

AEDs Incident Report Form



Record of AED Use & First Aid Rendered

Here's a form, which comes from the Canadian Red Cross, that you should complete any time you use your AED in a first aid emergency situation. Have the person who used the AED complete and submit the form within 48 hours of the incident.

Victim's name: (if known)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Age:
Address: (if known)		
Date of emergency: mm/dd/yyyy		Time:
Nature of emergency: <input type="checkbox"/> Motor vehicle collision <input type="checkbox"/> Near drowning <input type="checkbox"/> Heart condition <input type="checkbox"/> Diabetes <input type="checkbox"/> Unknown <input type="checkbox"/> Workplace incident <input type="checkbox"/> Choking <input type="checkbox"/> Seizure <input type="checkbox"/> Pregnancy <input type="checkbox"/> Recreation/Sport <input type="checkbox"/> Fall <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Severe bleeding		
Location of emergency:		
Primary Assessment: Level of consciousness <input type="checkbox"/> Alert <input type="checkbox"/> Responds to verbal <input type="checkbox"/> Responds to pain <input type="checkbox"/> Unresponsive Airway <input type="checkbox"/> Spontaneously opened <input type="checkbox"/> Head tilt/Chin lift <input type="checkbox"/> Modified jaw thrust <input type="checkbox"/> Airway obstruction, successfully cleared <input type="checkbox"/> Not cleared Breathing <input type="checkbox"/> Spontaneously <input type="checkbox"/> Rescue breathing <input type="checkbox"/> Barrier device used: <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation <input type="checkbox"/> Pulse present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CPR initiated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Successful: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Severe bleed present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Controlled by dressing: <input type="checkbox"/> Yes <input type="checkbox"/> No		
AED Use Make: _____ Model: _____ Number of shocks indicated/delivered: _____ Number of no shock indicated/Check pulse: _____		