DEATH OR CARDIAC ARREST REVIEW

Patient I.D. ____-__-__ ____

Date of death or cardiac arrest __/__/__ (mo dy yr) DATE4Ø

DTHCA4Ø

2 Event was: ☐1 Death ☐2 Cardiac arrest with resuscitation

3 CAUSE of death or cardiac arrest:

☐1 NON-CARDIAC

CAUSE4Ø specify: _____

☐2 CARDIAC

If CARDIAC,

ARRHTH4Ø

4 ☐1 Arrhythmic ☐2 Non-arrhythmic

IF CARDIAC, COMPLETE THE FOLLOWING SECTION:

5 ☐1 Witnessed:

6 ☐1 Asymptomatic instantaneous death (no NEW, ACCELERATING OR PERSISTENT symptoms)

SYMPT4Ø

☐2 Symptomatic

If SYMPTOMATIC, check ONE box below

CARDWT4Ø

	SUMMRY4Ø	Time from onset of NEW, ACCELERATING, OR PERSISTENT SYMPTOMS: < 5 min	5-60 min	61- 24 min hr	> 24 hr
7	Ischemic symptoms	☐1	☐2	☐3	☐4
8	Arrhythmic symptoms	☐5	☐6	☐7	☐8
9	Documented VT -> VF, > 60 min			☐9	☐10
10	Other cardiac	☐11	☐12	☐13	☐14
11	specify: _____				
12	Severe CHF symptoms	☐15	☐16	☐17	☐18

13 ☐2 Unwitnessed (patient not seen or heard for ≥ 5 minutes)

Presumed arrhythmic? ☐1 yes ☐2 no

If NO, specify cause: _____

DCAREV
CAST 40.01
3/15/88

Name of person filling out form ____ Code Number