



**SREMS  
COUNCIL**

**Susquehanna Regional EMS Council, Inc.**

311 Exchange Avenue ▪ 2nd Floor Unit 2

Endicott, NY 13760

Ph 607.699.1367 ▪ Fax 607.397.2728

**PUBLIC ACCESS DEFIBRILLATION CASE REPORT**

Name of PAD Agency: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ ☐ AM ☐ PM

Location (Address) of Incident: \_\_\_\_\_

\_\_\_\_\_

Location within Building/Facility: \_\_\_\_\_

Victim Information: Age: \_\_\_\_\_ Sex: \_\_\_\_\_

AED Operator: ☐ Member/Employee ☐ Licensed/Certified Healthcare Provider ☐ Layperson

Name of Ambulance Service Transporting Victim: \_\_\_\_\_

Patient Response to AED Treatment:

☐ Unknown ☐ Continued cardiac arrest ☐ Victim became responsive ☐ Victim Deceased

☐ Spontaneous return of pulse ☐ Spontaneous return of pulse and respirations

Hospital Patient was Transported to: \_\_\_\_\_

Minutes from Collapse to CPR \_\_\_\_\_ Minutes to Shock \_\_\_\_\_ # of Shocks \_\_\_\_\_

Brief Description of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Report Completed By (Name)

Title

Date/Time

Fax completed report to (607) 397-2728, or mail to address above.