# 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**

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<th>Address:</th>
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<tbody>
<tr>
<td>City:</td>
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<td>State:</td>
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<td>Zip:</td>
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**DATE OF EVENT:**  
**TIME OF EVENT:**  
AM ☐ PM ☐

**LOCATION (ADDRESS) OF EVENT**

**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**