AED USAGE REPORT

MARIN COUNTY EMS AGENCY
1600 Los Gamos Drive #220, San Rafael, CA 94903
ph. 415-473-6871 fax 415-473-3747
www.MarinEMS.org

Please mail of fax completed form to EMS Agency within 72 hours

Data Elements	Insert Information Here
Name of AED Program	
Name of AED Provider (Who was the authorized individual treating the patient?)	
Place of Occurrence (Address and specific site)	
Date	
Time of incident	
Patient's Name (If known)	
Patient's Age (If known)	
Patient's Sex (If able to determine)	
Times (Indicate best known or approximate time)	
• Witnessed arrest to first CPR	
• Witnessed arrest to 9-1-1 Called	
• 9-1-1 called to arrival on scene	
• Witnessed arrest to 9-1-1 CPR	
• Patient contact to first shock/Witnessed arrest to first shock	
• 9-1-1 to first shock	
Total number of shocks	
Patient prehospital outcome?	
Patient discharged from hospital? (If known)	
Was there any return of spontaneous circulation?	
Was there any return of spontaneous respiration?	
Circumstances of Cardiac Arrest	
Was cause of arrest determined?	
Any patient history?	
Patient allergies?	
Patient medications?	