AED POST EVENT REPORT FORM

Location of event: _____

Date of event: _____ Time of event: _____

Automated External Defibrillator oversight physician: _____

Building AED Coordinator: _____

Victim's initials: _____ Was the event: ☐ Witnessed ☐ Non-witnessed

Name of trained responder(s): _____

Was 911 called? ☐ Yes ☐ No If yes, name of 911 caller: _____

Was pulse taken at initial assessment? ☐ Yes ☐ No

Was CPR given before the AED arrived? ☐ Yes ☐ No

If yes, name(s) of CPR responder(s): _____

_____

Were shocks given? ☐ Yes ☐ No Total number of shocks: _____

Did victim: Regain a pulse? ☐ Yes ☐ No

Resume breathing? ☐ Yes ☐ No

Regain consciousness? ☐ Yes ☐ No

Was the procedure for transferring patient care to the local EMS agency executed? ☐ Yes ☐ No

If no, please explain: _____

_____

Were any problems encountered? ☐ Yes ☐ No If yes, please explain: _____

_____

Name of person completing form: _____

Other Responders: _____

Copy to:
- ☒ Director of Safety and Security
- ☒ Operations Specialist
- ☐ Risk Manager
- ☐ Building AED Coordinator