

Arkansas Department of Health

ATTN: Trauma Systems Administrator
 5800 West 10th Street, Suite 800
 Little Rock, AR 72204-1743

AED INCIDENT REPORT FORM



AED TAG NUMBER

DATE MONTH DAY YEAR

CALL TIMES (MILITARY)

CALL RECEIVED

NAME OF RESPONSE SERVICE: _____

DISPATCHED

PATIENT AGE COUNTY CODE

ENROUTE TO SCENE

PATIENT SEX (CIRCLE ONE) M F COMMUNITY CODE

ARRIVE SCENE

PATIENT RACE (CIRCLE ONE) : ASIAN BLACK HISPANIC NATIVE AMERICAN WHITE OTHER

RETURN TO SERVICE

CHIEF COMPLAINT: _____

PRIOR MEDICAL HISTORY: _____

BRIEF NARRATIVE: _____

CREW MEMBER NAMES: _____

PATIENT TRANSPORTED TO: _____

TIME	PULSE	RESP	BP	CPR AND AED PROCEDURES				
				<i>Minutes</i>	<i>CIRCLE ONE:</i>			
				TIME FROM ARREST TO CPR	<4	4-8	>9	UNK
				ARREST TO DEFIBRILLATION	<4	4-8	>9	UNK
				ARREST TO ALS CARE	<4	4-8	>9	UNK
				TOTAL NUMBER OF AED				
				DEFIBRILLATION ATTEMPTS	1	2	3	4+
				AED MALFUNCTION/FAILURE	Y	N		
				CARE TRANSFERRED TO BLS?	Y	N		
				CARE TRANSFERRED TO ALS?	Y	N		
				WITNESSED ARREST?	Y	N	UNK	
				PULSE RESTORED?	Y	N	UNK	

EYES	VERBAL	MOTOR
4 Spontan	5 Oriented	6 Obeys
3 To speech	4 Confused	5 Localizes
2 To pain	3 Inapp	4 Withdraws
1 None	2 Garbled	3 Flexion
GCS		
	1 None	2 Extension
		1 None

RESPONSE OUTCOME (CIRCLE ONE) : CARE TRANSFER DOA

NAME OF TRANSFERRING SERVICE (IF CARE TRANSFER): _____

Note: This Form Is To Be Used For Every AED Use.