UNIVERSITY OF TOLEDO HEALTH SCIENCE CAMPUS
DEVICE TRACKING REPORT

(Use when manufacturer's registration document is not available)

Section 1: Device Status

Status change date: ______________________

- ☐ Receipt
- ☐ Returned to Manufacturer
- ☐ Implantation or Distribution
- ☐ Returned to Inventory
- ☐ Removed from Service
- ☐ Removed from Patient
- ☐ Death of Patient

Date Device Received: ______________________

Date device put in service: ______________________

Section 2: Device Information

Manufacturer Name: ______________________ ECRI Manufacturer Code: ______________________

Device Supplier: ______________________ Rep name: ______________________

Address: ______________________ Telephone: (______) ______________________

City: ______________________ State/Province: __________ Zip/Postal Code: __________-__________

Device Type: ______________________ ECRI Device Code: ______________________

Model Name: __________ Model #: __________ Lot #: __________ S/N: __________

Intended Use: ☐ Single Patient ☐ Multiple Patient

AFFIX DEVICE LABEL IF AVAILABLE

Device Type: ______________________ ECRI Device Code: ______________________

Model Name: __________ Model #: __________ Lot #: __________ S/N: __________

Intended Use: ☐ Single Patient ☐ Multiple Patient

AFFIX DEVICE LABEL IF AVAILABLE

Device Type: ______________________ ECRI Device Code: ______________________

Model Name: __________ Model #: __________ Lot #: __________ S/N: __________

Intended Use: ☐ Single Patient ☐ Multiple Patient

AFFIX DEVICE LABEL IF AVAILABLE

Section 3: Patient Information

Patient Name: ______________________

Medical Record No.: ______________________

Social Security No.: __________-__________-__________

☐ Y ☐ N Hospital Consent Form Signed

☐ Y ☐ N Release of Social Security Number

Section 4: Physician Information

Physician Name printed: ______________________ Telephone: (______) ______________________

Address: ______________________ City: __________ State: ______ Zip: __________

Physician involvement: ☐ Prescribing ☐ Implanting ☐ Explanting ☐ Primary Care/Following

Physician Name printed: ______________________ Telephone: (______) ______________________

Address: ______________________ City: __________ State: ______ Zip: __________

Physician involvement: ☐ Prescribing ☐ Implanting ☐ Explanting ☐ Primary Care/Following

Employee: ______________________ (please print) Department: ______________________ Date: ____/____/____

UPON COMPLETION RETURN TO **RISK MANAGEMENT, MULFORD LIBRARY & COPY TO MANUFACTURER**