

Mountain Lakes Regional EMS Council
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Watertown, NY 13601
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Public Access Defibrillation Incident Report

Name of PAD Provider Organization: _____

Date of Incident: ____ / ____ / ____

Time of Incident: ____ : ____ am/pm

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

Estimated Time (in minutes) from Arrest to: CPR ____ : ____ Shock: () Indicated () Not Indicated

Estimated Time (in minutes) from Arrest to 1st shock ____ : ____ Number of Shocks: ____

Additional Comments: _____

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 Transported to: _____

Name of Emergency Health Care Provider: _____

Signature of Health Care Provider

Date of Report

This report is to be completed **within five (5) business days of use** of an AED and mailed to:

**Mountain Lakes Regional EMS Council
120 Washington Street Suite 230
Watertown, NY 13601**

The information obtained from this report will be maintained as confidential Quality Assurance information pursuant to Article 30, Section 3004-A and 3006 of the Public Health Law of the State of New York.