

Granby Public Schools

AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TREATMENT FORM

Medtronic Physio-Control LivePak 500 Unit #: _____

Date: _____ Time: _____ Location of call: _____

Patient Name: _____ DOB: ___/___/___ Age: _____

Address: _____

Conditions(s) immediately prior to cardiac arrest (check any that apply):

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Not Breathing	<input type="checkbox"/> Airway Obstruction
<input type="checkbox"/> Exercise/Sports	<input type="checkbox"/> Trauma	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Found Unresponsive

Events prior to cardiac arrest (if known): _____

Time (in minutes) from initial event to AED arrival to patient & utilization: _____

Total Number of "shocks" performed: _____ Results:

<input type="checkbox"/>	Regained pulses
<input type="checkbox"/>	Regained breathing
<input type="checkbox"/>	No change in condition

Procedures & Equipment Used:

<input type="checkbox"/>	Immediate call to 911 upon utilization of AED
<input type="checkbox"/>	CPR / FBAO Treatment
<input type="checkbox"/>	OPA (Oropharyngeal Airway Insertion)
<input type="checkbox"/>	Ambu Bag / Mouth-to-Mask Ventilations
<input type="checkbox"/>	Supplemental Oxygen

Comments: _____

Care Transferred to: _____ Granby Police / Fire & EMS Dept. Personnel

_____ Other _____

Name of AED Operator(s): _____ Title: _____

_____ Title: _____

Treatment form completed by: _____ Title: _____

387 East State Street • Granby, Massachusetts 01033 - 9560

(413) 467-7193 • Fax (413) 467-3909

Adopted October 5, 2005
Granby Public Schools – 2005