

**SHARE PROGRAM AED USE DATA FORM**  
**Bureau of Emergency Medical Services & Trauma System**  
**Arizona Department of Health Services**

Property/Business/Individual Name: \_\_\_\_\_

Incident Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated Time of Collapse: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Gender: M  F  Age: \_\_\_\_\_

Employee  Customer  Guest  Employee Family

Other, please specify: \_\_\_\_\_

1. Where on your property did this incident occur? \_\_\_\_\_  
(i.e. kitchen, lobby, single office, outdoor grounds, restroom, 6<sup>th</sup> hole, club house, etc.)
2. Was this incident witnessed by anyone? YES  NO
3. Who witnessed? Employee/Co-worker  Friend  Family  Stranger   
Doctor/Nurse/Paramedic  Other: \_\_\_\_\_
4. Was conventional CPR or Hands-Only (Compression-Only) CPR performed before the AED was connected to the patient?  
Conventional CPR  Hands-Only
5. Did the AED instruct you to shock? YES  NO  If yes, number of shocks \_\_\_\_\_
6. Was the patient transported from your property by ambulance? YES  NO   
If yes, which Fire Department or Ambulance Company: \_\_\_\_\_
7. Name of destination hospital, if known: \_\_\_\_\_
8. Did the patient exhibit any of the following after collapse and prior to departure from your property?  
Pulse  Breathing on own  Eye opening  Confusion/combativeness   
Vomiting  Moving arms/legs  Talking
9. Do you have any questions or would you like to review this AED use with the Bureau of EMS & Trauma System medical direction representative? YES  NO

Person completing form: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Best time to call you: \_\_\_\_\_

**Please FAX completed form to: Paula Brazil at (602) 364-3568**

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