Marathon County AED Post Incident Evaluation Form

Patient Data

Incident Date:	Incident Time:
Patient Name:	Patient Gender: ☐ Male ☐ Female

Call Notification

How was responder alerted?	Time:
How was responder dispatched?	Time:
Who initiated 9-1-1 call?	Time:
AED Response Team Member arrival time:	AED arrival time:

Sudden Cardiac Arrest Event Report

Collapse/Recognition Time:	Bystander CPR Started Time:
911 Called Time:	EMS Dispatched Time:
AED RTM Arrival Time:	AED Arrival Time:
Patient Unresponsive: ☐ Yes ☐ No	AED Applied: ☐ Yes ☐ No
Rescue Breathing Started: ☐ Yes ☐ No	First Shock Advised: ☐ Yes ☐ No
CPR Started: ☐ Yes ☐ No	Additional Shocks: ☐ Yes ☐ No
Return of Circulation: ☐ Yes ☐ No	Return of Respiration: ☐ Yes ☐ No
Patient Condition at EMS Handoff:	
Transported to:	
Patient Condition at hospital (if known):	

Comments:

Report completed by:	Phone:	Date:

Submit copy to the AED Coordinator within 24 hours of medical event.