

APPENDIX I

AED INCIDENT REPORT

Complete this form with every incident necessitating AED use, submitting within 24 hours of use.

PATIENT'S NAME: _____

STUDENT'S ID NUMBER (If applicable): _____

DOB: _____ **AGE:** _____ **SEX:** F M **PHONE:** _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

PERTINENT MEDICAL HISTORY: _____

DATE & TIME OF AED USE: _____ **AED SERIAL NUMBER:** _____

EXACT LOCATION OF INCIDENT: _____

DESCRIPTION OF INCIDENT: _____

WITNESSES: _____

PHONE NUMBER: _____

NAME OF AED OPERATOR: _____

OTHER ASSISTING RESPONDERS: _____

EMS UNIT RECEIVING PERSON: _____

TIME AND LOCATION OF TRANSPORT: _____

REPORTED BY: _____ **DATE:** _____

PHONE NUMBER: _____

MEDICAL DIRECTOR'S COMMENTS: _____

Copy Distribution

White: Medical Director

Yellow: Risk Management

Pink: AED Coordinator