PROSPECTIVE OBSERVATIONAL STUDY OF DECOMPRESSION SICKNESS IN SCUBA DIVERS WITH PATENT FORAMEN OVALE

ENROLLMENT FORM

Filled by administrator

PFO Closure Study Code _____Date of Signed Consent:_____

Filled by study participant

First name:_____ Middle Initial: ___ Last name:_____

Date of birth (mm/dd/yyyy):_____/____/_____

Mailing address
Street address, Apt.#:_____

City:_____State:_____ZIP_____

Country:_____

Home telephone number, area code first: (____) _____

Day phone number, area code first: (____) _____

Mobile telephone number, area code first: ( ) _____

Email address: _____

Are you a certified diver? Yes No
When was your PFO diagnosed? Year _____, Month
Copy of medical record documentation of PFO attached. Yes_____ No_____
Copy of photograph, if applicable attached. Yes_____ No_____

Have you undergone a PFO closure? Yes_____ No_____

When and where did you undergo PFO closure? Year ____ Month _____
Location_____
Copy of medical record documentation of PFO attached. Yes_____ No_____

Which device was used:
Amplatzer _____
Cardioseal/Starflex _____
Gore _____

Other _____ If "other", which device _____

Describe any complications from your PFO closure procedure:

_____

_____

PFO DIAGNOSIS VERIFICATION

Diagnostic method used

TTE
Date:_____
Findings:

TEE
Date:_____
Findings:

Catetherization:
Date:_____
Findings: