EARLY DEFIBRILLATION REPORT

Date:	*Time:*	*Agency:*	
Incident Location:		*Incident Number:*	
Patient Name:	*Patient Age:*	*Patient Weight:*	*Down Time:*
Medications:		*Witnessed Arrest:* (CIRCLE ONE) *YES NO*	
Cardiac History: (CIRCLE ONE) *YES NO*		*CPR Before Arrival:* (CIRCLE ONE) *YES NO*	
ON ARRIVAL:	*Responsive:* (CIRCLE ONE) *YES NO*	*Pulse Rate:*	*Resp. Rate:*

TIME	*TREATMENT*	*RESPONSE*
	CPR Started	
	Defib	
	Defib	
	Defib	
	Check Pulse - CPR x 1 min if no pulse	
	Defib	
	Defib	
	Defib	
	Check pulse - CPR x 1 min - if no pulse repeat above procedure	

AED Operator:		*CPR By:*	
Officer In Charge:		*Time Dispatched:*	*Time Enroute:*
Time On Scene:	*Time ALS On Scene:*	*PCR #:*	
Ambulance Provider:		*Transported To:*	
COMMENTS:			
Form Completed By:			

Please send: Original copy to hospital with patient or within 24 hours.
Duplicate copy to the EMS Agency, 1101 Standiford Ave., Ste. D-1, Modesto, CA 95350