IRWAYS$_2$

RESOURCE USE — INDEX ADMISSION

RU$_1$

Hospital: _____ **Patient ID:** ☐☐☐☐☐☐☐

PLEASE DO NOT PUT ANY PATIENT IDENTIFIERS ON THIS FORM E.G. NAME, NHS NUMBER

Date of ED/hospital arrival after OHCA: __ __ /__ __ /__ __ __ __ (d d m m y y y y)

Date of hospital discharge after OHCA, or death (if in hospital): __ __ /__ __ /__ __ __ __ (d d m m y y y y)

Discharged from hospital ☐ *Died* ☐

If died, no need to complete RU$_2$

DURING THE PATIENT INDEX ADMISSION ONLY (DATES ABOVE):

Did the patient have any CT scans of any part of the body? *Yes* ☐ *No* ☐ If **YES**, total number of CT scans: ☐

Did the patient have any MRI scans of any part of the body? *Yes* ☐ *No* ☐ If **YES**, total number of MRI scans: ☐

Did the patient have any angiograms? *Yes* ☐ *No* ☐ If **YES**, total number of angiograms: ☐

If **YES**, was PCI also performed at each angiogram?

Angiogram 1: *Yes* ☐ *No* ☐

Angiogram 2: *Yes* ☐ *No* ☐ *N/A* ☐

Angiogram 3: *Yes* ☐ *No* ☐ *N/A* ☐

Angiogram 4: *Yes* ☐ *No* ☐ *N/A* ☐

Did the patient have any surgery or implantable devices during the index admission? *Yes* ☐ *No* ☐

If **YES**, please provide brief details e.g. surgery type or implantable device type (pacemaker, implantable defibrillator or both):

_____

_____

_____

_____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy)*: __ __ /__ __ /__ __ __ __

** Names must appear on the site signature & delegation log*

IRWAYS$_2$

RESOURCE USE — FOLLOW UP

RU$_2$

Hospital: _____ **Patient ID:** | | | | | | | |

PLEASE DO NOT PUT ANY PATIENT IDENTIFIERS ON THIS FORM E.G. NAME, NHS NUMBER

Date of hospital discharge after OHCA: __ __ /__ __ /__ __ __ __ (d d m m y y y y)

Date 6 months post OHCA or date of death (if sooner): __ __ /__ __ /__ __ __ __ (d d m m y y y y)

PERIOD POST DISCHARGE FROM INDEX ADMISSION TO 6 MONTHS POST OHCA ONLY (DATES ABOVE):

Was the patient readmitted to your hospital in the follow up period? *Yes* ☐ *No* ☐

If **YES**, number of readmissions: ☐

If **YES,**

Readmission 1

For how many days? ☐

Did the patient spend any days in intensive care? *Yes* ☐ *No* ☐

If **YES**, how many days? ☐

Readmission 2

For how many days? ☐

Did the patient spend any days in intensive care? *Yes* ☐ *No* ☐

If **YES**, how many days? ☐

Readmission 3

For how many days? ☐

Did the patient spend any days in intensive care? *Yes* ☐ *No* ☐

If **YES**, how many days? ☐

Did the patient have any surgery or implantable devices at your hospital in the follow up period? *Yes* ☐ *No* ☐

If **YES**, please provide brief details e.g. surgery type or implantable device type, elective/emergency, re-do:

_____

_____

_____

Name of person completing form* (capitals): _____

Signature of person completing form: _____ Date completed *(dd/mm/yyyy):* __ __ /__ __ /__ __ __ __

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