Salter Ferguson, LLC

Patient's Name:_____ Address:_____

Telephone: _____ Other phone: _____

Patient's Date of Birth:_____ Social Security Number:_____

Email address:_____ Emergency Contact:_____

1. Have you, a family member, or some other person you know suffered a serious side effect which may have been caused by an IVC filter?
   ( )Yes( )No
2. Was the IVC Filter implanted after 2002? If so, what is the approximate date of implantation?
3. What brand of IVC Filter was implanted?
4. Please indicate which complications occurred; check all that apply:
   [ ]Implant fractured
   [ ]Implant migrated
   [ ]Implant perforated
   [ ]Implant tilted
   [ ]Implant became irretrievable
   [ ]Other: _____
5. Is there any additional information you would like to include?