Monroe-Livingston Regional EMS Council
Public Access Defibrillation Quality Improvement Form

Submit this form and AED report to pad@mlrems.org within 48 hours of AED use

PAD Entity Name:

Incident location:

Incident Date: Incident Time:

Patient Age: ☐ Unknown Sex of Patient: ☐ Male ☐ Female

Was the cardiac arrest witnessed? ☐ Yes ☐ No

Estimated time (in minutes) from arrest to CPR:

Was shock indicated? ☐ Yes ☐ No

If Yes, estimated time (in minutes) from arrest to first shock:
If Yes, how many shocks were delivered?

Name of responding EMS agency:

Patient outcome at incident site:

- ☐ Return of pulse and breathing
- ☐ Return of pulse, but not breathing
- ☐ Return of pulse, then loss of pulse
- ☐ No return of pulse or breathing

Hospital to which the patient was transported:

Name of Person Completing This Form:

Phone Number: Email Address:

The information in this report will be maintained as confidential Quality Assurance information pursuant to Article 30, Section 3004-A, and 3006 of the New York State Public Health Law.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655-P
Rochester, NY 14642