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 any airway management concerns encountered during the resuscitation? (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 a ROSC?	☐ No	☐ Yes
Did the patient have 'signs of circulation' when the ambulance paramedics arrived?	☐ No	☐ Yes

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 _____

*** All times must be recorded in 24 hour format.**

FAX / SCAN COMPLETED REPORT TO: 604.648.8120 / admin@peakemergencytraining.com 04/2019