Public Access Defibrillation Program
EVENT SUMMARY FORM

Location of event: ____________________

Date of event: ____________ Time of event: ____________

PAD Oversight Physician: *Michael Leonard, M.D., BU Health Services*

PAD Program Coordinator: *David J. Hubeny, BU Dept. of Environmental Health and Safety*

Patient's Name: ____________________

Patient's Age: ____________ Patient's Gender M ☐ F ☐

Was the event witnessed or non-witnessed? Witnessed ☐ Non-witnessed ☐

Estimated time between arrest to beginning of CPR: ____________

Estimated time between arrest and first AED shock: ____________

Name(s) of trained rescuer(s): ____________________

Was the BU internal 911 system activated? Yes ☐ No ☐

Was Broome County EMS notified? Yes ☐ No ☐

Was patient transported by EMS agency? Yes ☐ No ☐

Was pulse taken at initial assessment? Yes ☐ No ☐

Was CPR given before the AED arrived? Yes ☐ No ☐

If yes, name(s) of CPR rescuer(s):

Were shocks given? Yes ☐ No ☐

Did victim . . .

- regain a pulse? Yes ☐ No ☐
- resume breathing? Yes ☐ No ☐
- regain consciousness? Yes ☐ No ☐

Were any problems encountered? ____________________

Name of person completing form: ____________________

Date form completed: ____________

This form shall be submitted to the PAD Oversight Physician upon completion. The PAD Oversight Physician shall review this form and issue a written or verbal communication to the PAD Program Coordinator outlining the results or findings of the review.