


181018 DECHOKER SPAIN – SOME LIVES SAVED WITH DECHOKER DEVICE – Confidential – Do not share or distribute without permission


SUBJECT	1	2	3	4	5	6	7	8	9	10
PATIENT	Woman	Woman 71 years old Mild dementia	Woman 90 years old Severe dementia	Woman	Woman	Woman	Woman	Unknown	Woman	Man 76 years old
ESTIMATED DATE	2017	11th Sept 2017	24th Sept 2017	March 2018	February 2018	April 2018	11th May 2018	August 2017	May 2018	17th October 2018
		(both saved in the same month in the same care home)								
PLACE:	Care Home <small>NGO Association of Persons with Physical Disabilities</small>	Care Home		Care Home	Care Home	Care Home	Care Home	Care Home	Care Home	Care Home
• City:	Gerona	Pamplona		Pineda de Mar	Las Rozas	Badalona	Montant	Unknown	Logroño	Barakaldo
• Province:	Gerona	Navarra		Barcelona	Madrid	Barcelona	Castellón	Unknown	La Rioja	Vizcaya
CHOKING CAUSE	Food	Food	Food	Food	Food (Hard-boiled egg)	Food (Omelette)	Food	Unknown	Food	Food (Apple)
Report	<p>Las cuidadoras de una Residencia en Girona hicieron uso del dispositivo anti-atragantamiento Dechoker para salvar la vida de una paciente que se encontraba en estado cianótico tras atragantarse durante la comida. A los pocos minutos apareció en el lugar una unidad medicalizada del Sistema de Emergencias Médicas que valoró a la usuaria y dado el estado que presentaba, se le dio el alta in situ.</p>	<p>El 11 de septiembre, una mujer de 71 años con demencia leve, y el 24 de ese mismo mes, otra anciana de 90 con demencia avanzada, se “salvaron” gracias a un nuevo dispositivo denominado Dechoker.</p> <p><i>Published in the “Navarra Diary”</i></p>		<p>Cuando me informan del atragantamiento, acudo a valorar a la usuaria y utilizo la mascarilla según indicaciones. veo que no está muy insuflado y me valgo de otra persona que le sujete bien la cabeza a la usuaria para que la mascarilla haga el vacío correcto para poder succionar el alimento que estaba produciendo el atragantamiento.</p> <p>Al aspirar consigo extraer un trozo de huevo que había ingerido en la comida.</p> <p>Tras extraerlo la usuaria se queda tranquila, recupera saturación y continúa atendiéndose como es habitual en estos casos, con aerosolterapia y medicación.</p> <p>Me pareció realmente útil, ya que rápidamente pude conseguir extraer lo que estaba produciendo el problema respiratorio a la usuaria.</p> <p><i>Ángela Barahona Testimony</i></p>	<p>Una residente que se alimenta de manera autónoma, a la hora de la merienda presentó una obstrucción de las vías aéreas, la rápida actuación del equipo, fue fundamental y dicho episodio fue revertido gracias a la utilización del DECHOKER y a la formación recibida por el equipo yo te salvo, distribuidores oficiales para la Comunidad Valenciana.</p> <p>La residente que presentaba una situación crítica, tras la liberación de las vías aéreas, se recuperó rápidamente, y recuperó estado basal.</p> <p>Resaltamos el papel central que juega el dispositivo en situaciones de emergencia (Atragantamientos), junto con la inmediata y coordinada actuación del equipo del centro.</p> <p>El Dechoker es fácil de utilizar, rápido y cómodo de transportar de un lugar a otro. Cuyas características hicieron posible que pese a que la residente se oponía con la presión mandibular que presentaba por el suceso salvara la vida en esta ocasión.</p> <p>La valoración es muy positiva en casos críticos de atragantamiento. Indispensable.</p>	<p>Reported by a comment in Facebook of a Crae Home worker</p> <p>Try to contact again with her but she didn't answer</p>	<p>El servicio médico hizo uso del dispositivo médico anti-atragantamiento Dechoker para salvar la vida de una paciente.</p>	<p>Cianótico mientras comía una manzana.</p> <p>Compresiones abdominales + palmadas interescapulares sin resultado</p> <p>Se le torció en el suelo y empezó RCP</p> <p>mientras traían Dechoker</p> <p>Después de dos intentos con Dechoker el paciente respira y recupera consciencia</p> <p>Atienden: Enfermera Fisioterapeuta Personal auxiliar</p>		

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	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

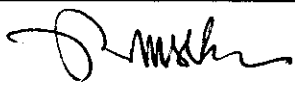
1. Date of Incident (DD-MMM-YYYY)	UNK-AUG-2017		
2. Patient's Demography	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input checked="" type="checkbox"/> Unknown		
	Age (years): Data Unavailable		
	Place of Event: Data Unavailable		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Data Unavailable		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> <td style="width: 50%; vertical-align: top;"> After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> </tr> </table>	Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable
Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable		
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	# of Attempts: # of Cycles Cycles # of Pulls Pulls. <input checked="" type="checkbox"/> Data Unavailable		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		


1. Foreign Body Airway Obstruction (FBAO)

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	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

<p>8. Choking Event Details:</p> <p>a. Original Version: Reported by a comment in Facebook of a Care Home worker. Try to contact again with her but she didn't answer</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p> <p>b. English Translation Version: N/A</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p>


<p>Principal Investigator's Signature Statement:</p> <p>I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.</p>		
<p>Principal Investigator Name</p> <p>Dr. Randall Snook</p>	<p>Signature</p> 	<p>Data Signed (DD/MON/YYYY)</p> <p>07/01/2019</p>

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	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	17-OCT-2018		
2. Patient's Demography	Sex: <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male		
	Age (years): 76		
	Place of Event: Care Home Barakaldo, Vizcaya, Spain		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Food (Apple)		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Before (check all that apply): <input type="checkbox"/> None <input checked="" type="checkbox"/> Back Blows <input checked="" type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: </td> <td style="width: 50%; vertical-align: top;"> After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> </tr> </table>	Before (check all that apply): <input type="checkbox"/> None <input checked="" type="checkbox"/> Back Blows <input checked="" type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other:	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable
Before (check all that apply): <input type="checkbox"/> None <input checked="" type="checkbox"/> Back Blows <input checked="" type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other:	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input checked="" type="checkbox"/> Lying down <input type="checkbox"/> Standing <input type="checkbox"/> Unknown		
	Patient Status: <input type="checkbox"/> Conscious <input checked="" type="checkbox"/> Unconscious <input type="checkbox"/> Unknown		
	# of Attempts: 1_Cycles 2 Pulls <input type="checkbox"/> Unknown		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	1	0
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

Cianótico mientras comía una manzana. Compresiones abdominales + palmadas interescapulares sin resultado Se le tumbó en el suelo y empezó RCP. Mientras traían Dechoker. Después de dos intentos con Dechoker el paciente respira y recupera consciencia

Atienden: Enfermera Fisioterapeuta Personal auxiliar

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

b. English Translation Version:

Cyanotic while eating an apple. Abdominal compressions + interscapular slaps without result He laid on the floor and CPR was started while they brought the Dechoker. After two attempts with the Dechoker, the patient breathes and regains consciousness

Any problems after the use of Dechoker device? No Yes, describe below


Describe the problem, start date, end date, and problem status (resolved/unresolved) here


Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.


Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019

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	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT


1. Date of Incident (DD-MMM-YYYY)	UNK-APR-2018		
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		
	Age (years): Data Unavailable		
	Place of Event: Care Home Badalona, Barcelona, Spain		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Food (Omelette)		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> <td style="width: 50%; vertical-align: top;"> After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other Data Unavailable </td> </tr> </table>	Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other Data Unavailable
Before (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	After (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other Data Unavailable		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable		
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	# of Attempts: # of Cycles Cycles # of Pulls Pulls. <input checked="" type="checkbox"/> Data Unavailable		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	6
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

<p>8. Choking Event Details:</p> <p>a. Original Version: No details provided</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p>
<p>b. English Translation Version: No details provided</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p>

<p>Principal Investigator's Signature Statement:</p> <p>I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.</p>		
<p>Principal Investigator Name</p>	<p>Signature</p>	<p>Data Signed (DD/MON/YYYY)</p>
Dr. Randall Snook		07/01/2019



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Protocol #: DC-01 (Retrospective)


Site Number

Subject Number

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	11-MAY-2018														
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male														
	Age (years): Data Unavailable														
	Place of Event: Care Home Montant, Castellón, Spain														
3. Primary Diagnosis	Data Unavailable														
4. Choking Cause	Food														
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table border="0"> <tr> <td>Before (check all that apply):</td> <td>After (check all that apply):</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Back Blows</td> <td><input type="checkbox"/> Forceps</td> </tr> <tr> <td><input type="checkbox"/> Abdominal Thrusts</td> <td><input type="checkbox"/> Back Blows</td> </tr> <tr> <td><input type="checkbox"/> Chest Compression</td> <td><input type="checkbox"/> Abdominal Thrusts</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other: Data Unavailable</td> <td><input type="checkbox"/> Chest Compression</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other: Data Unavailable</td> </tr> </table>	Before (check all that apply):	After (check all that apply):	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps	<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts	<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression		<input checked="" type="checkbox"/> Other: Data Unavailable
Before (check all that apply):	After (check all that apply):														
<input type="checkbox"/> None	<input type="checkbox"/> None														
<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps														
<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows														
<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts														
<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression														
	<input checked="" type="checkbox"/> Other: Data Unavailable														
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable														
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable														
	# of Attempts: # of Cycles <u> </u> Cycles # of Pulls <u> </u> Pulls. <input checked="" type="checkbox"/> Data Unavailable														
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators														
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use														

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	7
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

Una residente que se alimenta de manera autónoma, a la hora de la merienda presentó una obstrucción de las vías aéreas, la rápida actuación del equipo, fue fundamental y dicho episodio fue revertido gracias a la utilización del DECHOKER y a la formación recibida por el equipo yo te salvo, distribuidores oficiales para la Comunidad Valenciana.

La residente que presentaba una situación crítica, tras la liberación de las vías aéreas, se recuperó rápidamente, y recuperó estado basal.

Resaltamos el papel central que juega el dispositivo en situaciones de emergencia (Atragantamientos), junto con la inmediata y coordinada actuación del equipo del centro.

La valoración es muy positiva en casos críticos de atragantamiento. Indispensable.
Reported

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

El Dechoker es fácil de utilizar, rápido y cómodo de transportar de un lugar a otro. Cuyas características hicieron posible que pese a que la residente se oponía con la presión mandibular que presentaba por el suceso salvara la vida en esta ocasión.


b. English Translation Version:

A resident who feeds autonomously, at the time of the snack presented an obstruction of the airways, the rapid performance of the equipment, was fundamental and this episode was reversed thanks to the use of the DECHOKER and the training received by the team of the official distributors for the Valencian Community.

The resident who presented a critical situation, after the release of airways, recovered quickly, and regained baseline status.

We highlight the central role played by the device in emergency situations (choking), together with the immediate and coordinated action of the center team.

The assessment is very positive in critical cases of choking. Indispensable.

	0	2	0	2	-	0	7
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

Any problems after the use of Dechoker device? No Yes, describe below

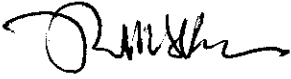
Describe the problem, start date, end date, and problem status (resolved/unresolved) here


Any Dechoker device usage feedback? No Yes, describe below

The Dechoker is easy to use, fast and convenient to transport from one place to another. Whose characteristics made it possible that despite the resident was opposed to the mandibular pressure that presented by the event saved his life on this occasion.

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.


Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019

	0	2	0	2	-	0	9
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	UNK-MAY-2018		
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		
	Age (years): Data Unavailable		
	Place of Event: Care Home Logroño, La Rioja, Spain		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Food		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <i>Before</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> <td style="width: 50%; vertical-align: top;"> <i>After</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> </tr> </table>	<i>Before</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	<i>After</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable
<i>Before</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	<i>After</i> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable		
6. Anti-choking Treatment with Dechoker Device	<i>Patient Position:</i> <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable		
	<i>Patient Status:</i> <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	<i># of Attempts:</i> # of Cycles_Cycles # of Pulls Pulls. <input checked="" type="checkbox"/> Data Unavailable		
	<i>Administered By:</i> <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

 DeCHOKER Because every <u>second</u> counts.	0	2	0	2	-	0	9
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

El servicio médico hizo uso del dispositivo médico antiatragantami ento Dechoker para salvar la vida de una paciente.

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

b. English Translation Version:

The medical service made use of the anti-choking medical device Dechoker to save the life of a patient.

Any problems after the use of Dechoker device? No Yes, describe below

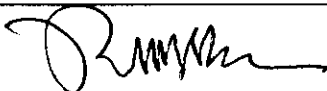
Describe the problem, start date, end date, and problem status (resolved/unresolved) here


Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.


Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019

	<div style="border: 1px solid black; padding: 5px; display: inline-block;">0 2</div>		<div style="border: 1px solid black; padding: 5px; display: inline-block;">0 2 - 0 5</div>					
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number			

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	UNK-FEB-2018		
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		
	Age (years): Data Unavailable		
	Place of Event: Care Home Las Rozas, Madrid, Spain		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Food (Hard-boiled egg)		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Before</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u> </td> <td style="width: 50%; vertical-align: top;"> <u>After</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u> </td> </tr> </table>	<u>Before</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>	<u>After</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>
<u>Before</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>	<u>After</u> (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing. <input checked="" type="checkbox"/> Data Unavailable		
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	# of Attempts: # of Cycles Cycles # of Pulls Pulls <input checked="" type="checkbox"/> Data Unavailable		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, 2 administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	5
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

Cuando me informan del atragantamiento, acudo a valorar a la usuaria y utilizo la mascarilla según indicaciones, veo que no está muy insuflado y me valgo de otra persona que le sujete bien la cabeza a la usuaria para que la mascarilla haga el vacío correcto para poder succionar el alimento que estaba produciendo el atragantamiento.

Al aspirar consigo extraer un trozo de huevo que había ingerido en la comida. Tras extraerlo la usuaria se queda tranquila, recupera saturación y continua atendiéndose como es habitual en estos casos, con aerosolterapia y medicación.

Ángela Barahona Testimony

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Me pareció realmente útil, ya que rápidamente pude conseguir extraer lo que estaba produciendo el problema respiratorio a la usuaria.

b. English Translation Version:

When I was informed of the choking, I came to assess the person and I use the mask according to indications, I saw that it is not very sufficient and I had another person hold the head well so that the mask makes the correct vacuum to be able suck the food that was causing the choking.

We extracted a piece of egg that the person had eaten. After removing the user remains calm, recover saturation and continues to attend as usual in these cases, with aerosol therapy and medication.


Ángela Barahona Testimony

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

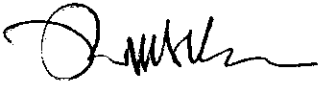
Any Dechoker device usage feedback? No Yes, describe below

I found it really useful, since I could quickly extract what was producing the respiratory problem to the user.

	<div style="border: 1px solid black; padding: 5px; display: inline-block;">0 2</div>		<div style="border: 1px solid black; padding: 5px; display: inline-block;">0 2 - 0 5</div>					
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number			

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.

Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019



0 2

0 2 - 0 4

Protocol #: DC-01 (Retrospective)


Site Number

Subject Number

DECHOKER USE REPORT

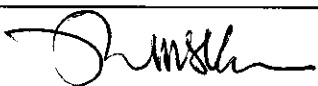
1. Date of Incident (DD-MMM-YYYY)	UNK-MAR-2018														
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male														
	Age (years): Unknown														
	Place of Event: Care Home Pineda de Mar, Barcelona, Spain														
3. Primary Diagnosis	Unknown														
4. Choking Cause	Food														
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table border="0"> <tr> <td>Before (check all that apply):</td> <td>After (check all that apply):</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Back Blows</td> <td><input type="checkbox"/> Forceps</td> </tr> <tr> <td><input type="checkbox"/> Abdominal Thrusts</td> <td><input type="checkbox"/> Back Blows</td> </tr> <tr> <td><input type="checkbox"/> Chest Compression</td> <td><input type="checkbox"/> Abdominal Thrusts</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other: Data Unavailable</td> <td><input type="checkbox"/> Chest Compression</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other: Data Unavailable</td> </tr> </table>	Before (check all that apply):	After (check all that apply):	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps	<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts	<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression		<input checked="" type="checkbox"/> Other: Data Unavailable
Before (check all that apply):	After (check all that apply):														
<input type="checkbox"/> None	<input type="checkbox"/> None														
<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps														
<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows														
<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts														
<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression														
	<input checked="" type="checkbox"/> Other: Data Unavailable														
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable														
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable														
	# of Attempts: # of Cycles Cycles # of Pulls Pulls. <input checked="" type="checkbox"/> Data Unavailable														
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators														
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use														

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	4
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

<p>8. Choking Event Details:</p> <p><i>a. Original Version:</i> No details provided</p> <p><i>Any problems after the use of Dechoker device?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below. <input checked="" type="checkbox"/> Data unavailable Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p><i>Any Dechoker device usage feedback?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below. Describe the feedback here</p> <hr/> <p><i>b. English Translation Version:</i> No details provided.</p> <p><i>Any problems after the use of Dechoker device?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below. <input checked="" type="checkbox"/> Data Unavailable Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p><i>Any Dechoker device usage feedback?</i> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below. Describe the feedback here</p>
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<p>Principal Investigator's Signature Statement:</p> <p>I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.</p>		
<p>Principal Investigator Name</p> <p>Dr. Randall Snook</p>	<p>Signature</p> 	<p>Data Signed (DD/MON/YYYY)</p> <p>07/01/2019</p>



0	2
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0	2	-	0	3
---	---	---	---	---

Protocol #: DC-01 (Retrospective)


Site Number

Study Number

DECHOKER USE REPORT

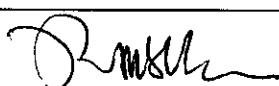
1. Date of Incident (DD-MMM-YYYY)	24-SEP-2017														
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male														
	Age (years): 90														
	Place of Event: Care Home Pamplona, Navarra, Spain														
3. Primary Diagnosis	Severe Dementia														
4. Choking Cause	Food														
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table border="0"> <tr> <td>Before (check all that apply):</td> <td>After (check all that apply):</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Back Blows</td> <td><input type="checkbox"/> Forceps</td> </tr> <tr> <td><input type="checkbox"/> Abdominal Thrusts</td> <td><input type="checkbox"/> Back Blows</td> </tr> <tr> <td><input type="checkbox"/> Chest Compression</td> <td><input type="checkbox"/> Abdominal Thrusts</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other: Data Unavailable</td> <td><input type="checkbox"/> Chest Compression</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other: <u>Data Unavailable</u></td> </tr> </table>	Before (check all that apply):	After (check all that apply):	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps	<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows	<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts	<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression		<input checked="" type="checkbox"/> Other: <u>Data Unavailable</u>
Before (check all that apply):	After (check all that apply):														
<input type="checkbox"/> None	<input type="checkbox"/> None														
<input type="checkbox"/> Back Blows	<input type="checkbox"/> Forceps														
<input type="checkbox"/> Abdominal Thrusts	<input type="checkbox"/> Back Blows														
<input type="checkbox"/> Chest Compression	<input type="checkbox"/> Abdominal Thrusts														
<input checked="" type="checkbox"/> Other: Data Unavailable	<input type="checkbox"/> Chest Compression														
	<input checked="" type="checkbox"/> Other: <u>Data Unavailable</u>														
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable														
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable														
	# of Attempts: # of Cycles <u>Cycles</u> # of Pulls <u>Pulls</u> . <input checked="" type="checkbox"/> Data Unavailable														
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data Unavailable for number of administrators														
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use														


1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	3
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

<p>8. Choking Event Details:</p> <p><i>a. Original Version:</i></p> <p>El 11 de septiembre, una mujer de 71 años con demencia leve, y el 24 de ese mismo mes, otra anciana de 90 con demencia avanzada, se "salvaron" gracias a un nuevo dispositivo denominado Dechoker.</p> <p>Published in the "Navarra Diary".</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p> <hr/> <p><i>b. English Translation Version:</i></p> <p>On September 11, a 71-year-old woman with mild dementia (See subject 02-02), and on the 24th of that same month, another elderly woman of 90 with advanced dementia, was "saved" thanks to a new device called Dechoker</p> <p>Any problems after the use of Dechoker device? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the problem, start date, end date, and problem status (resolved/unresolved) here</p> <p>Any Dechoker device usage feedback? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe below Describe the feedback here</p>
--


<p>Principal Investigator's Signature Statement:</p> <p>I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.</p>		
<p>Principal Investigator Name</p>	<p>Signature</p>	<p>Data Signed (DD/MON/YYYY)</p>
<p>Dr. Randall Snook</p>		<p>07/01/2019</p>

	0	2	0	2	-	0	2
	Protocol #: <i>(Faint text)</i>						

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	11-SEP-2017		
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		
	Age (years): 71		
	Place of Event: Care Home Pamplona, Navarra, Spain		
3. Primary Diagnosis	Mild Dementia		
4. Choking Cause	Food		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Before</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> <td style="width: 50%; vertical-align: top;"> <u>After</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable </td> </tr> </table>	<u>Before</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	<u>After</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable
<u>Before</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable	<u>After</u> (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input checked="" type="checkbox"/> Other: Data Unavailable		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable		
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	# of Attempts: # of Cycles Cycles # of Pulls Pulls. <input checked="" type="checkbox"/> Data Unavailable		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

	0	2	0	2	-	0	2
	Protocol #: DC-04 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

El 11 de septiembre, una mujer de 71 años con demencia leve, y el 24 de ese mismo mes, otra anciana de 90 con demencia avanzada, se "salvaron" gracias a un nuevo dispositivo de nominado Dechoker.

Published in the "Navarra Diary".

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

b. English Translation Version:

On September 11, a 71-year-old woman with mild dementia, and on the 24th of that same month, another elderly woman of 90 (See subject 02-03) with advanced dementia, was "saved" thanks to a new device called Dechoker.

Any problems after the use of Dechoker device? No Yes, describe below

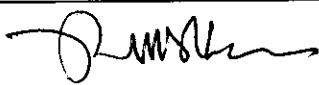
Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.


Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019

	0	2	0	2	-	0	1
	Protocol #: DC-01 (Retrospective)		Site Number		Subject Number		

DECHOKER USE REPORT

1. Date of Incident (DD-MMM-YYYY)	UNK-UNK-2017		
2. Patient's Demography	Sex: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male		
	Age (years): Data Unavailable		
	Place of Event: Care Home (NGO Association of Persons with Physical Disabilities) Gerona, Gerona, Spain		
3. Primary Diagnosis	Data Unavailable		
4. Choking Cause	Food		
5. Anti-choking Treatments Prior/After Use of Dechoker Device	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Before (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u> </td> <td style="width: 50%; vertical-align: top;"> After (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u> </td> </tr> </table>	Before (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>	After (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>
Before (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>	After (check all that apply): <input checked="" type="checkbox"/> None <input type="checkbox"/> Forceps <input type="checkbox"/> Back Blows <input type="checkbox"/> Abdominal Thrusts <input type="checkbox"/> Chest Compression <input type="checkbox"/> Other: <u>Specify Other</u>		
6. Anti-choking Treatment with Dechoker Device	Patient Position: <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Data Unavailable		
	Patient Status: <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input checked="" type="checkbox"/> Data Unavailable		
	# of Attempts: # of Cycles <u>Cycles</u> # of Pulls <u>Pulls</u> . <input checked="" type="checkbox"/> Data Unavailable		
	Administered By: <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Not Patient, Data unavailable for number of administrators		
7. Anti-choking Treatment Outcome:	<input checked="" type="checkbox"/> Dechoker device removed FBAO ¹ without a problem after use <input type="checkbox"/> Dechoker device removed FBAO ¹ but with problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ and no problems after use <input type="checkbox"/> Dechoker device did not remove FBAO ¹ but with problems after use		

1. Foreign Body Airway Obstruction (FBAO)

 DeCHOKER Because every second counts.	0	2	0	2	-	0	1
	Protocol #: DC-01 (Prospective)						

DECHOKER USE REPORT

8. Choking Event Details:

a. Original Version:

Las cuidadoras de una Residencia en Girona hicieron uso del dispositivo antiatragantamiento Dechoker para salvar la vida de una paciente que se encontraba en estado cianótico tras atragantarse durante la comida. A los pocos minutos apareció en el lugar una unidad medicalizada del Sistema de Emergencias Médicas que valoró a la usuaria y dado el estado que presentaba, se le dio el alta in situ.

Any problems after the use of Dechoker device? No Yes, describe below

Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

b. English Translation Version:

The caregivers of a Residence in Girona made use of the Dechoker anti-trapping device to save the life of a patient who was in a cyanotic state after choking during a meal. A few minutes later, a medicalized unit of the Medical Emergency System appeared on the site, assessing the client and, given the condition she presented, she was discharged in situ.

Any problems after the use of Dechoker device? No Yes, describe below

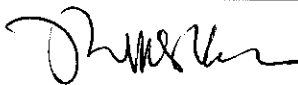
Describe the problem, start date, end date, and problem status (resolved/unresolved) here

Any Dechoker device usage feedback? No Yes, describe below

Describe the feedback here

Principal Investigator's Signature Statement:

I have reviewed this CRF and confirm that, to the best of my knowledge, it accurately reflects the study information obtained for this participant per protocol requirements.

Principal Investigator Name	Signature	Data Signed (DD/MON/YYYY)
Dr. Randall Snook		07/01/2019