Automated External Defibrillators

**North Gem School District No. 149**
**AUTOMATED EXTERNAL DEFIBRILLATOR (AED)**
**INCIDENT REPORT**

Date of Incident: _____ Time of Incident: _____

Location of Incident (which building, where in building, etc.): _____

_____

Patient's Age: _____ Patient's Sex: _____ Male _____ Female

CPR prior to defibrillation: _____ Attempted _____ Not Attempted

Cardiac Arrest: _____ Not Witnessed _____ Witnessed by Bystander
_____ Witnessed by AED team member

Estimated time (in minutes) from arrest to CPR: _____

Shock: _____ Indicated _____ Not Indicated

Estimated time (in minutes) from arrest to 1st AED shock: _____

Number of shocks: _____

Additional Comments: _____

_____

Patient Outcome at Incident Site:

_____ Return of pulse and breathing
_____ Return of pulse with no breathing
_____ Return of pulse, then loss of pulse
_____ No return of pulse or breathing
_____ Became responsive
_____ Remained unresponsive

Name of AED Operator: _____

Transporting Ambulance: _____

Name of Facility Patient was Transported To: _____

Name of Emergency Health Care Provider: _____

_____ _____

Signature of Health Care Provider Date of Report

**This report is to be completed by the Emergency Health Care Provider or AED User within 5 business days of use of an AED.**

The completed report must be mailed/returned to: _____