GOODING JOINT SCHOOL DISTRICT
AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
INCIDENT REPORT

Date of Incident: _____ Time of Incident: _____

Location of Incident (which building, where in building, etc.):_____

_____

Patient's Age: _____ Patient's Sex: _____ Male _____ Female

CPR prior to defibrillation: _____ Attempted _____ Not Attempted

Cardiac Arrest: _____ Not Witnessed _____ Witnessed by Bystander
_____ Witnessed by AED team member

Estimated time (in minutes) from arrest to CPR: _____

Shock: _____ Indicated _____ Not Indicated

Estimated time (in minutes) from arrest to 1st AED shock: _____

Number of shocks: _____

Additional Comments: _____

_____

Patient Outcome at Incident Site:

☐	Return of pulse and breathing	☐	No return of pulse or breathing
☐	Return of pulse with no breathing	☐	Became responsive
☐	Return of pulse, then loss of pulse	☐	Remained unresponsive

Name of AED Operator: _____

Transporting Ambulance: _____

Name of Facility Patient was Transported To: _____

Name of Emergency Health Care Provider: _____

_____ _____

Signature of Health Care Provider Date of Report

This report is to be completed by the Emergency Health Care Provider or AED User within 5 business days of use of an AED.

The completed report must be mailed/returned to: _____