AED INCIDENT REPORT

Please complete the form below. Items with a red asterisk (*) are required fields.

AED Facility Name and Location*

AED Brand and Serial Number*	**Facility Phone Number***
Date of Incident* _____ / _____ / 2020	**Time of Incident*** _____:_____ am / pm

Responder #1* _____ _____
First Last

Responder #2 _____ _____
First Last

Location of Incident within the facility (Be specific)

Age of Patient	**Gender*** M__ / F __	**Cause of Incident** Medical ___ / Trauma ___

Estimated Time that bystander(s) performed CPR prior to arrival of AED
None ____ Unknown ____ <4 Minutes _____ 4-8 Minutes ____ 8-12 Minutes ___ >12 Minutes ____

Estimated Time between arrival of AED to initial shock delivered
No Shock Advised ____ Unknown ____ <4 Minutes _____ 4-8 Minutes ____ >8 Minutes ___ No Shock Given ___

Total Number of Shocks given prior to EMS arrival* _____

Estimated time of arrival of EMS
Unknown ____ <4 Minutes _____ 4-8 Minutes ____ 8-12 Minutes ___ >12 Minutes ____

Initial Arrest Witnessed by Bystanders* Y __ / N __ / Unknown __

Patient regained a pulse at the scene Y __ / N __ / Unknown __

Patient regained spontaneous breathing at the scene Y __ / N __ / Unknown __

Patient Transported by EMS* Y __ / N __	**Name of EMS Agency***

Comments

Person Completing Report* _____ _____ First Last	Date ___ / ___ / 2021