AED POST INCIDENT FORM

Defibrillator Guidelines 2022

1. Details of the Patient

Contact Name of Patient	Sex (tick) Male Female	
Date of Birth of Patient (DD/MM/YY)	Age or estimated age of patient if date of birth is unknown	
Telephone Number of Patient (during business hours)	Email Address of Patient	
Postal Address of Patient		
Suburb / City	State / Territory	Postcode

2. Details of the Incident

Date of Incident (DD/MM/YY)	Time of Incident (AM/PM)	
Location of Incident		
Address of Incident		
Suburb / City	State / Territory	Postcode

3. Incident Data

Did the patient collapse (become unresponsive)?

Yes No

If witnessed, time of collapse (AM/PM)

If yes, what were the signs observed immediately prior to the collapse? (select all that apply)

Difficulty breathing
Chest pain
Trauma or injury
Drowning
Known drug overdose
Blood loss
Electrical shock
No signs or symptoms
Unknown
Other abnormal behaviour / unconsciouness

Was the rescuer trained in AED use and/or first aid?

Yes No

Were sign(s) of life restored? *(eg. consciousness, normal breathing)*

Yes No

If yes, when were sign(s) of life restored (Time AM/PM)

4. Treatment Data

Was an ambulance called?

Yes No

If yes, what time called (AM/PM)

Indicate the patient's status on arrival of ambulance, if applicable

Return of sign(s) of life
No sign(s) of life
Unconscious
Conscious

Record time of arrival of ambulance, if applicable (AM/PM)

5. Basic Life Support (BLS)

Was CPR commenced prior to the arrival of the ambulance?

Yes No

If yes, estimated start time when CPR was commenced?

Was CPR started prior to the arrival of a trained AED user?

Yes No

Who started CPR?

Bystander
Trained AED user
Other (Details: ______________________)

Was breathing restored?

Yes No

If yes, estimated time when breathing was restored?

6. AED Use

After the collapse, and just prior to the AED pads being applied, was the person breathing normally?

Yes No

Was an AED brought to the patient prior to the arrival of the ambulance?

Yes No

Record time of arrival of ambulance, if applicable (AM/PM)

If no, briefly explain why and skip to the next section

Were the AED pads placed on the patient?

Yes No

If yes, was the person who put the AED pads on the patient a

Bystander

Trained AED user

Other (Details: ______________________)

Name of person who operated AED

Was the AED used to shock the patient?

Yes No

If yes, estimated time of first shock by AED (Time AM/PM)

Total number of shocks that were delivered prior to the arrival of ambulance? (Number)

Was there any mechanical difficulty or failure with the use of the AED?

Yes No

If yes, briefly explain

Were there any unexpected events or injuries that occurred during the use of the AED?

Yes No

If yes, briefly explain

Manufacturer of AED

Model of AED

Date of Birth of Patient (DD/MM/YY)

Serial Number of AED

7. Hospital Transport

Was the patient transported to the hospital?

Yes No

If yes, how was the patient transported?

What was the ambulance vehicle number? (ID Number)

8. Police Contact

Were the police notified?

Yes No

What was the police reference number? (ID Number)

9. Outcome Data

Patient status (please tick as applicable)

Survived event at scene

Survived to hospital discharge

If so, date of hospital discharge (DD/MM/YY)

Died at scene

Died at hospital

If so, date of death (DD/MM/YY)

I completed this form to the best of my knowledge.

Name

Signature

Date (DD/MM/YY)

Medical Support

This section to be completed by a medical practitioner

Name of Doctor

Telephone number (during business hours)

ECG report reference ID (attached)

Comments (You may wish to attach further documentation.)

Signature

Date (DD/MM/YY)