



State of Louisiana

Bureau of Emergency Medical Services

AED EVENT SUMMARY FORM

This form is to be completed every time the AED is applied to a patient. This form assists you in providing complete and accurate data to the Bureau of EMS, in compliance with the project evaluation section of your agreement.

Upon completion, please submit a copy to the Bureau of EMS, AED Program:
11224 Boardwalk Drive Suite A1 Baton Rouge, LA 70816 OR Fax: 225-275-1651

Responding Agency Information:

Agency name: _____

Responder(s) name: _____

PAD physician/coordinator: _____

Person completing form: _____

Phone number: _____

Victim Data:

Name: _____ Gender: _____

Date of birth: _____ Home zip: _____

Event Data:

Location of event: _____

Date: _____ Time: _____

Was 9-1-1 called? _____ By whom? _____

Was CPR given before the AED arrived? _____ By whom? _____

Were shocks given? _____ Total number of shocks? _____

Did the patient: _____

Regain pulse? _____

Resume breathing? _____

Regain consciousness? _____

Please list any problems encountered, comments or suggestions.
