AED USE EVENT SUMMARY FORM

Orange County Health Care Agency, Emergency Medical Services

Location of event:			
Date of event:		Time of event:	
Oversight physician:			
Program coordinator:			
Was the event witnessed or non-witnessed?		☐ Witnessed	☐ Non-witnessed
Name of trained rescuer involved:			
Internal response plan activated?		☐ Yes	☐ No
Was 9-1-1 called?	☐ Yes ☐ No	If yes, name of 9-1-1 caller:	
Was pulse taken at initial assessment?		☐ Yes	☐ No
Was CPR given before the AED arrived?		☐ Yes	☐ No
If yes, name(s) of CPR rescuer(s)			
Were shocks delivered?		☐ Yes	☐ No
Total number of shocks:			
Did victim...			
Regain a pulse?		☐ Yes	☐ No
Resume breathing?		☐ Yes	☐ No
Regain consciousness?		☐ Yes	☐ No
Was the procedure for transferring patient care to the local EMS agency executed?			
☐ Yes	☐ No	If No, please explain:	
Any problems encountered?			
Name of person completing form:			

To be completed on attempted or actual use of AED.

Please mail or fax this completed form to:

Attn: AED Coordinator
Orange County Health Care Agency
Emergency Medical Services
405 W. Fifth Street, Suite 301A
Santa Ana, CA 92701
Office Phone: (714) 834-3500
Office Fax: (714) 834-3125

Print Form