AED USE EVENT SUMMARY FORM

Orange County Health Care Agency, Emergency Medical Services

Location of event:				
Date of event:			Time of event:	
Oversight physician:				
AED Service Provider:				
Program coordinator:				
Was the event witnessed or non-witnessed?			Witnessed	Non-witnessed
Name of trained rescuer involved:				
Internal response plan activate	ed?		Yes	No
Was 9-1-1 called?	Yes	No	If yes, name of 9-1-1 caller:	
Was pulse taken at initial assessment?			Yes	No
Was CPR given before the AED arrived?			Yes	No
If yes, name(s) of CPR rescuer(s)				
Were shocks delivered?			Yes	No
Total number of shocks:				
Did victim				
Regain a pulse?			Yes	No
Resume breathing?			Yes	No
Regain consciousness? Yes No				No
Was the procedure for transferring patient care to the local EMS agency executed?				
Yes	No If	If No, please explain:		
Any problems encountered?				
Name and contact information of person completing this form:				

To be completed on attempted or actual use of AED.

Please print and mail, fax or scan and email this completed form to:



Attn: AED Coordinator
Orange County Health Care Agency
Emergency Medical Services
405 W. Fifth Street, Suite 301A
Santa Ana, CA 92701
Office Phone: (714) 834-3500

Office Phone: (714) 834-3500
Office Fax: (714) 834-3125
Email: EMSlicensing@ochca.com

