PERIPHERAL ARTERIAL THROMBOEMBOLISM			
Protocol Identifier	**Subject Identifier** ☐☐☐☐☐☐		**Visit Description** **Treatment Period ABC** **Visit XYZ**

Date and time of onset of thromboembolism ☐☐ ☐☐☐ ☐☐ ☐☐:☐☐
Day Month Year Hr:Min(00:00-23:59)

SYMPTOMS

Typical signs and symptoms of acute vascular occlusion	(Y) ☐ Yes	(N) ☐ No Not known
If Yes, complete the following:		
Loss of palpable pulse	(Y) ☐ Yes	(N) ☐ No
Acute signs and symptoms	(Y) ☐ Yes	(N) ☐ No
Chronic + subchronic signs and symptoms	(Y) ☐ Yes	(N) ☐ No
Other, specify_________		

RISK FACTORS

Risk factors present	(Y) ☐ Yes	(N) ☐ No
If Yes, complete the following:		
Afib/Flutter	(Y) ☐ Yes	(N) ☐ No
Hypercoagulable state	(Y) ☐ Yes	(N) ☐ No
Malignancy	(Y) ☐ Yes	(N) ☐ No
Known atherosclerotic process	(Y) ☐ Yes	(N) ☐ No
Other risk factors	(Y) ☐ Yes	(N) ☐ No

Other CV risk factors (may not need to be included if included in a separate CV risk factor eCRF)

INTERVENTION REQUIRED OR GIVEN FOR THIS EVENT

Medication	(Y) ☐ Yes	(N) ☐ No
Percutaneous If yes, specify:________	(Y) ☐ Yes	(N) ☐ No
Surgical If yes, specify:_________	(Y) ☐ Yes	(N) ☐ No

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Diagnostic Test Name	Test Performed Y=Yes N=No	Consistent with peripheral arterial thromboembolism Y=Yes N=No	If yes, is the Thromboembolism within a peripheral stent? Y=Yes N=No	Location		Date of Test Day Month Year	Time of Test Hr:Min 00 00-23:59
				1=Upper extremity 2=Lower extremity 3=Renal 4=Mesentric 5=Spienic 6=Hepatic 7=Occular/ Retinal OT=Other	Other location, specify		
Ultrasound							:
CT							:
MRI							:
Angiography							: