CONFIDENTIAL

DISTRICT of COLUMBIA FACILITY AED REPORT FORM FOR CARDIAC ARRESTS

To be completed immediately after a cardiac arrest occurs at your facility or the facility AED is put on a patient.
Form should be filled out by the main caregiver at the scene & the Facility AED Operator and returned to DCFEMS within 72 hours
Please Return Completed Form with your AED Summary Report and copy of FDA Incident Form (if applicable) to:

DC Fire and Emergency Medical Services Department Attention: PAD Program Coordinator
2000 14th St NW, Suite 500, Washington, DC 20009
Fax: (202) 462-0807
Phone: (202) 673-3320

1. Facility Name: _____

2. Incident Location: _____
Street Address

_____
City State Zip Code County

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.
Hr. Min. Hr. Min.

5. Name of Patient: _____
First Middle Last

6. Patient Gender: Male [ ] Female [ ] 7. Estimated Age of Patient: _____Yrs.

7. Did the patient collapse (become unresponsive, i.e., no breathing, no coughing, no movement)? Yes [ ] Not [ ]

7a. 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 [ ]

7b. Was someone present to see the person collapse? Yes [ ] No [ ]
If yes, was that person a trained AED Employee? _____ Yes [ ] No [ ]

7c. After the collapse, at the time of Patient Assessment and just prior to the Facility AED pads being applied.
Were there signs of circulation (breathing, coughing, or movement)? Yes [ ] No [ ]
Was pulse checked? Yes [ ] No [ ]
If yes, did the person have a pulse? Yes [ ] No [ ]

8. Was CPR given prior to 911 EMS arrival? _____ Yes [ ] GO to #8a No [ ] Go to #17

8a. Estimated time CPR Started:_____ a.m. / p.m.
Hr. Min.
8b. Was CPR started prior to the Arrival of a Trained AED Employee? Yes [ ] No [ ]
8c. Who Started CPR? Bystander [ ] Trained AED Employee [ ]

10. Was a Facility AED brought to the patient's side prior to 911 EMS arrival? Yes [ ] No [ ]
10a. If No, Briefly describe why and skip to question 17:_____
10b. If Yes, Estimated Time (based on your watch) Facility AED at patient's side: a.m. /p.m. Hr. Min.

11. Were the Facility 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 Facility Employee [ ] Untrained AED Facility Employee [ ] Bystander [ ]

12. Was the Facility AED tuned on? Yes [ ] No [ ]

12a. If Yes, Estimated Time (Based on your watch) Facility AED was turned on: _____ a.m. /p.m.

13. Did the Facility AED ever shock the patient? Yes [ ] No [ ]

If Yes,

13a. Estimated Time (Based on your watch) of 1°' shock by facility AED: _____a.m. / p.m.

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

14. Name of person operating AED:

_____

First *Middle* *Last*

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

14b. Highest level of medical training of person administering the Facility AED:

Public AED Trained [ ] First Responder AED Trained [ ] EMT-B [ ]

Nurse/Physician [ ] CRT/EMT-P [ ] Other Health Care Provider [ ] No Known Training [ ]

15. Was there any mechanical difficulty or failure associated with the use of the Facility 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 Facility 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: _____

17d. Signs of circulation present: Yes [ ] No [ ] Don't Know [ ] If Yes, Time Circulation Returned: _____

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

_____

Signature *Date*

Make/Model of the Facility AED that was used? _____

Manufacturer Make *Model #*

QUESTIONS? GIVE US A CALL OR SEND US A FAX AT: (202) 673-3320 (P) or (202) 462-0807 (F)