



Post Incident AED Cardiac Arrest Report

Facility Name: _____

Incident Location: _____

Street Address: _____

City, State, Zip Code: _____

1. Date of Incident: _____
2. Estimated time of incident: ____:____ (HH:MM) circle AM or PM
3. Patient Gender: Male Female
4. Estimated age of patient: _____ yrs.
5. Did the patient collapse (become unresponsive)? Yes No
 - a) If yes, what were the events immediately prior to collapse? check all that apply: Difficulty breathing Chest pain No signs or symptoms Drowning Electrical shock Injury Unknown
 - b) Was someone present to see the person collapse? Yes No
If yes, was that person a trained AED employee? Yes No
 - c) After collapse, at the time of patient assessment and just prior to the facility AED pads being applied: was the person breathing? Yes No
Did the person have signs of circulation? Yes No
6. Was CPR given prior to 911 EMS arrival? Yes, go to 6a No, go to 7
 - a) Estimated time CPR started: ____:____ (HH/MM) circle AM or PM
 - b) Was CPR started prior to the arrival of a trained AED employee? Yes No
 - c) Who started CPR? Bystander Trained AED Employee
7. Was a facility AED brought to the patient's side prior to 911 EMS arrival? Yes No
 - a) If no, briefly describe why and skip to #15 _____
 - b) If yes, estimated time (based on your watch) facility AED at patient's side: ____:____ (HR:MM) AM or PM
8. Were the facility AED pads placed on the patient? Yes No
 - a) If yes, was the person who put the AED pads on the patient a: Trained AED facility employee
 Untrained AED facility employee Bystander
9. Was the facility AED turned on? Yes No
 - a) If yes, estimated time (based on your watch) facility AED was turned on: ____:____ (HR:MM) AM or PM
10. Did the facility AED ever shock the patient? Yes No if yes:
 - a) Estimated time (based on your watch) of 1st shock by facility AED: ____:____ (HR:MM) AM or PM

- b) If shocks were given, how many shocks were delivered prior to the EMS ambulance arrival? _____
11. Name of person operating the facility AED: _____
- a) Is this person a trained AED employee? Yes No
- b) Highest level of medical training of person administering the facility AED: Public AED trained First responder AED trained EMT-B CRT/EMT-P Nurse/Physician Other health care provider No known training
12. Were there any mechanical difficulties or failures associated with the use of the facility AED?
 Yes No If yes, briefly explain & attach a copy of the completed FDA reporting form (required by law):

13. Did any of the below personal concerns regarding the patient apply? Vomiting Excessive chest hair
 Sweaty Water/wet surface Other concerns not listed above: _____
14. Were there any unexpected events or injuries that occurred during the use of the facility AED? Yes No
If yes, briefly explain: _____
15. Indicate the patient's status at the time of the 911 EMS arrival:
Circulation restored: Yes No Unsure If yes, time restored: ____:____ (HH:MM) AM or PM
Breathing restored: Yes No Unsure if yes, time restored: ____:____ (HH:MM) AM or PM
Responsiveness restored: Yes No Unsure if yes, time restored: ____:____ (HH:MM) AM or PM
16. Was the patient transported to the hospital? Yes No
- a) If yes, how was the patient transported? EMS Ambulance Private vehicle Other _____
- b) If yes, please provide name of transporting ambulance service and the facility the patient was transported to: _____
17. Other comments/concerns not referenced on this form that may be useful for the medical director?

Report completed by: _____

Please print name/date: _____

Signature/date: _____

Title/phone: _____

Manufacturer/model of the AED used: _____

PLEASE RETURN TO RISK MANAGEMENT WITH 24 HOURS FOLLOWING INCIDENT