CLARK COUNTY SCHOOL DISTRICT AUTOMATED EXTERNAL DEFIBRILLATOR (AED) INCIDENT REPORT

Date of Incident:______________________________ Time of Incident: ________________

Location of Incident (which building, where in building, etc.):______________________________

____

Patient's Age:_____________ Patient's Sex:_______Male________Female

CPR prior to defibrillation: ____________Attempted ____________Not Attempted

Cardiac Arrest: ______Not Witnessed ______Witnessed by Bystander

______ Witnessed by AED team member

Estimated time (in minutes) from arrest to CPR: _____________________

Shock: ______Indicated ______Not Indicated

Estimated time (in minutes) from arrest to 1st AED shock: ___________________

Number of shocks: ________

Additional Comments: ____

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Patient Outcome at Incident Site:

_____ Return of pulse and breathing ☐ _____ No return of pulse or breathing

_____ Return of pulse with no breathing _____ Became responsive

☐ Return of pulse, then loss of pulse ☐ Remained unresponsive

Name of AED Operator: ______________________________

Transporting Ambulance: ______________________________

Name of Facility Patient was Transported To: ______________________________

Name of Emergency Health Care Provider: ______________________________

______________________________ ______________________________

Signature of Health Care Provider Date of Report

This report is to be completed by the Emergency Health Care Provider or AED User within 5 business days of use of an AED.

The completed report must be mailed/returned to: ______________________________