SUFFOLK REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL
360 Yaphank Avenue, Suite 1B, Yaphank, NY 11980 (631) 852-5080

Public Access Defibrillation Quality Improvement Report

Name of PAD Provider Organization:_____

Date of Incident:_____ **Time of Incident:**_____

Location of Incident Within Facility:_____

Patient Age:_____ **Patient Sex:** o **Male** o **Female** **Patient Race:**_____

CPR Prior to Defibrillation: o**YES** o **NO** **If yes, by:** o **Layperson** o **Medical Personnel**

Was Cardiac Arrest: o **Witnessed by Bystander** o **Witnessed by AED User** o **Not Witnessed**

FOR SCHOOLS ONLY: ***AED Care Performed By:*** ***o School Medical Personnel*** ***o PAD Layperson***

Estimated Time in Minutes From Arrest to 1st Shock_____ **Total # of Shocks Delivered**_____

Brief Description of Events:_____

_____

Patient Outcome at Incident Site: o **Return of Pulse and Breathing** o **Return of Pulse ONLY**

o **Return of Pulse, Then Loss of Pulse** o **No Return of Pulse or Breathing**

Name of AED Operator:_____ **Signature of AED Operator:**_____

Name of Transporting Ambulance Service_____ **Hospital:**_____

This Report is to be Completed by the AED Operator as soon as Feasible After the Event and Forwarded *within 5 business days* to:

University Hospital Stony Brook
Medical Control Console
L4 Room 515 – EMS
Stony Brook, NY 11794-8350
FAX (631) 706-4498

o **Forwarded to Emergency Health Care Provider per your Organization's Collaborative Agreement. Date:**_____

o **EHCP Review** **EHCP Signature**_____

Disposition:_____

_____

The information obtained from this report is required, and will be maintained as confidential quality improvement information, pursuant to Article 30, Sections 3004-A and 3006 of the *Public Health Law of the State of New York.*