COUNTY of SAN LUIS OBISPO

Addendum C

# AED USE FORM

| DATE | INCIDENT# | AGENCY | RESPONDING UNIT |
|---|---|---|---|

| INCIDENT LOCATION | PATIENT AGE | MALE ☐ | FEMALE ☐ |
|---|---|---|---|

| TIME OF PATIENT COLLAPSE | COLLAPSE TO 911 CALL (ESTIMATED MINUTES) | ARREST ☐ YES ☐ NO | WITNESSED ☐ YES ☐ NO |
|---|---|---|---|

| IF WITNESSED, WAS THE INITIAL MONITORED CARDIAC RHYTHM<br>☐ VENTRICULAR TACHYCARDIA<br>☐ VENTRICULAR FIBRILLATION | CPR PRIOR TO ARRIVAL<br>☐ YES ☐ NO |
|---|---|

| COLLAPSE TO INITIAL CPR (ESTIMATED MINUTES) | TIME 911 ACTIVATED | TIME OF DISPATCH |
|---|---|---|

| TIME OF ARRIVAL FOR AED UNIT | TIME AED APPLIED TO PATIENT |
|---|---|

| FIRST "PRESS TO ANALYZE" RESULTED IN<br>☐ SHOCK ☐ NO SHOCK | NUMBER OF SHOCKS PRIOR TO ALS |
|---|---|

PERFUSABLE RHYTHM POST DEFIBRILLATION ☐ YES ☐ NO

RETURN OF PULSE ☐ YES ☐ NO

PATIENT TRANSPORTED ☐ YES ☐ NO

IF SUCCESSFUL DEFIBRILLATION:

| TIME | B/P | PULSE | RESPIRATORY RATE |
|---|---|---|---|

COMMENTS:

| COMPLETED BY PRINT NAME | COMPLETED BY SIGNATURE |
|---|---|

**This report must be returned to the EMS Agency along with Patient Care Report and printout from the AED device by the 15th day of the month following the date of the call.**