either study
- For protocol violations/deviations/unusual circumstances

Report this information to the CTC within 1 business day of discovery



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss: 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

0. Is this issue associated with an episode:

- No** → Date of Situation: / /
- Yes** → Episode Id: (type at least 3 digits to activate autocomplete)

1. Date reported to CTC (today's date):

/ /

2. Type of situation: (check all that apply and explain circumstances in item 3*)

Potential Safety Issues Related to Study Protocol or ITD use

- ITD protocol caused delay/interruption of treatment → Estimated delay minutes
- Analyze late vs. early protocol caused delay/interruption in treatment → Estimated delay minutes
- Public formal objection to Trial
- Other potential safety issue
- Pulmonary edema found on CXR within 48 hours of arrest
- Suspected mechanical failure of ITD → ITD # - - (nn-*nnn*-n)
- Failure to immediately remove the ITD after ROSC → number of seconds on with ROSC
- ITD filled with fluid: once more than once

AIRBL1 Airway bleeding → complete ALL items a, b & c below:

a. Bleeding occurred?

		1	2	3
		Before	After	N/A
ABEMS1	EMS arrival:	<input type="radio"/>	<input type="radio"/>	--
ABITD1	ITD placed:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> (ITD not placed/timing unknown)
ABADA1	EMS advanced airway:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> (No advanced airway/timing unknown)
ABHSP1	ED/Hospital arrival:	<input type="radio"/>	<input type="radio"/>	--

b. Patient history information:

	Yes	No/not noted	
ABANT1	<input type="radio"/> 1	<input type="radio"/> 0	Anticoagulants/antiplatelets → drug name: <input type="text"/> (30)
ABCHM1	<input type="radio"/>	<input type="radio"/>	Patient receiving cancer chemotherapy → drug name: <input type="text"/> (30)
ABCAN1	<input type="radio"/>	<input type="radio"/>	Known lung cancer
ABLID1	<input type="radio"/>	<input type="radio"/>	Known gastrointestinal disease → describe: <input type="text"/> (60)
ABMRB1	<input type="radio"/>	<input type="radio"/>	Other relevant comorbidity → describe: <input type="text"/> (60)



Episode Information:

Date (mm/dd/yyyy) / / **Time call received at dispatch** (hh:mm:ss: 24hr clock) : :

From PCR/other From dispatch

Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)

ROC PRIMED ID: - - **Incident Number (optional)** **Site Linking ID (optional)**

c. Site PI/Investigator determination of severity of bleed:

Fluid description:	
Yes	No
<input type="radio"/> ABPNK1	<input type="radio"/> Pink, frothy
<input type="radio"/> ABTIN1	<input type="radio"/> Blood tinged fluid
<input type="radio"/> ABBLF1	Bloody fluid: <input type="radio"/> ¹ Small <input type="radio"/> ² Moderate <input type="radio"/> ³ Large BLFLD1
<input type="radio"/> ABFRK1	Frank blood: <input type="radio"/> ¹ Small <input type="radio"/> ² Moderate <input type="radio"/> ³ Large FRKBL1
<input type="radio"/> ABDTH1	<input type="radio"/> Bleeding was cause of death

Life threatening?	Related to study intervention?	Expected?
<input type="radio"/> ¹ Yes	<input type="radio"/> ¹ Yes	<input type="radio"/> ¹ Yes
<input type="radio"/> ⁰ No	<input type="radio"/> ⁰ No	<input type="radio"/> ⁰ No
<input type="radio"/> ² May be/Possibly LIFE1	<input type="radio"/> ² May be/Possibly RTITV1	<input type="radio"/> ² May be/Possibly EXPT1

Potential Protocol Violations/Deviations

- Age < age of consent (e.g. known prior to ITD use or ITD not removed after EMS aware age < age of consent)
- Traumatic arrest/burns and ITD used
- Other potential protocol violation/protocol deviation (e.g. failure to remove the ITD when entering the ED)
- Known prisoner
- Known pregnancy prior to starting treatment
- ITD opened, but not used → ITD # - - (nn-*nnn*-n)
- More than one ITD opened:
ITD # - - (nn-*nnn*-n) → Used? Yes No
ITD # - - (nn-*nnn*-n) → Used? Yes No
- Case entered more than 30 days after episode date

Other Situation not listed

- MISIT1** Missing ITD # - - (nn-*nnn*-n) → Date found: / / (mm/dd/yyyy)
- BRKIT1** Broken/Damaged ITD # - - (nn-*nnn*-n)
- Pregnancy discovered after treatment started or hospital admit
- Age < age of consent and unknown until after ITD removed
- Other situation

3. Explain circumstances *:

(300 of 300 characters remaining)



Episode Information:

Date (mm/dd/yyyy)

/ /

ROC PRIMED ID

Estimated injury time (hh:mm:ss)

: :

- Unable to obtain (Non-ROC agency 1st arrival,
patient excluded from trial) From PCR/other From dispatch

Incident Number (optional)

Site-linking ID (optional)

1. Was patient and/or family and/or LAR notified that patient was in the study?

- NOTIFY** Yes → Who was notified? (check all that apply)
- NFAM** Family → Date: / / (**NFAMDT** /dd/yyyy) → Relationship: (20)
- NPA** Patient → Date: / / (**NPATDT** /dd/yyyy)
- LAR → Date: / / (mm/dd/yyyy) → Relationship: (20)
- No → explain:
- (60)
- (60)

2. Did the patient (and/or family/LAR) withdraw from hospital record review after notification? (Remember all records up to the time of withdrawal can be reviewed)

- No
- Yes → Who withdrew? (check all that apply)
- Family/LAR → Date: / / (mm/dd/yyyy) → Relationship: (20)
- Patient → Date: / / (mm/dd/yyyy)
- Reason: (100)
- Other → Explain: (100)

3. Did patient and/or family and/or LAR consent to follow-up calls?

- CONSEN** Yes → Who gave consent? (check all that apply)
- CONFAM** Family → Date: / / (**CONFDT** /dd/yyyy) → Relationship: (20)
- CONPAT** Patient → Date: / / (**CONPDT** /dd/yyyy)
- LAR → Date: / / (mm/dd/yyyy) → Relationship: (20)
- No → Why not? (check one only)
- Patient refused consent → Date: / / (mm/dd/yyyy)
Explain: (60)
- Family/LAR refused consent → Date: / / (mm/dd/yyyy)
Explain: (60)
- Expired - date of death: / / (mm/dd/yyyy)
- Not required per exclusion on **Patient Enrollment** form
- Language barrier (Non-English or Spanish-speaking patient)
- Consent deferred until 1 month follow-up
- Unable to contact patient/family/LAR (by phone/consent form not returned/no forwarding address) as required by the consent/notification plan approved by the IRB/REB. Document the contact attempts in either **item 4**, on the Site's Documentation of Patient/Family Contact form, or in the episode file maintained by the site.
Explain: (60)
- Other → explain: (60)

Complete this form:
 - for all patients who were enrolled for
 which this form shows "R" status on the
 Episode List.



Patient/Family Consent

Date: 08-11-2009

Version: 1.01.00

Page: 2 of 2

Episode Information:

Date (mm/dd/yyyy)

/ /

Estimated injury time (hh:mm:ss)

: :

Incident Number (optional)

ROC PRIMED ID

Unable to obtain (Non-ROC agency 1st arrival,
 patient excluded from trial) From PCR/other From dispatch

Site-linking ID (optional)

4. Document and explain attempts to contact patient or patient representative:

(The CTC expects sites to keep a log of attempts made to contact the patient, family or LAR. This can be accomplished by either keeping a local log using the CTC provided Documentation of Patient/Family Contact form, in the site episode file or by using this web form)

- Documentation maintained by local log or episode file
- Documentation maintained on this form

Date (mm/dd/yyyy)	Type of attempt: (Phone, clinic visit, Letter, Certified letter, In person, Email & Other)	Results/notes (200 characters)
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> If Other, specify: <input type="text"/> (30)	

Person responsible for data on this form

Name:

Complete this form:

- for all patients that were discharged alive from the hospital and consented to follow-up



Follow-up

Version 1.04.00

Date: 01/13/2009

Page 1 of 1

Episode Information:

Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	Time call received at dispatch (hh:mm:ss; 24hr clock) <input type="text"/> : <input type="text"/> : <input type="text"/>	<input type="radio"/> From PCR/other	<input type="radio"/> From dispatch
ROC PRIMED ID: <input type="text"/> - <input type="text"/> - <input type="text"/>	Incident Number (optional) <input type="text"/>	<input type="radio"/> Unable to obtain (Non-ROC agency first arrival & no agreement in place to get data, patient is excluded from Trial)	
		Site Linking ID (optional) <input type="text"/>	

1. Follow-up period:

- 1 month → Complete **ALFI-MMSE** measures

2. Was the patient (or patient representative) successfully contacted?

- Yes → Date of contact: / / (mm/dd/yyyy)
- No → Why not? (30)

3. Was consent obtained?

- ¹ Yes, previously
- ² Yes
- ³ No, refused all further contact
- ⁴ No, deferred until next follow-up period

4. Follow-up conducted with whom?

- ¹ Patient
- ² Family → Relationship to patient: (30)
- ³ Other → Relationship to patient: (30)

5. Vital status:

- ¹ Alive
- ² Dead → Date of death: / / (mm/dd/yyyy) → If day of death is not available: / (mm/yyyy)
(Skip the remaining questions)

6. What QOL measures were done? (check all that apply)

- ALFI-MMSE
- None

7. If any of the measures listed for this F/U in item 1 were not completed & consent was obtained, why not?

(300 characters)

Person responsible for data on this form:

1. **What is the year?**

(yyyy) Cannot answer Other refusal

2. **What is the season?**

Spring Autumn
 Summer Winter

Cannot answer Other refusal

3. **What is the date?**

(dd) Cannot answer Other refusal

4. **What is the day of the week?**

Monday Wednesday Friday Sunday
 Tuesday Thursday Saturday

Cannot answer Other refusal

5. **What is the month?**

January April July October
 February May August November
 March June September December

Cannot answer Other refusal

6. **Can you tell me where you are right now? For instance, what State/Province are you in?**

Correct Incorrect Cannot answer Other refusal

7. **What county are you in?**

Correct Incorrect Cannot answer Other refusal

8. **What town are you in?**

Correct Incorrect Cannot answer Other refusal

9. **What is the name of the place that you are in? ("home", "house", address, other correct name of a facility or other person's house)**

Correct Incorrect Cannot answer Other refusal

10. **I shall say three words for you to remember. Repeat them after I have said all three words. (Check each bubble if the word was repeated correctly)**

Shirt Brown Honesty

11. **Please subtract 7 from 100.**

(Do this 5 times - may coach patient if needed)

(Count only 1 error if subject makes subtraction error, but subsequent answers are 7 less than the error)

Number Correct: 5 4 3 2 1 0

12. **What are the three words that I asked you to remember?**

Shirt

Brown

Honesty

<input type="radio"/> Spontaneous recall	<input type="radio"/> Spontaneous recall	<input type="radio"/> Spontaneous recall
<input type="radio"/> Cue: something to wear	<input type="radio"/> Cue: a color	<input type="radio"/> Cue: good personal quality
<input type="radio"/> Multiple: shoes, shirt, socks	<input type="radio"/> Multiple: blue, black, brown	<input type="radio"/> Multiple: charity, honesty, modesty
<input type="radio"/> Unable to recall	<input type="radio"/> Unable to recall	<input type="radio"/> Unable to recall

13. **Repeat what I say: "No ifs, ands, or buts"?**

Correct 1 out of 3 words in the phrase correct
 2 out of 3 words in the phrase correct Unable to repeat, or misses the 's'

14. **What is the name of the thing that we are using to talk now? (Do not wait for the patient to name it)**

Telephone, receiver, mouthpiece, etc Cannot answer
 Inaccurate Other refusal

15. **Now I'm going to give you some instructions to follow. I want you to do a 3 step task.**

First, say "hello", then tap the telephone receiver 3 times with your finger, then say "I'm back" into the phone

Hello Tap I'm back Cannot answer Other refusal

Structured Interviews for Assessment of Cerebral Performance Category

Introduction

The research assistant will ask/review the following questions in order to categorize the patient as Cerebral Performance Category (CPC) scale 1 - 4, based upon current status. Telephone questions may be asked of a caregiver, if necessary.

Telephone Interview of Caregiver

1. **Is the patient able to follow simple commands and say a few words (i.e. conscious)?**
 - No → Stop here
 - Yes → Go on
2. **Is the patient able to do normal daily activities without assistance (dressing, preparing meals, local travel, shopping)?**
 - No → Stop here
 - Yes → Go on
3. **Does the patient have any problems that are more than mild, i.e. problems that prevent him/her from doing things that he/she would like to do or have to do (difficulty speaking, moving an arm, or walking; poor memory; getting along with others)?**
 - No → Stop here
 - Yes → Go on
4. **Has the patient returned to a normal life (work, leisure, family activities)?**
 - No → Stop here
 - Yes → Stop here

Telephone Interview of Patient

1. **Are you able to do your normal daily activities without assistance (dressing, preparing meals, local travel, shopping)?**
 - No → Stop here
 - Yes → Go on
2. **Do you have any problems that are more than mild, i.e. problems that prevent you from doing things that you would like to do or have to do (difficulty speaking, moving an arm, or walking; poor memory; getting along with others)?**
 - No → Stop here
 - Yes → Go on
3. **Have you returned to a normal life (work, leisure, family activities)?**
 - No → Stop here
 - Yes → Stop here

Person responsible for data on this form:

Structured Interview for Assessment of Modified Rankin Scale

Please record responses to all questions (unless otherwise indicated in the text), including those concerning status before cardiac arrest. See guidelines on the facing page for further information.

1. Constant Care:

<i>Constant care means that someone needs to be available at all times. Care may be provided by either a trained or untrained caregiver. The patient will usually be bedridden and may be incontinent.</i>	Now		Before cardiac arrest	
	Yes	No	Yes	No
a. Does the person require constant care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Assistance to attend to bodily needs/for walking:

<i>Assistance includes physical assistance, verbal instruction, or supervision by another person.</i>	Now		Before cardiac arrest	
	Yes	No	Yes	No
a. Is assistance essential for eating? <i>(Eating without assistance: food and implements may be provided by others)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Is assistance essential for using the toilet? <i>(Using toilet without assistance: reach toilet/commode; undress sufficiently, clean self; dress and leave)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Is assistance essential for routine daily hygiene? <i>(Routine hygiene: washing face, doing hair, cleaning teeth/fitting false teeth. Implements may be provided by others and this should not be considered assistance)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Is assistance essential for walking? <i>(Walking without assistance: able to walk indoors around house or ward, may use any aid (e.g. stick/cane, walking frame/walker), however not requiring physical help or verbal instruction or supervision from another person)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Assistance to look after own affairs:

<i>Assistance includes physical assistance, or verbal instruction, or supervision by another person.</i>	Now		Before cardiac arrest	
	Yes	No	Yes	No
a. Is assistance essential for preparing a simple meal? <i>(For example, able to prepare breakfast or a snack)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Is assistance essential for basic household chores? <i>(For example, finding and putting away clothes, clearing up after a meal. Exclude chores that do not need to be done every day, such as using a vacuum cleaner)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Is assistance essential for looking after household expenses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Is assistance essential for local travel? <i>(Patients may drive or use public transport to get around. Ability to use a taxi is sufficient, provided the person can phone for it themselves and instruct the driver)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Is assistance essential for local shopping? <i>(Local shopping: a least able to buy a single item)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

4. Usual duties and activities:

The next sets of questions are about how the patient usually spends his/her day.

a. Work:

i. **Before the cardiac arrest, was the person working or seeking work or studying as a student?** (If the person was not employed or seeking work before the cardiac arrest, or the person was retired then indicate "No" and go to **item 4b**)

- Yes
- No → go to **item 4b**

ii. **Since the cardiac arrest has there been a change in the person's ability to work or study?** (Change in ability to work or study includes loss of employment or reduction in level of responsibility; change in education or problems with study)

- Yes → How restricted are they?
 - Reduced level of work (e.g. change from full-time to part-time or change in level of responsibility)
 - Currently unable to work
- No

b. Family responsibilities:

i. **Before the cardiac arrest was the person looking after family at home** (If this was not a major role before the cardiac arrest, indicate "No" and go to **item c**)

- Yes
- No → go to **item 4c**

ii. **Since the cardiac arrest has there been a change in their ability to look after family at home?**

- Yes → How restricted are they?
 - Reduced responsibility for looking after family
 - Currently unable to look after family
- No

c. Social & leisure activities:

(Social and leisure activities include hobbies and interests. Includes activities outside the home or at home. Activities outside the home: going to the pub/bar, restaurant, club, church, cinema, visiting friends, going for walks. Activities at home: involving "active" participation including knitting, sewing, painting, games, reading books, home improvements).

i. **Before the cardiac arrest did the person have regular free-time activities?** (If the person had very restricted social & leisure activities before the cardiac arrest then indicate "No" and go to **item 4d**)

- Yes
- No → go to **item 4d**

ii. **Since the cardiac arrest has there been a change in their ability to participate in these activities?**

- Yes → How restricted are they?
 - Participate a bit less: *at least half as often as before the cardiac arrest*
 - Participate much less: *less than half as often*
 - Unable to participate: *rarely, if ever, take part*
- No

Structured Interview for Assessment of Modified Rankin Scale

d. Family & Friendship:

(Problems with relationships include difficulties in relationships with people at home, loss of friendships or increase in isolation. Changes in the person may include: communication problems, quick temper, irritability, anxiety, insensitivity to others, mood swings, depression, and unreasonable behavior).

i. Since the cardiac arrest has the person had problems with relationships or become isolated?

- Yes → What is the extent of disruption/strain?
 - Occasional: *less than weekly*
 - Frequent: *once a week or more, but tolerable*
 - Constant: *daily & intolerable*
- No

ii. Before the cardiac arrest were any similar problems present?

- Yes
- No

5. Symptoms as a result of the cardiac arrest:

(Can be any symptoms or problems reported by the patient or found on neurological examination)

a. Does the patient have any symptoms resulting from the cardiac arrest? (Record spontaneous answer to the question from respondent)

- Yes
- No

b. Symptom checklist:

	Now		Before cardiac arrest	
	Yes	No	Yes	No
i. Does the person have difficulty reading or writing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Does the person have difficulty speaking or finding the right word?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Does the person have problems with balance or coordination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iv. Does the person have visual problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
v. Does the person have numbness (face, arms, legs, hands, feet)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
vi. Has the person experienced loss of movement (face, arms, legs, hands, feet)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
vii. Does the person have difficulty with swallowing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
viii. Any other symptoms? Please record: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Person responsible for data on this form:

Start time: : (24-hour clock)

Read to Patient:

The next set of questions ask about various aspects of your health. When answering these questions we would like you to think about your health and your ability to do things on a day-to-day basis, during the past week. To define the 1 week period, please think about what the date was 7 days ago and recall the major events that you have experienced during this period. Please focus your answer on your abilities, disabilities and how you have felt during the past 1 week.

You may feel that some of these questions do not apply to you, but it is important that we ask the same questions to everyone. Also, a few questions are similar; please excuse the apparent overlap and answer each question independently.

All information you provide is confidential. There are no right or wrong answers; what we want is your opinion about your abilities and feelings.

Interviewer:

For each question, read the entire question/sentence as written following the question number, emphasizing the words in italics, if any. **Do not read the response options** listed below the question. If the responses are included as part of the question (eg: Q26, Q31 etc) read them as part of the questions. The answer given by the respondent to each question should be clearly marked in the circle beside the one appropriate answer listed below the question.

VISION

1. **During the past week, have you been able to see well enough to read ordinary newspaper *without* glasses or contact lenses?**
 - Yes → Go to **Item 4**
 - No
 - Don't know
 - Refused
2. **Have you been able to see well enough to read ordinary newspaper *with* glasses or contact lenses?**
 - Yes → Go to **Item 4**
 - No
 - Don't know/Didn't wear glasses or contact lenses
 - Refused
3. **During the past week, have you been able to see at all?**
 - Yes
 - No → Go to **Item 6**
 - Don't know
 - Refused
4. **During the past week, have you been able to see well enough to recognize a friend on the other side of the street *without* glasses or contact lenses?**
 - Yes → Go to **Item 6**
 - No
 - Don't know
 - Refused
5. **Have you been able to see well enough to recognize a friend on the other side of the street *with* glasses or contact lenses?**
 - Yes
 - No
 - Don't know/Didn't wear glasses or contact lenses
 - Refused

HEARING

6. **During the past week, have you been able to hear what is said in a group conversation with at least three other people *without* a hearing aid?**
 - Yes → Go to **Item 11**
 - No
 - Don't know
 - Refused

7. **Have you been able to hear what is said in a group conversation with at least three other people *with* a hearing aid?**
- Yes → Go to **Item 9**
 - No
 - Don't know/Didn't wear a hearing aid
 - Refused
8. **During the past week, have you been able to hear at all?**
- Yes
 - No → Go to **Item 11**
 - Don't know
 - Refused
9. **During the past week, have you been able to hear what is said in a conversation with one other person in a quiet room *without* a hearing aid?**
- Yes → Go to **Item 11**
 - No
 - Don't know
 - Refused
10. **Have you been able to hear what is said in a conversation with one other person in a quiet room *with* a hearing aid?**
- Yes
 - No
 - Don't know/Didn't wear a hearing aid
 - Refused

SPEECH

11. **During the past week, have you been able to be understood *completely* when speaking your own language with people who do not know you?**
- Yes → Go to **Item 16**
 - No
 - Don't know
 - Refused
12. **Have you been able to be understood *partially* when speaking with people who do not know you?**
- Yes
 - No
 - Don't know
 - Refused
13. **During the past week, have you been able to be understood *completely* when speaking with people who know you well?**
- Yes → Go to **Item 16**
 - No
 - Don't know
 - Refused
14. **Have you been able to be understood *partially* when speaking with people who know you well?**
- Yes → Go to **Item 16**
 - No
 - Don't know
 - Refused
15. **During the past week, have you been able to speak at all?**
- Yes
 - No
 - Don't know
 - Refused

GETTING AROUND

16. During the past week, have you been able to bend, lift, jump and run *without difficulty* and *without help or equipment* of any kind?
- Yes → Go to **Item 24**
 - No
 - Don't know
 - Refused
17. Have you been able to walk around the neighborhood *without difficulty* and *without help or equipment* of any kind?
- Yes → Go to **Item 24**
 - No
 - Don't know
 - Refused
18. Have you been able to walk around the neighborhood *with difficulty* but *without help or equipment* of any kind?
- Yes → Go to **Item 24**
 - No
 - Don't know
 - Refused
19. During the past week, have you been able to walk at all?
- Yes
 - No → Go to **Item 22**
 - Don't know
 - Refused
20. Have you needed mechanical support, such as braces or a cane or crutches, to be able to walk around the neighborhood?
- Yes
 - No
 - Don't know
 - Refused
21. Have you needed the help of another person to walk?
- Yes
 - No
 - Don't know
 - Refused
22. Have needed a wheelchair to get around the neighborhood?
- Yes
 - No
 - Don't know
 - Refused
23. Have you needed the help of another person to get around in the wheelchair?
- Yes
 - No
 - Don't know
 - Refused

HANDS AND FINGERS

24. During the past week, have you had the *full use* of both hands and ten fingers?
- Yes → Go to **Item 28**
 - No
 - Don't know
 - Refused

25. **Have you needed the help of another person because of limitations in the use of your hands and fingers?**
- Yes
 - No → Go to **Item 27**
 - Don't know
 - Refused
26. **Have you needed the help of another person with some tasks, most tasks, or all tasks?**
- Some tasks
 - Most tasks
 - All tasks
 - Don't know
 - Refused
27. **Have you needed special equipment, for example special tools to help with dressing or eating, because of limitations in the use of your hands or fingers?**
- Yes
 - No
 - Don't know
 - Refused

SELF-CARE

28. **During the past week, have you been able to eat, bathe, dress and use the toilet without difficulty?**
- Yes → Go to **Item 31**
 - No
 - Don't know
 - Refused
29. **Have you needed the help of another person to eat, bathe, dress or use the toilet?**
- Yes
 - No
 - Don't know
 - Refused
30. **Have you needed special equipment or tools to eat, bathe, dress or use the toilet?**
- Yes
 - No
 - Don't know
 - Refused

FEELINGS

31. **During the past week, have you been feeling happy or unhappy?**
- Happy
 - Unhappy → Go to **Item 33**
 - Don't know
 - Refused
32. **Would you describe yourself as having felt:**
- happy and interested in life → Go to **Item 34**
 - somewhat happy → Go to **Item 34**
 - Don't know
 - Refused
33. **Would you describe yourself as having felt:**
- somewhat unhappy
 - very unhappy
 - so unhappy that life is not worthwhile
 - Don't know
 - Refused

34. During the past week, did you ever feel fretful, angry, irritable, anxious or depressed?

- Yes
- No → Go to **Item 37**
- Don't know
- Refused

35. How often did you feel fretful, angry, irritable, anxious or depressed?

(rarely, occasionally, often, or almost always)

- Rarely
- Occasionally
- Often
- Almost always
- Don't know
- Refused

36. During the past week did you feel *extremely* fretful, angry, irritable, anxious or depressed; to the point of needing professional help?

- Yes
- No
- Don't know
- Refused

MEMORY

37. How would you describe your ability to remember things, during the past week:

- Able to remember most things
- Somewhat forgetful
- Very forgetful
- Unable to remember anything at all
- Don't know
- Refused

THINKING

38. How would you describe your ability to think and solve day to day problems, during the past week:

- Able to think clearly and solve problems
- Had a little difficulty
- Had some difficulty
- Had a great deal of difficulty
- Unable to think or solve problems
- Don't know
- Refused

PAIN AND DISCOMFORT

39. Have you had any trouble with pain or discomfort, during the past week?

- Yes
- No → Go to **Item 41**
- Don't know
- Refused

40. How many of your activities, during the past week, were limited by pain or discomfort?

- None
- A few
- Some
- Most
- All
- Don't know
- Refused

41. Overall, how would you rate your health during the past week?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

Thank you. That ends this set of questions.

TIME FINISHED: : (24-hour clock)

Person responsible for data on this form:

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life?

Yes No

2. Have you dropped many of your activities and interests

Yes No

3. Do you feel that your life is empty?

Yes No

4. Do you often get bored?

Yes No

5. Are you in good spirits most of the time?

Yes No

6. Are you afraid that something bad is going to happen to you?

Yes No

7. Do you feel happy most of the time?

Yes No

8. Do you often feel helpless?

Yes No

9. Do you prefer to stay at home, rather than going out and doing new things?

Yes No

10. Do you feel you have more problems with memory than most?

Yes No

11. Do you think it is wonderful to be alive now?

Yes No

12. Do you feel pretty worthless the way you are now?

Yes No

13. Do you feel full of energy?

Yes No

14. Do you feel that your situation is hopeless?

Yes No

15. Do you think that most people are better off than you are?

Yes No

Person responsible for data on this form: