33 Airport Center Drive
Suite 204
New Windsor, NY 12553

Public Access Defibrillation QI Report

Name of PAD Provider Organization: _____

Date of Incident: _____ **Time of Incident:** _____:_____ am / pm

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

CPR prior to Defibrillation: ☐ Attempted ☐ Not Attempted

Cardiac Arrest: ☐ Not Witnessed ☐ Witnessed by Bystander ☐ Witnessed by EMS

Estimated time (in minutes) from Arrest to CPR _____:_____ **Shock** ☐ Indicated ☐ Not Indicated

Estimated time (in minutes) from Arrest to 1st Shock _____:_____ **Number of Shocks:** _____

Additional Comments: _____

_____

_____

Patient Outcome at Incident Site:

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

Name of AED Operator: _____ **Transporting Ambulance:** _____

Name of Facility Patient Transported to: _____

Name of Emergency Health Care Provider: _____

_____ _____

Signature of Health Care Provider **Date of Report**

This report is to be completed by the Organization's Emergency Health Care Provider (Physician or Hospital-Designated Physician) or AED user within five (5) business days of use of an AED.

e-Mail completed reports to:

qaqi@hvremsco.org

Questions regarding this form should be directed to qaqi@hvremsco.org Ph. (845) 245-4292

The information obtained from this report will be maintained at confidential Quality Assurance information pursuant to Article 30, Section 3004-A, and 3006 of the Public Health Law of the State of New York.