PEAK
EMERGENCY RESPONSE TRAINING
A division of Peak Project Management, Inc.

POST AED INCIDENT REPORT (PAIR)

INCIDENT INFORMATION

RESORT, COMPANY or SAR TEAM	LOCATION OF INCIDENT	POSITION OF PATIENT WHEN FOUND	INCIDENT DATE (DD / M/M / YY)

INCIDENT TIMES

TIME OF COLLAPSE	REPORTED TO DISPATCH	AED DISPATCHED	AED AT SCENE	EMS ARRIVAL AT SCENE
☐ KNOWN ☐ ESTIMATED				BCAS _____ FIRE _____

PATIENT INFORMATION

NAME	GENDER	DATE OF BIRTH (DD / M/M / YY)	AGE	ADDRESS
	☐ MALE ☐ FEMALE			

CARDIAC ARREST SPECIFIC INFORMATION

BYSTANDER CPR (MEMBER OF THE PUBLIC)

☐ NO ☐ YES NAME(S) _____ CPR QUALITY ☐ GOOD ☐ FAIR ☐ POOR ☐ N/A

COLLAPSE WITNESSED

☐ NO ☐ YES NAME(S) _____

EVENTS IMMEDIATELY PRIOR TO COLLAPSE

☐ CHEST PAIN/DISCOMFORT ☐ NAUSEA/VOMITING ☐ LIGHT-HEADED/DIZZY ☐ SHORTNESS OF BREATH ☐ UNKNOWN ☐ OTHER _____

CAUSE OF COLLAPSE

☐ TRAUMATIC ☐ MEDICAL ☐ UNKNOWN

PATIENT CARE INFORMATION

RETURN OF SPONTANEOUS CIRCULATION

☐ NO ☐ YES ☐ Estimated Time _____

RESUSCITATION DISCONTINUED AT SCENE

☐ NO ☐ YES ☐ By Whom & When? _____

Were there any airway management concerns? (e.g. vomiting/regurgitaton, FBAO, etc.)	☐ No	☐ Yes
Was suction used to clear the airway?	☐ No	☐ Yes
Did the patient appear to breathe on their own following return of circulation?	☐ No	☐ Yes
Did the patient have 'signs of circulation' when the ambulance paramedics arrived?	☐ No	☐ Yes

Who turned the AED off? _____ Who removed the data chip from the AED (if applicable)? _____

AED PROVIDER INFORMATION

	NAME OF RESPONDERS	TIME ON SCENE	ROLE AT THE SCENE	RESPONDERS INITIALS
1				
2				
3				
4				
5				

Form Completed By _____ **Date & Time Completed** _____

Signature _____

FAX COMPLETED REPORT TO 604.648.8120