REGIONAL EMERGENCY MEDICAL ORGANIZATION
1653 Central Avenue Albany, NY 12205
e-mail remoqi@nycap.rr.com 518 464-5097 Ext. 3001

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 AED

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 with 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
PAD QI
1653 Central Avenue
Albany, NY 12205

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