



AED Incident Report

Incident ID: _____ Date: ____/____/____

Incident Location _____

AED Program Sponsor _____ Contact Person _____

Phone Number _____ Email: _____

Device Manufacturer _____ Model #: _____ ID# _____

Victim Detail

Last Name _____ First Name _____ Middle Initial _____

Additional Information

AED Operator: _____

Response Team Members: _____

Comments: _____

Report Completed by: _____ Date: _____

NOTE: Use back of this sheet for additional comments.

You may also be required to complete a state or local EMS report that should be submitted according to specified local/state regulation.



Post-Incident Review Form

Victim Data

Victim Name: _____ Incident Date: _____

Employee Number: _____ DOB: _____ Age: _____ Sex: _____

Call Notification (include hour : minute : second for times recorded)

How was Team alerted? _____ Time alerted: ____ : ____ : ____

How was Team dispatched? _____ Dispatch time: ____ : ____ : ____

Who initiated 9-1-1 call? _____ Time called: ____ : ____ : ____

ERT or AED Team arrival time: ____ : ____ : ____ AED arrival time: ____ : ____ : ____

SCA Event Report

Collapse/recognition: ____ : ____ : ____ Bystander CPR started: ____ : ____ : ____

9-1-1 called: ____ : ____ : ____ EMS dispatched: ____ : ____ : ____

ERT Team arrival: ____ : ____ : ____ AED arrival: ____ : ____ : ____

Patient unresponsive: ☐ Yes ☐ No Documented time: ____ : ____ : ____

Rescue breathing started: ☐ Yes ☐ No Documented time: ____ : ____ : ____

CPR started: ☐ Yes ☐ No Documented time: ____ : ____ : ____

AED applied: ☐ Yes ☐ No Documented time: ____ : ____ : ____

First shock advised: ☐ Yes ☐ No Documented time: ____ : ____ : ____

Additional shocks: ☐ Yes ☐ No Total # of shocks delivered: _____

Return of pulse: ☐ Yes ☐ No Documented time: ____ : ____ : ____

Return of respiration: ☐ Yes ☐ No Documented time: ____ : ____ : ____

EMS scene arrival: ____ : ____ : ____ EMS arrival at patient: ____ : ____ : ____

Patient condition at EMS hand-off: _____

Care Given by EMS: ☐ ALS ☐ BLS Patient transported: ____ : ____ : ____

Transported to: _____

Patient condition at hospital: _____

Report Completed by: _____ Date: _____