Public Access Defibrillation Utilization Form

Use this form to report any event, incident or situation that resulted in use or possible use of an AED.

PAD provider name and organization:  Southern Illinois University Carbondale

Department:  _______________________________________________________

Location of victim:  _______________________________________________________

Date of incident:  ________________  Time of incident:  ________________

Name of and contact information for victim, if known:  _____________________________________________

Name of and contact information for person(s) who found the victim:  _____________________________________________

Name of and contact information for person(s) who determined victim was unresponsive:  _____________________________________________

Name of and contact information for person(s) who operated the AED:  _____________________________________________

Did the victim have a pulse?  Yes  No  How was the pulse checked?  _____________________________________________

Was the victim breathing?  Yes  No  How was breathing checked?  _____________________________________________

Was EMS (911) called?  Yes  No  If yes, what time did that happen?  _____________________________________________

Briefly describe the event, incident, or situation that resulted in the AED being brought to this victim:

Was the AED applied to the victim?  Yes  No

If yes, describe what actions the AED advised and how many times the patient was defibrillated:

Status of patient at the time EMS personnel arrived:

Did the victim have a pulse?  Yes  No  How was the pulse checked?  _____________________________________________

Was the victim breathing?  Yes  No  How was breathing checked?  _____________________________________________

Name of person completing this form:  _____________________________________________

Date completed:  _____________________________________________

Contact information:  _____________________________________________

Signature:  _____________________________________________ Date signed:  _____________________________________________

Return this form to:  AED Program Medical Director - Student Health Center MC6740.