Poway Unified School District
Use of Automatic External Defibrillators (AEDs)

POST-INCIDENT REPORT

AS SOON AS POSSIBLE - Contact the Program Manager at San Diego Project HeartBeat at (619) 243-0911 to report use of an AED.

Patient's Last Name: ______________________ First Name: __________________________

Patient's Address: ____

City: _____________________________________State: ______________ Zip: __________

Patient's Phone Number : (______) _____________________

Patient DOB: ___/___/____ Age: ____________ Gender: _______M ______F

Date of Incident: ______________________________ Time of Incident:_________AM / PM

Exact Location of Incident (School Name, Building, Room):

____

____

Name of AED Operator: ____

AED Operator's Address: ____

City: _____________________________________State: ______________ Zip: __________

AED Operator's Phone Number: (___________) _____________________

Was cardiac arrest witnessed? ________Yes _______ No ______ Unknown

If yes, by whom? _______________________________ Time ____________________

Was CPR started? ______ Yes ______ No

If yes, by whom? _____________________________________ Time____________________

Was 9-1-1 called? ______ Yes ______ No

USE OF AUTOMATIC EXTERNAL DEFIBRILLATOR (AEDS) (continued)

If yes, by whom? ____________________________________ Time ____________________

Hospital Patient Taken to: _____________________________ Time ____________________

Transporting Agency: ____

Patient Condition at Hospital: ____

Assessment and Treatment

Estimated time from patient's collapse until CPR begun? _____________________________

Estimated total time of CPR until application of AED: _______________________________

Were ABCs assessed? _______Yes ______ No If yes, Time: ____________________

Were AED shock pads applied? ______ Yes ______ No Time: ________________

Was shock #1 delivered? ______ Yes ______ No Time: ________________

Was shock #2 delivered? ______ Yes ______ No Time: ________________

Was shock #3 delivered? ______ Yes ______ No Time: ________________

Did patient ever regain a pulse? ______ Yes ______ No Time: ________________

Did patient begin breathing? ______ Yes ______ No Time: ________________

Did patient ever regain consciousness? _____ Yes ______ No Time: ________________

Was shock #1 delivered? ______ Yes ______ No Time: ________________

Was shock #1 delivered? ______ Yes ______ No Time: ________________

Patient condition at EMS hand-off": ____

Patient Activity Prior to Event: ____

Patient Complaints Prior to Event (check all that apply):

[ ] Chest Pain [ ] Difficulty breathing [ ] No signs or symptoms
[ ] Drowning [ ] Injury [ ] Electrical shock [ ] Unknown
[ ] Other (describe) ____

USE OF AUTOMATIC EXTERNAL DEFIBRILLATOR (AEDS) (continued)

Was AED Response Team notified? ________ Yes ________ No

If yes: Time of Notification: ____________________ AM / PM

By whom: ____

Name of person notified: ____

Was Program Manager Notified? __________ Yes ________ No

If yes: Time of Notification: _______________ AM / PM

By whom: ____

Name of person notified: ____

Comments/Concerns: ____

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Post-Incident Report Completed By:

______________________________________ ____________________________________

(Print Name) (Title)

______________________________________ Date Completed: ____________________

(Signature)

PUSD AED Coordinator Review

Comments/Recommendations: ____

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______________________________________ ____________________________________

(Print Name) (Title)

______________________________________ Date Signed: _______________________

(Signature)

PUSD Program Manager Review

Comments/Recommendations: ____

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______________________________ ______________________________
(Print Name) (Title)

______________________________ Date Completed: ________________
(Signature)