PAD QUALITY ASSURANCE REPORT

POST-USE OF AN AUTOMATED EXTERNAL DEFIBRILLATOR BY A PUBLIC ACCESS DEFIBRILLATION PROVIDER IN THE STREMS REGION

The information obtained from this report is protected from discoverability and will be maintained as confidential Quality Assurance information pursuant to Article 30, Sections 3004-A and 3006 of the *Public Health Law of the State of New York.*

This report is to be completed by the PAD Provider's *Emergency Health Care Provider* (physician or hospital CEO or designee) within 5 business days of use of an Automated External Defibrillator (AED). The completed report may be emailed to education@emstar.org or mailed to STREMS Council: PO Box 191, Elmira, New York, 14902.

PLEASE PRINT CLEARLY

Name of PAD Provider (Organization): _____

Date of Incident: _____ Time of Incident: _____

Patient Age: _____ Patient Sex: ~ M ~ F

CPR prior to defibrillation: ☐ Attempted ☐ Not Attempted

Cardiac Arrest: (choose one)

☐ Not Witnessed ☐ Witnessed by Bystanders ☐ Witnessed by AED Operator

Estimated time from arrest to CPR: _____

CHOOSE ONE:

☐ **AED Indicated Shock** ☐ **AED Indicated No Shock**

Estimated time from arrest to 1st shock: _____ Number of shocks delivered: _____

Additional Comments: _____

_____

_____

Patient outcome at incident site:(choose one)

☐ Return of spontaneous circulation

☐ Return of spontaneous circulation, then cessation of spontaneous circulation

☐ Never achieved return of spontaneous circulation

Name of AED Operator: _____

Name of Transporting Ambulance Service: _____

Name of Emergency Health Care Provider: _____

_____ _____

Signature of Emergency Health Care Provider (Physician or Hospital CEO or Designee)

Date