

Marathon County AED Incident Report

Incident Details

Incident Date:	Incident Time:
Incident Location:	
How were you alerted to the event:	
Patient Name:	Patient Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Event History

Patient Activity Prior to Event:		
Patient Complaints Prior to event (if known):		
Was the event witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Was CPR started? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:

Assessment and Treatment

Were ABC's witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Was CPR initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Number of shocks delivered:		
Was pulse achieved? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Was respiration regained? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Was consciousness regained? <input type="checkbox"/> Yes <input type="checkbox"/> No	By Whom?	Time:
Was patient transferred to EMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time:	

Comments:

Report completed by:	Phone:	Date:
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Submit copy to the AED Coordinator within 24 hours of medical event.