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: __________________________________________

3. Date of Incident: Mo.____ Day____ Yr.____

4. Estimated Time of Incident: _______ a.m./p.m.

5. Name of Patient: ______________________________________________________________________________________

6. Patient Gender: Male [ ] Female [ ]

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 [ ]

7c. Was that person a trained AED Employee? Yes [ ] No [ ]

8. Was CPR given prior to 911 EMS arrival? Yes [ ] No [ ]

8a. Estimated time CPR Started: _______ a.m./p.m.

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 [ ]

13a. If Yes, estimated time (based on your watch) of 1st 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:

   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)