Mountain Lakes Regional EMS Council
375 Bay Road, Suite 202
Queensbury, NY 12804
518-793-8200

Public Access Defibrillation Incident Report

Name of PAD Provider Organization:____

Date of Incident:_____/____/_____ Time of Incident:______:_____ am/pm

Patient's Age:________ Patient's Sex: ( ) Male ( ) Female

CPR prior to Defibrillation: ( ) Attempted ( ) Not Attempted

Cardiac Arrest: ( ) Not Witnessed ( ) Witnessed by Bystander ( ) Witnessed by AED

Estimated Time (in minutes) from Arrest to: CPR _____:______ Shock: ( ) Indicated ( ) Not Indicated

Estimated Time (in minutes) from Arrest to 1st shock ______:_______ Number of Shocks:______

Additional Comments:____

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Patient Outcome at Incident Site:

( ) Return of pulse and breathing
( ) Return of pulse with no breathing
( ) Return of pulse, then loss of pulse
( ) No return of pulse or breathing
( ) Became responsive
( ) Remained unresponsive

Name of AED Operator:_____________________ Transporting Ambulance:________________________

Name of Facility Patient Transported to:____

Name of Emergency Health Care Provider:____

____ ____________________________
Signature of Health Care Provider Date of Report

This report is to be completed **within five (5) business days of use** of an AED and mailed to:

Mountain Lakes Regional EMS Council
375 Bay Road, STE 202
Queensbury, NY 12804

The information obtained from this report will be maintained as confidential Quality Assurance information pursuant to Article 30, Section 3004-A and 3006 of the Public Health Law of the State of New York.