San Bernardino County
Superintendent of Schools

AED USAGE REPORT FORM

1. Location/Site: ______________________________

2. Date of Incident: _____ / _____ / _____

3. Estimated time of incident: _____ : _____ AM ☐ PM ☐
   HH MM

4. Patient Gender: Male ☐ Female ☐

5. Estimated age of patient: ________ Years

6. Did the patient collapse (become unresponsive)? Yes ☐ No ☐

   a. If **YES**, what were the events immediately prior to collapse? (Check all that apply)
      ☐ Difficulty Breathing ☐ Chest Pain
      ☐ Injury ☐ Unknown
      ☐ No signs or symptoms

   b. Was someone present to see the person collapse? Yes ☐ No ☐

   c. After collapse and just prior to the AED pads being applied, was the patient:
      Breathing? Yes ☐ No ☐
      Showing signs of circulation? Yes ☐ No ☐

7. Was CPR given prior to 911 EMS arrival? Yes ☐ (go to 7A) No ☐ (skip to 8)

   a. Estimated time CPR started: _____ : _____ AM ☐ PM ☐
      HH MM

   b. Was CPR started prior to use of AED? Yes ☐ No ☐

   c. Who performed CPR? Bystander ☐ CPR trained employee? ☐

8. Was an AED brought to the patient's side prior to 911 EMS arrival? Yes ☐ No ☐

   a. If **NO**, briefly describe why and skip to #15.

      ____

   b. If **YES**, estimated time the AED was at patient's side: _____ : _____ AM ☐ PM ☐
      HH MM

9. Was the AED turned on? Yes ☐ No ☐

   a. If **YES**, estimated time AED was turned on: _____ : _____ AM ☐ PM ☐

10. Did the AED ever shock the patient? Yes ☐ No ☐

    a. If **YES**, estimated time (based on your watch) of 1st shock by AED: _____ : _____ AM ☐ PM ☐
       HH MM

    b. If shock were given, how many shocks were delivered prior to the EMS ambulance arrival? ______________

11 Nam of person operating the AED: ______________________________

12. Were there any mechanical difficulties or failures associated with the use of the facility AED?

Yes ☐ No ☐ If **YES**, briefly explain: ______________________________

13. Did any of the following personal concerns regarding the patient apply?

☐ Vomiting ☐ Excessive chest hair
☐ Sweaty ☐ Water/Wet surface
☐ Other concerns not listed above: Click or tap here to enter text.

14. Where there any unexpected events or injuries that occurred during the use of the facility AED?

Yes ☐ No ☐ If **YES**, briefly explain: ______________________________

15. Indicate the patient's status at the time of the 911 EMS arrival:

Circulation restored: Yes ☐ No ☐ If yes, time restored: ____ : ____ (HH/MM) AM ☐ PM ☐

Breathing restored: Yes ☐ No ☐ If yes, time restored: ____ : ____ (HH/MM) AM ☐ PM ☐

Breathing restored: Yes ☐ No ☐ If yes, time restored: ____ : ____ (HH/MM) AM ☐ PM ☐

16. Was the patient transported to a hospital? Yes ☐ No ☐

a. If **YES**, how was the patient transported? Yes ☐ No ☐

☐ EMS Ambulance ☐ Private Vehicle

☐ Other ______________________________

b. If **YES**, provide name of transporting ambulance service and the hospital the patient was transported to:

____

17. Other comments/concerns not referenced on this form that may be useful for the medical director?

____

____

Report completed by (please print): ______________________________
Signature: ______________________________ Date: ______________
Site: ______________________________
Serial Number of AED used: ______________ Location of AED used: ______________

Form is to be completed and submitted to Risk Management Services with 24 hours of use of AED.