

**NEW YORK STATE – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION  
PUBLIC ACCESS DEFIBRILLATION Q.I. REPORT**

**INCIDENT INFORMATION**

INCIDENT DATE: \_\_\_\_\_ INCIDENT TIME: \_\_\_\_\_ am / pm

PATIENT AGE: \_\_\_\_\_ PATIENT SEX: \_\_\_\_\_

INCIDENT LOCATION: \_\_\_\_\_

Was CPR attempted prior to defibrillation? No Yes, at \_\_\_\_\_(time)

Was cardiac arrest witnessed? No Yes, at \_\_\_\_\_(time)

Estimated time (in minutes) from arrest to CPR \_\_\_\_\_ Shock: Indicated / Not Indicated

Estimated time (in minutes) from arrest to 1<sup>st</sup> shock \_\_\_\_\_ Number of Shocks \_\_\_\_\_

Name of AED Operator \_\_\_\_\_ Title \_\_\_\_\_

Transporting Ambulance \_\_\_\_\_

Name of Facility Patient Transported to \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT OUTCOME (on site)**

- |  |  |
|--|--|
| <input type="checkbox"/> Return of Pulse and Breathing       | <input type="checkbox"/> No Return of Pulse or Breathing |
| <input type="checkbox"/> Return of Pulse w/ No Breathing     | <input type="checkbox"/> Became Responsive               |
| <input type="checkbox"/> Return of Pulse, then Loss of Pulse | <input type="checkbox"/> Remained Unresponsive           |

Emergency Health Care Provider Completing Report \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Emergency Health Care Provider

*This report is to be completed by the Agency Emergency Health Care Provider and forwarded to REMO Emergency Medical Organization within 5 business day of the use of an AED.*