

CONFIDENTIAL

**Saint Cloud State University
Automated External Defibrillator (AED) POST-INCIDENT REPORT
FORM FOR CARDIAC ARRESTS**

To be completed immediately after a cardiac arrest occurs at your facility or the AED is put on a patient. Form should be filled out by the main caregiver at the scene and the AED Operator and **within 48 hours**.

1. Facility or Building Name: _____
2. Incident Location: _____
3. Date of Incident: ____/____/____ (Mo./Day/Yr.)
4. Estimated Time of **Incident**: ____:____ a.m./p.m.
 - 4a. Estimated Time that **911 Call** was placed: ____:____ a.m./p.m.
5. Name of Patient: _____
6. Patient Gender: Male Female
7. Estimated Age of Patient: _____ Yrs.
8. Did the patient collapse (become unresponsive)? Yes No
 - 8a. If Yes, what were the events immediately prior to the collapse (Check all that apply):
Difficulty Breathing Chest Pain No Signs or Symptoms
Drowning Electrical Shock Injury Unknown
 - 8b. Was someone present to see the person collapse? Yes No
If yes, was that person a trained AED Employee? Yes No
 - 8c. After the collapse, at the time of Patient Assessment and just prior to the AED pads being applied,
Was the person breathing? Yes No
Did the person have a pulse? Yes No
9. Was CPR given prior to 911 EMS arrival? Yes Go to #9a No Go to #10
 - 9a. Estimated time CPR Started: ____:____ a.m./p.m. (Hr./Min.)
 - 9b. Was CPR started prior to the Arrival of a Trained AED Employee?
Yes No
 - 9c. Who *Started* CPR? Bystander Trained AED Employee

10. Was an AED brought to the victim prior to 911 EMS arrival? Yes No
10a. If No, Briefly describe why and skip to question 17:

10b. If yes, estimated time AED was at patient's side: ____:____ (Hr./Min.)

11. Were the AED Pads put on the patient? Yes No

11a. If Yes, was the person who put the AED pads on the patient a:
Trained AED Employee Untrained AED Employee
Bystander

12. Was the AED turned on? Yes No

12a. If yes, estimated time (based on your watch) the AED was turned on:
____:____ a.m./p.m. (Hr./Min.)

13. Did the AED ever shock the patient? Yes No If Yes,

13a. Estimated time (based on your watch) of 1st shock by AED:
____:____ a.m./p.m. (Hr./Min.)

13b. If shocks were given, how many shocks were delivered prior to the EMS ambulance arrival? # _____

14. Name of Person operating the AED: _____

14a. Is this person a trained AED employee? Yes No

15. Was there any mechanical difficulty or failure associated with the use of the AED?
Yes No

15a. If Yes, briefly explain and attach a copy of the completed FDA reporting form (required by Federal law).

16. Were there any unexpected events or injuries that occurred during the use of the AED? Yes No

16a. If yes, Briefly explain:

17. Indicate the patient's status at the time of the 911 EMS arrival:

(Hr./Min.) _____

17a. Pulse restored: Yes No Don't Know

If Yes, Time Pulse Restored: __ __: __ __

17b. Breathing restored: Yes No Don't Know

If Yes, Time Breathing Restored: __ __: __ __

17c. Responsiveness restored: Yes No Don't Know

If Yes, Time Patient Responsive: __ __: __

18. Was the patient transported to the hospital? Yes No

18a. If Yes, How was the patient transported?

EMS Ambulance Private Vehicle Other _____

Report Completed by (please *print Name and Date*):

Signature
