Operational Services –
Automatic External Defibrillator Incident Report

To be completed by the person who used the AED

Patient name:_____ Age:_____

Patient identification: ☐ Student ☐ Parent ☐ Other:_____

Date of incident: _____ Description of incident:_____

_____

Name of person who determined victim's unresponsiveness:_____

Name of person applying AED:_____

Number of times patient was defibrillated:_____
Time 9-1-1 was called:_____

Patient vitals prior to arrival of EMS: Breathing ☐ Yes ☐ No
Pulse ☐ Yes ☐ No
Heart rhythm:_____

Time EMS arrived:_____

Patient vitals after arrival of EMS: Breathing ☐ Yes ☐ No
Pulse ☐ Yes ☐ No
Heart rhythm:_____

Patient transported to:_____

List series of events from start of emergency until conclusion:

_____

_____

_____

_____

Forward completed incident report to the Superintendent. Upon receipt, the Superintendent or designee shall send or fax this incident report to the EMS System Resource Hospital.

_____ _____
Signature of person who administered AED Date

_____ _____
Address Telephone