File: EBBC-E

AED INCIDENT REPORT

Complete this form with every incident necessitating AED use, submitting within 24 hours of use.

PATIENT'S NAME:_____

STUDENT'S ID) NUMBER (If applicable): _____

DOB: _____ **AGE**:_____ **SEX: F M PHONE:** _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

PERTINENT MEDICAL HISTORY: _____

DATE & TIME OF AED USE: _____ **AED SERIAL NUMBER:** _____

EXACT LOCATION OF INCIDENT: _____

DESCRIPTION OF INCIDENT: _____

WITNESSES: _____

PHONE NUMBER: _____

NAME OF AED OPERATOR: _____

OTHER ASSISTING RESPONDERS: _____

EMS UNIT RECEIVING PERSON: _____

TIME AND LOCATION OF TRANSPORT: _____

REPORTED BY: _____ **DATE:** _____

PHONE NUMBER: _____

MEDICAL DIRECTOR'S COMMENTS: _____

_____

Reviewed by _____ Date_____
Medical Director

_____ Date_____
Program Coordinator