431 New Karner Road, Albany. NY 12205
(518) 464.5097 Fax (518) 464.5099
www.remo-ems.com

PUBLIC ACCESS DEFIBRILLATION QI REPORT

Name of PAD Provider Organization: ____________________

Date of Incident: ____________________ **Time of Incident:** ______:_______ **am / pm**

Patient's Age: ____________________ **Patient's Sex:** ☐ **Male** ☐ **Female**

CPR prior to Defibrillation: ☐ **Attempted** ☐ **Not Attempted**

Cardiac Arrest: ☐ **Not Witnessed** ☐ **Witnessed by Bystander** ☐ **Witnessed by EMS**

Estimated time (in minutes) from Arrest to CPR _____:______ **Shock** ☐ **Indicated** ☐ **Not Indicated**

Estimated time (in minutes) from Arrest to 1st Shock _____:______ **Number of Shocks:** ____________________

Additional Comments: ____________________

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Patient Outcome at Incident Site:

- ☐ **Return of pulse and breathing**
- ☐ **Return of pulse and no breathing**
- ☐ **Return of pulse, then loss of pulse**
- ☐ **No return of pulse or breathing**
- ☐ **Became responsive**
- ☐ **Remained unresponsive**

Name of AED Operator: ____________________ **Transporting Ambulance:** ____________________

Name of Facility Patient Transported to: ____________________

Name of Emergency Health Care Provider: ____________________

____________________ ____________________

Signature of Health Care Provider **Date of Report**

This report is to be completed by the Organization's Emergency Health Care Provider (Physician or Hospital-Designated Physician) or AED user within five (5) business days of use of an AED.

The completed report must be mailed to:

REMO
Attn: PAD QI
431 New Karner Rd.
Albany, NY 12205

Questions regarding this form should be directed to qiremo@gmail.com or (518) 464-5097 ext 2001

The information obtained from this report will be maintained at confidential Quality Assurance information pursuant to Article 30, Section 3004-A, and 3006 of the Public Health Law of the State of New York.