County of San Diego EMS

Notification of Defibrillator Use

To be completed by on-site contact & submitted within 24 hours of AED:
Print and FAX to: 619-285-6531, attn: AED Coordinator
or

Name of Service Provider:

Date of Occurrence:

Time of Occurrence:

Place of Occurrence:
(address & specific location)

Patient's Name:

Patient's Age:

Patient's Sex: ◯ M ◯ F

Did anyone witness the collapse/ arrest? ◯ Yes ◯ No

Alert Time:
(time you were notified)

Approximate down time prior to your arrival:

Was CPR used prior to AED at victim? ◯ Yes ◯ No

Time of first shock (if given):

Total number of shocks:

Did victim regain a pulse at scene? ◯ Yes ◯ No

Lay Responder Name(s):

Name and phone number of person completing form:

Additional Comments/ Information: