

REGIONAL EMERGENCY MEDICAL ORGANIZATION

1653 Central Avenue Albany, NY 12205
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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 AED

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:

- | | |
|--|--|
| <input type="checkbox"/> Return of pulse and breathing | <input type="checkbox"/> No return of pulse or breathing |
| <input type="checkbox"/> Return of pulse with no breathing | <input type="checkbox"/> Became responsive |
| <input type="checkbox"/> Return of pulse, then loss of pulse | <input type="checkbox"/> 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.

The completed report must be mailed to:

REMO
PAD QI
1653 Central Avenue
Albany, NY 12205

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