



## Notice of AED Use by PAD Agency

Name of PAD Site: \_\_\_\_\_

Location of Incident: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Age of Patient (in years): \_\_\_\_\_ (approximate if unknown) Sex (circle): MALE FEMALE

Witnessed arrest (circle): YES NO Estimated time from arrest to CPR: \_\_\_\_\_ minutes.

CPR initiated by (circle): BYSTANDER STAFF OTHER (specify) \_\_\_\_\_

Total number of shocks delivered by PAD agency: \_\_\_\_\_

Name of transporting ambulance service: \_\_\_\_\_

Hospital name where the patient was transported: \_\_\_\_\_

Patient outcome on scene (circle):

Regained pulse                      Remained pulseless

Became responsive                      Remained unresponsive

### THIS SECTION IS TO BE COMPLETED BY EHCP for QI

Was code summary reviewed? YES NO If not, why? \_\_\_\_\_

Were actions appropriate? YES NO If not, why? \_\_\_\_\_

Was the agency contacted for follow-up? YES NO

Are there any unresolved issues with this incident? YES NO

If yes, what and how will they be addressed? \_\_\_\_\_

Incident reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Within 48 hours of AED use, please mail this form & downloaded "code summary" to:

Office of Prehospital Care  
ATTN: PAD Program  
462 Grider Street  
Buffalo, NY 14215