

# PAD QUALITY ASSURANCE REPORT

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

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 FAXED to the Offices of the STREMS Council at (607) 732-2661 or mailed to: STREMS Council, PO Box 3492, Elmira, New York, 14905.

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*.

### P L E A S E P R I N T C L E A R L Y

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 1<sup>st</sup> 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: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Emergency Health Care Provider

(Physician or Hospital CEO or Designee)