Notice of AED Use by PAD Agency

Name of PAD Site: _____

Location of Incident: _____ City: _____ State:_____ Zip: _____

Date of Incident: Time of Incident: am ☐ pm ☐

Age of Patient (in years): _____ (approximate if unknown) Sex: MALE ☐ FEMALE ☐

Witnessed arrest (circle): YES ☐ NO ☐ Estimated time of arrest to CPR: _____ minutes

CPR initiated by: BYSTANDER ☐ STAFF ☐ OTHER (specify):_____

Total number of shocks delivered by PAD agency: _____

Name of transporting ambulance service: _____

Hospital Name where the patient was transported: _____

Patient outcome on scene: ☐ Regained Pulse ☐ Remained pulseless

☐ Became responsive ☐ Remained unresponsive

THIS SECTION IS TO BE COMPLETED BY EHCP FOR QI

Was code summary reviewed? YES ☐ NO ☐ If not, why? _____

Were actions appropriate? YES ☐ NO ☐ If not, why? _____

Was the agency contacted for follow-up? YES ☐ NO ☐

Are there any unresolved issues with this incident? YES ☐ NO ☐

If yes, what and how will they be addressed? _____

_____

Incident reviewed by: _____ Date: _____

Within in 48 hours of AED use, please mail this form and download “code summary” to:

Southern Tier Health Care System Inc.
ATTN: PAD Program
150 North Union Street
Olean, NY 14760