PAD EVENT SUMMARY FORM

Mail or fax a copy of your medical director and mail or fax a copy to Riverside County EMS Agency –
4210 Riverwalk Parkway, Suite 300, Riverside, CA 92505
Phone: (951) 358-5182 ⍰ Fax: (951)358-5160 ⍰ TDD: (951)358-5124 ⍰ www.rivcoems.org

NAME OF FACILITY		
LOCATION (ADDRESS) OF EVENT		
Address:		
City:	State:	Zip:
DATE OF EVENT:	TIME OF EVENT:	AM ☐ PM ☐
NAME AND PHONE NUMBER OF AED MEDICAL DIRECTOR		
Name:	Phone #:	
NAME OF AED PROGRAM COORDINATOR		
Name:		
WAS THE COLLAPSE WITNESSED ☐ OR NON-WITNESSED ☐ ?		
NAME OF RESCUER(S)		
WAS THE INTERNAL RESPONSE PLAN ACTIVATED? YES ☐ NO ☐		
WAS 9-1-1 CALLED? YES ☐ NO ☐		
WAS CPR GIVEN BEFORE THE AED ARRIVAL? YES ☐ NO ☐		
IF YES, NAME OF RESCUER(S)		
DID AN AED ARRIVE? YES ☐ NO ☐		
WERE SHOCKS GIVEN? YES ☐ NO ☐	IF YES, HOW MANY?	UNKNOWN ☐
DID THE VICTIM REGAIN A PULSE? YES ☐ NO ☐		
DID THE VICTIM RESUME BREATHING? YES ☐ NO ☐		
DID THE VICTIM REGAIN CONSCIOUSNESS? YES ☐ NO ☐		
WAS THE VICTIM TRANSPORTED TO A HOSPITAL? YES ☐ NO ☐		
IF KNOWN, WHICH HOSPITAL?		
WERE ANY PROBLEMS ENCOUNTERED? YES ☐ NO ☐ IF YES, PLEASE USE NOTES SECTION TO EXPLAIN		
NAME AND PHONE NUMBER OF THE PERSON COMPLETING THIS FORM		
NAME :		
PHONE #:		
NOTES