

Event Summary Form
Please fax to 509-474-4454
Attention Project ADAM Coordinator

This form is to be filled out as completely as possible for EVERY event in which an Automated External Defibrillator (AED) was retrieved.

Date of event: _____ Time: _____

Location of event: _____

Age of victim (if known): _____ Sex: M F

Was the event witnessed? Yes No

If yes, by whom? _____

Time of victim assessment: _____

Assessment of victim:	Responsive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Airway opened:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Signs of circulation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Was CPR started? Yes No

Time CPR was started: _____

Time 911 was called: _____

Was AED used? Yes No

If no, why not? _____

If yes, number of shocks given? _____

Time of EMS arrival to victim: _____

Ambulance service responding to event: _____

Hospital to which patient was transported: _____

Did the patient survive? Yes No Unknown

Indicate any problems encountered: _____

Please attach a short description including any other important details of what occurred.

School site coordinator: _____