Suffolk Regional Emergency Medical Service Council
360 Yaphank Ave. Suite 1B. Yaphank, NY 11980.
Tel: 631-852-5080. Fax: 631-852-5028.
www.suffolkremsco.com

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: ☐ Male ☐ Female Patient Race:_____

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

Was Cardiac Arrest: ☐Witnessed by Bystander ☐ Witnessed by AED User ☐ Not Witnessed

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

Estimated Time in Minutes From Arrest to 1st Shock:_____ Total # of Shocks Delivered:_____

Brief Description of Events:

Patient Outcome at Incident Site: ☐ Return of Pulse and Breathing ☐ Return of Pulse ONLY
☐ Return of Pulse, Then Loss of Pulse ☐ 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 Supervisor
HSC Level 4, Room 4-049A
Stony Brook, NY 11794-8350
Fax: 631-706-4498

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

☐ EHCP Review EHCP Signature_____

The information obtained from this report is required, and will be maintained as confidential quality improvement information, pursuant to Article 30, Sections 3000-B, 3004-A and 3006 of the *Public Health Law of the State of New York.*