

EARLY DEFIBRILLATION REPORT

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

<i>TIME</i>	<i>TREATMENT</i>	<i>RESPONSE</i>
	<i>CPR Started</i>	
	<i>Defib</i>	
	<i>Defib</i>	
	<i>Defib</i>	
	<i>Check Pulse - CPR x 1 min if no pulse</i>	
	<i>Defib</i>	
	<i>Defib</i>	
	<i>Defib</i>	
	<i>Check pulse - CPR x 1 min - if no pulse repeat above procedure</i>	

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

***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***