BHA Medical
Customer Report Form

Forms should be completed and emailed to customerservice@bha-medical.com Product being returned, the RMA number MUST be referenced on the returned goods.

Date		Name	

1. CUSTOMER INFORMATION

Company Name			
Address			
Return Address (If different to above)			
Email		Tel/Fax	

2. PRODUCT INFORMATION

Product	D-Heart ☐ Other ☐ _____							
Part #		Serial / Batch #		UDI* #		Do you wish to return the product?		
						No ☐	Yes ☐ *Complete section 3*	Unknown ☐

3. PRODUCT RETURNS

Reason for Return			Product Under Warranty?			Decontamination Required?	
Upgrade ☐	Service ☐	Fault ☐	No ☐	Yes ☐ Please attach evidence	Unknown ☐	No ☐	Yes ☐ Nature of contaminant:_____

4. REPORT INFORMATION

Is a formal complaint response required?	No ☐ Yes ☐
Did the fault occur whilst the product was being used on a patient?	No ☐ Yes ☐ *If 'no', complete section 4 only. If 'yes', complete sections 4 & 5.*

* UDI is a 14-digit # that follows (01) and can be found by reading a UDI barcode. Not all devices will have a UDI.

Description of Issue / Detailed Reason for Return:	*Please describe as fully as possible. Provision of photos/emails is highly recommended.*

5. FURTHER INFORMATION

Has a patient or user been injured? Or has there been a misdiagnosis / loss of functionality which has exacerbated the management of a patient?	
What was the outcome of the event on the patient or user's condition?	
In what environment was the product being used at the time of the incident?	
What features of the product were in use at the time of the incident?	
Was the product interacting (physically or electronically) with any other products at the time of the incident?	
Has the incident been reported to a regulatory authority?	*If available, please provide the vigilance report reference number*
Has the device been quarantined?	

Date of Incident: _____ Time of Incident: _____ Patient Age: _____ Patient Sex: M ☐ F ☐

Location Where Incident Occurred: Hospital ☐ Home ☐ Nursing Home ☐ Ambulance ☐ Air Ambulance ☐ Other Aircraft ☐
Maritime vessel ☐ Outpatient Diagnostic Facility ☐ Ambulatory Surgical Facility ☐ Other _____

Operator of Device: Paramedic ☐ Doctor ☐ Emergency Medical Technician ☐ Physician ☐ Nurse ☐ Other: _____

Operator trained on device: Yes ☐ No ☐ Unknown ☐ Current location of device: _____

Relevant pre-existing patient conditions:

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Internal Use Only	RMA #		CCR #		Date of Issue		Initials	