AED USE REPORT
To Be Filled Out Each Time an AED is Attached to a Patient

SUPervising Physician: ________________________________
Name (who attached and operated AED): ________________________________
Address: ________________________________
Phone No: ________________________________

Patient Age: ___________  Patient Sex:  □ Male  □ Female

Location of cardiac arrest: ________________________________

Estimated Time of cardiac arrest: ___________ (use 24 hour time)

CPR Initiated Prior to Application of AED:  □ YES  □ NO

Cardiac Arrest Witnessed?  □ YES  □ NO

Time First Shock Delivered: ___________ (use 24 hour time)

Total Number of Shocks and Joules Delivered:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pulse After Shocking:  □ YES  □ NO If yes, was pulse sustained?  □ YES  □ NO

Patient Transported:  □ YES  □ NO

If transported, to where and by who?: ________________________________

INSTRUCTIONS:
1. Make one copy of this report, provide to Medical Supervisor
2. Send one copy to EMS & Trauma Systems, PO Box 202951, Helena MT 59620
3. Copy at will for other record keeping requirements.