**Equipment Checklist**

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|  | **Answer** | **Assessment**  |  | **Answer** | **Assessment**  |
| Is your area providing a service to patients because of a physical ill health need? |  | **Yes** | Is the area an inpatient area? With full time Registered nurse cover? |  | **Yes – there is a need for a defibrillator in your area. Please contact Resuscitation Services** |
| **No** – there is no need for a defibrillator for this criterion |  | **No** – there is no need for a defibrillator for this criterion |
| Does your area give treatment that may lead to or cause sudden cardiac arrest (restrain, rapid tranq, ECT)?  |  | **Yes** | Is the area an inpatient area? |  | **Yes – there is a need for a defibrillator in your area. Please contact Resuscitation Services** |
| **No** – there is no need for a defibrillator for this criterion |  | **No** – there is no need for a defibrillator for this criterion |
| Are there any Clinical Guidelines suggesting the requirement for defibrillation for your area/patient group? |  | **Yes** | Is the area an inpatient area? |  | **Yes – there is a need for a defibrillator in your area. Please contact Resuscitation Services** |
| **No** – there is no need for a defibrillator for this criterion |  | **No** – there is no need for a defibrillator for this criterion |
| Has there been a history of sudden cardiac arrest in the area – at least one arrest in the last 12 months? |  | **Yes** | Is the area an inpatient area? |  | **Yes – there is a need for a defibrillator in your area. Please contact Resuscitation Services** |
| **No** – there is no need for a defibrillator for this criterion |  | **No** – there is no need for a defibrillator for this criterion |