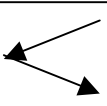


### EMT-D REPORT

INCIDENT NUMBER		DEPARTMENT		EMT-D-UNIT		PARAMEDIC UNIT	
AGE		SEX M    F		WITNESS ARREST? Y    N		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> </div>	
				<div style="display: flex; justify-content: space-around; font-size: small;"> <span>BH</span> <span>YEAR</span> <span>MONTH</span> <span>DAY</span> <span>RUN</span> <span>PT</span> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div>			
ESTIMATED TIME OF COLLAPSE HRS			BYSTANDER CPR? Y    N		RECEIVING CENTER		
COMMENTS/DETAILS							
EQUIPMENT MALFUNCTION (DESCRIBE)							

BELOW COMPLETED BY DEPARTMENT QUALITY ASSURANCE COORDINATOR

	_____ HRS	ESTIMATED TIME OF COLLAPSE
	_____ HRS	DISPATCH TIME
	_____ HRS	ON-SCENE TIME
	_____ HRS	PATIENT CONTACT TIME
	_____ HRS	TIME OF FIRST DEFIBRILLATION
	_____ HRS	PARAMEDIC CONTACT TIME

**90 SECOND GOAL**


COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

REVIEWED BY QA COORDINATOR AND  
SENT TO BASE HOSPITAL OR EMS AGENCY \_\_\_\_\_ DATE \_\_\_\_\_

INITIAL RHYTHM _____	
SHOCKABLE RHYTHM:	<input type="checkbox"/> S                      NO <input type="checkbox"/>
RHYTHM SHOCK (S) _____	
ED DISPOSTION:	<input type="checkbox"/> MMITTED                      EX <input type="checkbox"/> ED
DISCHARGED ALIVE:	<input type="checkbox"/> S                      NO <input type="checkbox"/>
COMMENTS: _____ _____ _____	
EDUCATIONAL OPPORTUNITY IDENTIFIED:	<input type="checkbox"/> YES <input type="checkbox"/>
REVIEWED BY BASE HOSPITAL OR EMS AGENCY _____ DATE _____	

**SEND THIS COMPLETED FORM AND ATTACHED REPORTS TO:**

Orange County Emergency Medical Services  
405 W. Fifth Street Suite 301A  
SANTA ANA, CA 92701