AED POST INCIDENT REPORT

Patient's last name	Patient's first name	Patient's address	
Phone number	City	State	Zip
Sex: Male Female	Incident Date:	AED operator:	
Incident date:		Assistant:	
Location:		Assistant:	
Estimated time from patient's collapse until CPR begun:		Estimated total time of CPR until application of AED	
Was cardiac arrest witnessed? Yes No Unknown	By whom:	Time:	
Was CPR started? Yes No	By whom:	Time:	
Did the patient ever regain a pulse?	Time:	Did the patient begin breathing?	Time:
Did patient ever regain consciousness?	Time:	Hospital patient taken to:	Time:
Other treatment:		Transporting agency:	

Communications: ____

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Comment/concerns: ____

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Report completed by: ____

Date: ____________________ **EMS Notified:** ____________________

Prescribing physician review/recommendations:

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Coordinator reviewed:	Date:	Reviewed with responders:	Date:
Physician reviewed:	Date:	Comments:	