44832

**Complete this form:**
- **For each episode referred for review**

***by Committee Member***

# AED ECG Review (c)



**Patient ID:** ☐☐ – ☐☐☐ – ☐ (site) (patient) (chk)

**1. Date of Collapse (Episode):** ☐☐ / ☐☐ / 2 0 ☐☐ (month) (day) (year)

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**2. A. First rhythm type:** *(check one bubble only)*

1 ○ VF (≥ 1 mm amplitude @ 10mm/mV)
2 ○ VT (> 100/min)
3 ○ Asystole (< 10/min, i.e., at least 6 seconds without a QRS)
4 ○ Sinus rhythm (60-100/min)
5 ○ Sinus tachycardia (> 100/min)
6 ○ Sinus bradycardia (10-59/min)
7 ○ Atrial fibrillation or flutter
8 ○ Other organized rhythm, specify: (≥ 10/min, not VT) spfst45 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**B. Time of first rhythm:** ☐☐ : ☐☐ → ○ (check if estimated)

**C. Ventricular rate of first rhythm (except VF):** ☐☐☐ or ○ VF

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**3. A. Rhythms recorded by the AED at any time:** *(check all rhythms that occurred at any time during the recording)*

○ VF (≥ 1 mm amplitude @ 10mm/mV)
○ VT (> 100/min)
○ Asystole (< 10/min, i.e., at least 6 seconds without a QRS)

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**4. Final Diagnosis:** *(please keep in mind the **PAD definitions** as explained on separate sheet)*

1 ○ Definite cardiac arrest
○ Probable cardiac arrest
○ Uncertain cardiac arrest
→ **Did patient have a shockable rhythm at any time during the resuscitation?** ○ Yes ○ No
○ Not a cardiac arrest

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(month) (day) (year)
☐☐ / ☐☐ / 2 0 ☐☐ **(date completed)**

**Printed Name of Reviewer**

**For CTC Use Only**

0 **Member Code:** ☐☐ ☐☐ ○ Yes ○ No 1 4 7 0 1 0 0

**Signature of Reviewer**