



## APPENDIX E

### Early Defibrillation Incident Report

#### Incident Details

Incident ID: \_\_\_\_\_ Incident Date: \_\_\_\_\_

Incident Time: \_\_\_\_\_

Shocks Delivered: \_\_\_\_\_ Device ID: \_\_\_\_\_

Device Type: \_\_\_\_\_

#### Patient Detail

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Patient ID: \_\_\_\_\_

#### Additional Information

Defibrillator Operator: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Report Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Incident Date: \_\_\_\_\_

Employee Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

How was Team alerted? \_\_\_\_\_ Time alerted: \_\_\_\_\_:\_\_\_\_\_



## APPENDIX F

### Post-Incident Critique Form

How was Team dispatched? \_\_\_\_\_ Dispatch time: \_\_\_\_ : \_\_\_\_  
Who initiated 9-1-1 call? \_\_\_\_\_ Time called: \_\_\_\_ : \_\_\_\_  
ERT or AED Team arrival time: \_\_\_\_ : \_\_\_\_ AED arrival time: \_\_\_\_ : \_\_\_\_  
Collapse/recognition: \_\_\_\_ : \_\_\_\_ Bystander CPR started: \_\_\_\_ : \_\_\_\_  
9-1-1 called: \_\_\_\_ : \_\_\_\_ EMS dispatched: \_\_\_\_ : \_\_\_\_

#### SCA Event Report

ERT Team arrival: ____ : ____ : ____	AED arrival: ____ : ____
Patient unresponsive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
Rescue breathing started: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
CPR started: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
AED applied: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
First shock advised: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
Additional shocks: <input type="checkbox"/> Yes <input type="checkbox"/> No	Total # of shocks delivered: _____
Return of circulation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
Return of respiration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Documented time: ____ : ____
EMS scene arrival: ____ : ____ : ____	EMS arrival at patient: ____ : ____
Patient condition at EMS hand-off: _____	
Care Given by EMS: <input type="checkbox"/> ALS <input type="checkbox"/> BLS	Patient transported: ____ : ____
Transported to: _____	
Patient condition at hospital: _____	

Report Completed by: \_\_\_\_\_ Date: \_\_\_\_\_