LOVO X6R4917 Product Performance Report

Fax this report to 1-888-858-2983 or E-mail this report to

when returning a kit.

mdpmqa.usa@fresenius-kabi.com and include a copy of this form



Important: If reaction or injury has occurred call Fresenius Kabi Post-Market Quality Assurance at 1-800-933-6925. Incident Date: _____ Instrument S/N.: _____ Software Version: UDI No.: Lot No.: When Was the Problem Detected? ☐ Before Use ☐ During Use ☐ After Use **Problem Type** (Mark all applicable) Packaging: ☐ Packaging Open ☐ Mispacked ☐ Illegible Label ☐ Discolored ☐ Missing or Separated Component (e.g. cap) $\textit{Tubing:} \quad \Box \; \mathsf{Flattened} \quad \Box \; \mathsf{Kinked} \quad \Box \; \mathsf{Hole} \quad \Box \; \mathsf{Cut/Sliced} \quad \Box \; \mathsf{Blocked/Occluded} \quad \Box \; \mathsf{Discolored}$ Air Filter: □ Cracked □ Leaking □ Discolored □ Blocked/Occluded Male Luer/Cap: ☐ Cracked ☐ Leaking ☐ Discolored ☐ Blocked/Occluded ☐ Poor Fit Other: Additional Problem Description/Explanation Please circle specific components on the diagram where incident occurred AIR FLOW 0.2 MICRON FILTER WITH FEMALE LUER WHITE SIDE **CLEAR SIDE** Picture available for evaluation? Yes □ No □ If a picture is available, please e-mail a clear picture along with this report to mdpmqa.usa@fresenius-kabi.com Please answer the following questions: 1. Was there any adverse event or injury? Yes \square No \square 2. Was the procedure successfully completed? Yes \square No \square N/A □ 3. If no, was the procedure stopped due to a soft goods incident? Yes \Box No □ N/A □ 4. Was product lost? Yes □ No □ N/A □ 5. Did the procedure involve clinical or patient material? Yes \square No \square N/A \square Check box if you do **NOT** wish to receive response letters. \Box E-mail address for letter recipient (if applicable) **Customer Information (please print)** Kit Return to Fresenius Kabi The following information is required to receive a credit 1. Sample available for evaluation? Yes \Box No □ Facility Name: 2. Return label needed? Yes □ No □ Contact Name: 3. Sample return box needed? Yes □ No □ Account Number (if known): _____ **Center Authorized Signature/Date:** Operator Name: Street Address: City/State/Zip: ___

Phone Number:

Contact Person's E-mail: _____