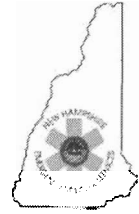


**New Hampshire Department of Safety
Bureau of Emergency Medical Services**

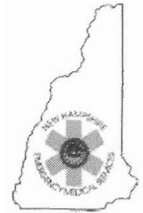


**Instructions for Completing the
Automated External Defibrillation (AED) Incident Report &
Quality Improvement Form**

Listed below are instructions intended to assist you while completing the AED Quality Improvement Form. The line numbers on this form correspond with the line numbers on the AED Quality Improvement Form. If you have any questions or need further assistance completing the form, please contact the NH Bureau of EMS at (603) 271-4568 or 1-888-827-5367.

Line 1	List the name of the entity providing the AED program.
Line 2	List the name of person who used the AED on the patient.
Line 3	Indicate the date and time the AED was used on the patient. For the date, indicate the month, day and year. For the time, indicate the hour and minutes of when the incident occurred.
Line 4	Indicate the patient's age and place a checkmark next to the patient's gender.
Line 5	Asking whether CPR was administered prior to use of the AED. Check whether CPR was attempted or not attempted.
Line 6	Check whether the patient's cardiac arrest was not witnessed, was witnessed by a bystander or was witnessed by the person who used the AED on the patient.
Line 7	Indicate the estimated number of minutes from the patient's cardiac arrest to when CPR was administered.
Line 8	Check whether shock was indicated or not indicated by the AED.
Line 9	Indicate the estimated number of minutes from the patient's cardiac arrest to the first shock from the AED. Also indicate the number of shocks given to the patient.
Line 10	Check the description(s) that best describes the patient after the use of the AED.
Line 11	List the name of the ambulance service that treated the patient and transported the patient to a hospital/medical facility.
Line 12	List the name of the hospital or other medical facility the patient was transferred to by the ambulance.
Line 13	List the name of the physician authorizing use of the AED program for your organization and providing Quality Assurance oversight.

**New Hampshire Department of Safety
Bureau of Emergency Medical Services**



**Automated External Defibrillation (AED) Incident Report &
Quality Improvement Form**

This form is to be completed by the entity's AED Program representative or the AED user. Once completed, send a copy of this report to the NH Bureau of EMS at 33 Hazen Drive, Concord, NH 03305.

Line 1	Name of Entity Providing AED _____
Line 2	Name of AED Operator _____
Line 3	Date of Incident ____ / ____ / ____ Time of Incident ____ : ____
Line 4	Patients Age _____ Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Line 5	CPR Prior to Defibrillation? <input type="checkbox"/> Attempted <input type="checkbox"/> Not Attempted
Line 6	Cardiac Arrest: <input type="checkbox"/> Not Witnessed <input type="checkbox"/> Witnessed by Bystander <input type="checkbox"/> Witnessed by AED Provider
Line 7	Estimated Time (in minutes) From Arrest To CPR ____ : ____
Line 8	Shock: <input type="checkbox"/> Indicated <input type="checkbox"/> Not Indicated
Line 9	Estimated Time (in minutes) From Arrest to First Shock: ____ : ____ Number of Shocks: _____
Line 10	Patient Outcome at Incident Site: (check all that apply) <input type="checkbox"/> Return of Pulse and Breathing <input type="checkbox"/> No Return of Pulse or Breathing <input type="checkbox"/> Return of Pulse with No Breathing <input type="checkbox"/> Became Responsive <input type="checkbox"/> Return of Pulse, Then Loss of Pulse <input type="checkbox"/> Remained Unresponsive

Line 11	Name of Transporting Ambulance _____
Line 12	Name of Facility Patient Transported To _____
Line 13	Name of Physician Authorizing Use of AED _____

Signature of AED Provider _____ Date _____