

**Operational Services**

**Exhibit - Automatic External Defibrillator Incident Report**

*To be completed by the person who used the AED*

Patient name: \_\_\_\_\_ Age: \_\_\_\_\_

Patient identification:  Student  Parent  Other: \_\_\_\_\_

Date of incident: \_\_\_\_\_ Description of incident: \_\_\_\_\_

Name of person who determined victim's unresponsiveness: \_\_\_\_\_

Name of person applying AED: \_\_\_\_\_

Number of times patient was defibrillated: \_\_\_\_\_

Time 9-1-1 was called: \_\_\_\_\_

Patient vitals prior to arrival of EMS: Breathing  Yes  No

Pulse  Yes  No

Heart rhythm: \_\_\_\_\_

Time EMS arrived: \_\_\_\_\_

Patient vitals after arrival of EMS: Breathing  Yes  No

Pulse  Yes  No

Heart rhythm: \_\_\_\_\_

Patient transported to: \_\_\_\_\_

List series of events from start of emergency until conclusion:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Forward completed incident report to the Superintendent. Upon receipt, the Superintendent or designee shall send or fax this incident report to the EMS System Resource Hospital.*

Signature of person who administered AED \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_