



GUAM PUBLIC LIBRARY SYSTEM
Sisteman Laibirihan Pubbleko Guáhan
Government of Guam



Attachment 5

REPORT OF CPR OR AED USE TO DPHSS-OFFICE OF EMS

Mandatory Data Elements
Name of PAD Program:
Name of AED Operator:
Place of occurrence: (specific location)
Date of Incident:
Patient's Name (if able to determine)
Patient's age: (approximate if unable to determine)
Patient's sex:
Times: (approximate time if unable to determine)
Patient collapsed:
911 called:
CPR initiated:
AED attached:
Shock delivered: (if applicable)
Total number of defibrillation shocks:
Was there any return of spontaneous signs of circulation (pulse)?
Was there any return of spontaneous breathing?
<i>Optional Data Elements</i>
Circumstances of cardiac arrest
Was cause of arrest determined?
Any patient history?
Patient's Allergies?
Patient's Medications?
<i>Office of EMS Use Only</i>
Medical Director/Program Manager submitting report:
Date report received at the Office of EMS:
Patient pre-hospital outcome:
Patient disposition:

Provide a copy within 72 hours to:

**PAD Program Manager
 Medical Director
 DPHSS-Office of EMS**