AED Incident Report

Incident ID: ______________________________ Date: _____/_____/______

Incident Location ____

AED Program Sponsor ______________________ Contact Person ______________________

Phone Number ______________________ Email: ______________________

Device Manufacturer ______________ Model #: ____________ ID# ______________________

Victim Detail

Last Name __________________ First Name __________________ Middle Initial __________

Additional Information

AED Operator: ____

Response Team Members: ____

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Comments: ____

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Report Completed by: ______________________ Date:______________________

NOTE: Use back of this sheet for additional comments.

You may also be required to complete a state or local EMS report that should be submitted according to specified local/state regulation.

Post-Incident Review Form

Victim Data

Victim Name: ___________________________________ Incident Date: ___________________________

Employee Number: ______________ DOB: ____________ Age: _______ Sex: ___________________

Call Notification (include hour : minute : second for times recorded)

How was Team alerted? _________________________ Time alerted: ___ : ___ : ___

How was Team dispatched? ______________________ Dispatch time: ___ : ___ : ___

Who initiated 9-1-1 call? _________________________ Time called: ___ : ___ : ___

ERT or AED Team arrival time: ___ : ___ : ___ AED arrival time: ___ : ___ : ___

SCA Event Report

Collapse/recognition: ___ : ___ : ___ Bystander CPR started: ___ : ___ : ___

9-1-1 called: ___ : ___ : ___ EMS dispatched: ___ : ___ : ___

ERT Team arrival: ___ : ___ : ___ AED arrival: ___ : ___ : ___

Patient unresponsive: ☐ Yes ☐ No Documented time: ___ : ___ : ___

Rescue breathing started: ☐ Yes ☐ No Documented time: ___ : ___ : ___

CPR started: ☐ Yes ☐ No Documented time: ___ : ___ : ___

AED applied: ☐ Yes ☐ No Documented time: ___ : ___ : ___

First shock advised: ☐ Yes ☐ No Documented time: ___ : ___ : ___

Additional shocks: ☐ Yes ☐ No Total # of shocks delivered: __________

Return of pulse: ☐ Yes ☐ No Documented time: ___ : ___ : ___

Return of respiration: ☐ Yes ☐ No Documented time: ___ : ___ : ___

EMS scene arrival: ___ : ___ : ___ EMS arrival at patient: ___ : ___ : ___

Patient condition at EMS hand-off: ____

Care Given by EMS: ☐ ALS ☐ BLS Patient transported: ___ : ___ : ___

Transported to: ____

Patient condition at hospital: ____

Report Completed by: ___________________________ Date: ____________________________________