Ventura County EMS Agency
REPORT OF CPR OR AED USE

AED Program (location name)	
AED Provider (defibrillator user)	
Place of Occurrence (address and specific site)	
Date Incident Occurred	
Time of Incident	
Patient's Name (if able to determine)	
Patient's Age (Estimate if unable to determine)	
Patient's Sex (Male or Female)	
Time (Indicate best known or approximated time lapse between events):	
• Witnessed arrest to CPR	min(s)
• Witnessed arrest to 9-1-1 Called	min(s)
• Witnessed arrest to first shock	min(s)
• Patient contact to first shock	min(s)
• 9-1-1 to arrival on scene	min(s)
• 9-1-1 to first shock	min(s)
Total number of defibrillation shocks	

Was the cause of the arrest determined?	☐ Yes	☐ No
Was the cause of the arrest cardiac?	☐ Yes	☐ No
Was the arrest witnessed?	☐ Yes	☐ No
Was bystander CPR implemented?	☐ Yes	☐ No
Was there any return of spontaneous circulation?	☐ Yes	☐ No

Please attach any additional information that you think would be helpful.

This form must be completed and sent to Ventura County EMS within 96 hours of a cardiac arrest incident at an AED site. Send this completed form to:

Ventura County EMS - AED Program
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-0619
FAX: 805-981-5300

Office Use Only

• Date Received by EMS Agency	
• Patient prehospital outcome	
• Patient discharged from hospital?	

Reset form