**1. Date of Discharge**: \_ \_ / \_ \_ \_ / \_ \_ \_ \_

Day Month Year

**2. Hospitalization**:

If not applicable enter 0

**Length of Stay in ICU** (from day of index procedure) days

**Length of Stay in Intermediate Care** (from day of index procedure) days

**Length of Stay on General Ward** (from day of index procedure) days

**Patient discharged to:**

* Home
* Another hospital
* Extended care
* Rehabilitation unit
* Nursing Home (permanent)
* Patient Died\*

\*Enter date of death as date of discharge

**3. Adverse Events** Yes  NO

(If yes, please complete Adverse Event Form)

|  |  |  |
| --- | --- | --- |
| My signature indicates that to the best of my knowledge all information entered on Form 3 is correct. | | Date |
|  |  |  |
|  |  | **\_\_ \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_** |
| *Investigator’s Signature* |  | mmm dd yyyy |