Prehospital CRF

Date of cardiac arrest

_____

EMS case number

_____

First EMS unit on scene (vehicle number)

_____
(E.g. 352-9410)

Second EMS unit on scene (vehicle number)

_____
(E.g. 352-9410)

Randomisation number

_____
(E.g. XX001)

Randomised to

◯ Double sequential defibrillation (2 defibrillators)
◯ Standard care (1 defibrillator)

Number of defibrillations before randomisation

_____
(Only defibrillations by EMS)

Location

◯ At home
◯ Public
◯ Other

Witnessed cardiac arrest? (Seen or heard)

◯ Yes
◯ No
◯ Unknown

CPR prior to EMS arrival?

◯ Yes
◯ No
◯ Unknown
(Bystander or first responder)

Was the patient defibrillated before EMS arrival?

◯ Yes
◯ No
◯ Unknown
(E.g Fire fighters or volunteer responders)

If yes, number of defibrillations before EMS AED attachment

_____

First EMS defibrillator?

◯ Corpuls 3
◯ Other
(brand)

Number first defibrillator (MTA)

_____
(E.g. SU648052)

Second EMS defibrillator?

◯ Corpuls 3
◯ Other

Number second defibrillator (MTA)	_____ (E.g. SU648052)
Was the patient attached with two sets of electrodes?	◯ Yes ◯ No
Was the patient shocked with double sequential defibrillation?	◯ Yes ◯ No
If yes, how many times was the patient shocked using DSED?	_____
Was DSED intervention withdrawn for transport?	◯ Yes ◯ No
Was vector change performed?	◯ Yes ◯ No (Vector change is defined as defibrillation pads placed in antero-posterior position)
How many defibrillations was performed with pads in standard antero-lateral position prior to vector change?	_____
How many defibrillations was performed with pads in antero-posterior position?	_____
How many defibrillations was performed with pads in standard antero-lateral position?	_____
Were there deviations from randomised treatment?	_____ (Describe in text)
Any ROSC?	◯ Yes ◯ No ("Any ROSC" is defined as the restoration of a palpable pulse or measurable blood pressure that is generated by the patient (i.e., not sustained only by mechanical support) after attempted CPR)
Transported to hospital?	◯ Yes ◯ No
Hospital	◯ Alingsås ◯ Kungälv ◯ Sahlgrenska ◯ Östra sjukhuset ◯ Mölndal ◯ Borås ◯ Trollhättan ◯ Halmstad ◯ Varberg ◯ Skövde ◯ Karlstad ◯ Other hospital

If "other hospital", name of hospital:

_____

Estimated weight of patient (in kilograms)

_____
(E.g. 80)

Adverse events

◯ Yes
◯ No

If yes, describe the adverse event

_____

Contact info (voluntary)

_____

Other comments (voluntary)

_____
(E.g difficulties or technical issues)

Center

_____
(Automatic, do not fill in form)