

NuMED
Post Market Clinical Follow-up Form
PTS & PTS-X 110cm Useable Length

1. PATIENT INFORMATION:

Date of Procedure:	Patient Date of Birth:
Physician:	Hospital:
Physician Phone No.:	Email Address:
Type of Follow-up: <input type="checkbox"/> Within 24 Hours <input type="checkbox"/> Other (Specify):	

2. DEVICE INFORMATION:

Catalog Number:	Lot Number:
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3. TYPE OF PROCEDURE BEING PERFORMED:

Sizing (110cm useable length) Other: _____

4. CONTRAINDICATIONS: Did the patient have any of the following:

Not Applicable

5. PROCEDURAL COMPLICATIONS REPORTED:

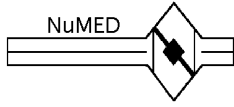
<input type="checkbox"/> Trauma / Overstretching of Septum	<input type="checkbox"/> Device Embolization
<input type="checkbox"/> Device Erosion	<input type="checkbox"/> Access Site Complications
<input type="checkbox"/> Balloon Rupture _____ ATMS	<input type="checkbox"/> None

Inflation Device with Pressure Gauge Used?
 Yes No

6. DEVICE COMPLICATIONS REPORTED:

<input type="checkbox"/> Guidewire Issue	<input type="checkbox"/> Inflation/Deflation Issues
<input type="checkbox"/> Catheter Damaged During Procedure	<input type="checkbox"/> Difficulty Withdrawing Catheter
<input type="checkbox"/> Difficulty with Introducer	<input type="checkbox"/> None
<input type="checkbox"/> Balloon Rupture: _____ ATMS	

Inflation Device with pressure Gauge Used?
 Yes No



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7. EXPLAIN ANY COMPLICATION NOTED AND ITS RELATIONSHIP TO THE DEVICE:

8. OTHER COMMENTS:

9. DO YOU CONSIDER THE PROCEDURE A SUCCESS: **Yes** **No**

Please either email or fax the filled out form to: mthomas@numedusa.com or 1-315-328-4941