APPENDIX C

POST EVENT (INCIDENT) SUMMARY REPORT FORM

Location of event: _____

Date of Event: _____Time of event: _____

Automated External Defibrillator oversight Physician: _____

District AED Coordinator: _____

Victim's initials: _____

Was the event Witnessed or non-witnessed? Witnessed ____Non-Witnessed___

Name of trained responder(s):_____

Internal response plan activated? Yes_____ No_____

Was 9-1-1 called? Yes _____No _____If yes, name of 9-1-1 called: _____

Was pulse taken at initial assessment? Yes_____ No_____

Was CPR given before the AED arrived: Yes_____ No _____

If yes, name (s) of CPR responder(s):_____

Were shocks given? Yes_____ No_____

Total number of shocks? _____

Did victim…..

Regain a pulse? Yes_____ No_____
Resume Breathing? Yes_____ No_____
Regain consciousness? Yes_____ No_____

Was the procedure for transferring patient care to the local EMS agency executed?
Yes_____ No_____

If no, please explain: _____

_____

Any problems encountered? _____

_____

Name of person completing form: _____
Form Reviewed By:

- ❑ District AED Coordinator
- ❑ Nurse
- ❑ Risk Manager
- ❑ Building AED Coordinator