

City of Excelsior Springs
Automatic External Defibrillator Event Summary Report

Location of Event: _____

Date of Event: _____ Time of Event: _____

PAD oversight physician: _____

PAD Program coordinator: _____

Victim's name: _____

Was the event witnessed or non-witnessed? Witnessed Non-witnessed

Name of trained rescuer(s) _____

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, names(s) of CPR rescuer(s): _____

Were shocks given? Yes No
Total number of shocks? _____

Did the victim...
Regain a pulse? Yes No
Resume breathing? Yes No
Regain consciousness? Yes No

Was the procedure for transferring patient care to EMS executed? Yes No
If no, explain

Any problems encountered?

Name of person completing form: _____