

Control Product Used	
<input type="checkbox"/> Amulet	<input type="checkbox"/> 16 mm <input type="checkbox"/> 18 mm <input type="checkbox"/> 20 mm <input type="checkbox"/> 22 mm <input type="checkbox"/> 25 mm <input type="checkbox"/> 28 mm <input type="checkbox"/> 31 mm <input type="checkbox"/> 34 mm
<input type="checkbox"/> Watchman FLX	<input type="checkbox"/> 20 mm <input type="checkbox"/> 24 mm <input type="checkbox"/> 27 mm <input type="checkbox"/> 31 mm <input type="checkbox"/> 35 mm
<input type="checkbox"/> Watchman FLX PRO	<input type="checkbox"/> 40 mm
Please confirm the primary reason for selection of the commercially available device	<input type="checkbox"/> Subject Anatomy <input type="checkbox"/> Investigator Preference <input type="checkbox"/> Other, specify: _____
Device Outcome	<input type="checkbox"/> Used <input type="checkbox"/> Opened, Not Used <input type="checkbox"/> Opened, Used, Disposed <input type="checkbox"/> Opened, Used, Returned <input type="checkbox"/> Opened, Not Used, Returned
Did device meet release criteria per Manufacturer DFU/IFU?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was partial recapture attempted?	<input type="checkbox"/> Yes, number of partial attempts: _____ <input type="checkbox"/> No
Was full recapture attempted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did device deficiency or device malfunction occur?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: If utilizing as source (no other source exists)- form should be signed by device implanter.

Site Personnel Signature

___/___/_____
Date (DD/MMM/YYYY)