

Appendix F: UC Riverside AED Post Use Form

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Instructions: This form is to be completed as much as possible on-site by the AED responder or professional responders after an AED activation.

Upon the completion of this form, immediately contact the EH&S AED Program Coordinator to coordinate the pick-up of both the AED and this form within 24 hours.

ehsochealth@ucr.edu

Your Name: _____

Department Affiliation: _____

Email: _____ Phone: _____

Were you the primary responder who used the AED? Yes No

If not, name the person who used the AED: _____

Individual's Name (optional): _____

Date of Incident: _____

Individual's Age: _____

Time of Incident: ___ : ___ AM PM

Gender: _____

Location of Incident
(Address and Precise Location)

How the Individual Was Found:

Witness Cardiac Arrest

Found Unresponsive

Was CPR Initiated? Yes No

Time of First Shock: ___ : ___ AM PM

Number of Shocks Delivered by AED: _____

Was the individual responsive following defibrillation with an AED? Yes No

On-Scene Outcome – Did the Individual:

Regain a heartbeat? Yes No

Resume breathing? Yes No

Regain consciousness? Yes No

Individual's Outcome (if known):

Discharged Alive _____ DOA at ER _____ Died in ER _____ Died within 24 hrs. _____ Died after 24 hrs. _____

Other: _____

Responding EMS Service:

Estimated Response Time: ____ : ____ AM PM

Receiving Hospital (if known):

Additional Responder Names:

Additional Comments
