



# CRITICAL CARE SKILLS CHECKLIST

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

YEARS OF EXPERIENCE: \_\_\_\_\_

PLEASE INDICATE YOUR LEVEL OF EXPERIENCE

1. THEORY, NO PRACTICE - DIDACTIC INSTRUCTION ONLY, NO HANDS ON EXPERIENCE
2. LIMITED EXPERIENCE - KNOWS PROCEDURE/HAS USED EQUIPMENT, BUT HAS DONE SO INFREQUENTLY OR NOT WITHIN THE LAST SIX MONTHS.
3. MODERATE EXPERIENCE. - ABLE TO DEMONSTRATE EQUIPMENT/PROCEDURE, PERFORMS THE TASK/SKILL INDEPENDENTLY WITH ONLY RESOURCE ASSISTANCE NEEDED
4. PROFICIENT/COMPETENT - ABLE TO DEMONSTRATE/PERFORM THE TASK/SKILL PROFICIENTLY WITHOUT ANY ASSISTANCE AND CAN INSTRUCT/TEACH

## A. CARDIOVASCULAR

	1	2	3	4
1. ASSESSMENT:				
A. ABNORMAL HEART SOUNDS/ MURMURS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. AUSCULTATION (RATE, RHYTHM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. BLOOD PRESSURE/ NON-INVASIVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. DOPPLER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PULSES/CIRCULATION CHECKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. INTERPRETATION OF LAB RESULTS:				
A. CARDIAC ENZYMES & ISOENZYMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. COAGULATION STUDIE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. EQUIPMENT & PROCEDURES:				
A. ASSIST WITH:				
1) ARTERIAL LINE INSERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) CENTRAL LINE INSERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) OPEN CHEST EMERGENCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) PA CATHETER/ SWAN-GANZ INSERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) PERICARDIOCENTESIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) TRANSESOPHAGEAL ECHOCARDIOGRAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. AUTOMATIC INTERNAL CARDIOVERTER DEFIBRILLATOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. CAVH-D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. CARDIOVERSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HEMODYNAMIC MONITORING:				
1) CARDIAC INDEX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) CARDIAC OUTPUT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) CVP MONITORING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) FEMORAL ARTERY SHEATH REMOVAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) MAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) PA/SWAN-GANZ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) PVR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) PCW PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) RADIAL A-LINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) SVO2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. INTRA AORTIC BALLOON PUMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. MONITORING:				
1) 12 LEAD EKG INTERPRETATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) ARRHYTHMIA INTERPRETATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) LEAD PLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) RHYTHM STRIP ASSESSMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) SET UP AND RUN 12 LEAD EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. PACEMAKER:				
1) EXTERNAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) PERMANENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) TEMPORARY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) TRANSTHORACIC (EPICARDIAL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. VENTRICULAR ASSIST DEVICE (RVAD OR LVAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CARE OF THE PATIENT WITH:				
A. ABDOMINAL AORTIC ANEURYSM REPAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. ACUTE MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. CARDIAC ARREST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. CARDIAC TAMPONADE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. CONGESTIVE HEART FAILURE (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. EP STUDY & ABLATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: \_\_\_\_\_

- |   | 1                        | 2                        | 3                        | 4                        |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| G. HEART TRANSPLANT                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. IMMEDIATE POST OPEN-HEART SURGERY                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. INFECTIVE ENDOCARDITIS                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. POST ACUTE MI (24-48 HOURS)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. PERICARDITIS   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. POST AICD INSERTION                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. POST ARTHRECTOMY (DCA)                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. POST COMMISSUROTOMY, VALVE REPAIR, VALVE REPLACEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| O. POST INTRACORONARY STENT PLACEMENT                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| P. POST PERCUTANEOUS BALLOON VALVULOPLASTY              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. POST ROTOBLADE                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| R. PRE/POST ANGIOPLASTY                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| S. PRE/POST CARDIAC CATH                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
5. MEDICATIONS:
- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| A. AMIODARONE (CARDARONE)                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ATROPINE                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. BICARBONATE                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BRETILUM (BRETLYOL)                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. DIGOXIN (LANOXIN)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. DILTIAZEM (CARDIZEM) DOBUTAMINE (DOBUTREX) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. DOPAMINE (INTROPIN)                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. EPINEPHRINE (ADRENALIN)                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. ESMOLOL (BREVIBLOC)                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. INOCOR (AMRINONE)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. LIDOCAINE (XYLOCAINE)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. METOPROLOL (LOPRESSOR)                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. NIPRIDE (NITROPRUSSIDE)                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. NITROGLYCERINE (TRIDIL)                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| O. PROCAINAMIDE (PRONESTYL)                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| P. RETEPLASE RECOMBINANT (RETAVASE)           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. STREPTOKINASE                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| R. TPA (ALTEPLASE)                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| S. VERAPAMIL (CALAN, ISOPTIN, VERELAN)        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**B. PULMONARY**  
1. ASSESSMENT:

- |                               | 1                        | 2                        | 3                        | 4                        |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| A. ADVENTITIOUS BREATH SOUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. RATE AND WORK OF BREATHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
2. INTERPRETATION OF LAB RESULTS:
- |                         |                          |                          |                          |                          |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| A. BLOOD CHEMISTRY      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ARTERIAL BLOOD GASES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
3. EQUIPMENT & PROCEDURES:
- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| A. AIR LEAK TROUBLESHOOTING:                                  |                          |                          |                          |                          |
| 1) MEDIASTINAL CHEST TUBE REMOVAL                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) PLEURAL CHEST TUBE REMOVAL                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. AIRWAY MANAGEMENT DEVICES/SUCTIONING:                      |                          |                          |                          |                          |
| 1) ENDOTRACHEAL TUBE/ SUCTIONING                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) EXTUBATION   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) NASAL AIRWAY/ SUCTIONING                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) OXIMETRY   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) SPUTUM SPECIMEN COLLECTION                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) TRACHEOSTOMY/ SUCTIONING                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ASSIST WITH:   |                          |                          |                          |                          |
| 1) BRONCHOSCOPY   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) CHEST TUBE INSERTION                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) EMERGENCY TRACHEOSTOMY                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) THORACENTESIS  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. ESTABLISHING AN AIRWAY:                                    |                          |                          |                          |                          |
| 1) ASSIST WITH INTUBATION                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) ORAL AIRWAY INSERTION                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. IDENTIFICATION/ INTERVENTION FOR RESPIRATORY COMPLICATIONS |                          |                          |                          |                          |
| 1) ASPIRATION   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) LARYNGOSPASM   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) TENSION PNEUMOTHORAX                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) USE OF PLEUREVAC OR THORACLEX DRAINAGE                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) USE OF WATER SEAL DRAINAGE                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. O2 THERAPY & MEDICATION DELIVERY SYSTEMS:                  |                          |                          |                          |                          |
| 1) AMBU BAG AND MASK  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) ET TUBE  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) FACE MASKS   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: \_\_\_\_\_

	1	2	3	4
4) NASAL CANNULA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) PORTABLE O2 TANK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) TRACH COLLAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. VENTILATOR MANAGEMENT</b>				
1) EXTERNAL CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) HIGH FREQUENCY JET VENTILATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) IMV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) PEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) PRESSURE SUPPORT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) WEANING MODES & T-PIECE WEANING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. CARE OF THE PATIENT WITH:</b>				
A. ACUTE PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. ARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. CHEST TRAUMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. LOBECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. COR PULMONALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. FRESH TRACHEOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. LUNG TRANSPLANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. NEAR DROWNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. PNEUMONECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. PULMONARY EDEMA/HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. PULMONARY EMBOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. STATUS ASTHMATICUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. THORACOTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. MEDICATIONS</b>				
A. ALUPENT (METAPROTERENOL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. AMINOPHYLLINE (THEOPHYLLINE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. BRONKOSOL (ISOETHARINE HYDROCHLORIDE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. CORTICOSTEROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. VENTOLIN (ALBUTEROL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. NEUROLOGICAL</b>				
<b>1. ASSESSMENT:</b>				
A. CRANIAL NERVES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. GLASGOW COMA SCALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. LEVEL OF CONSCIOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. PATHOLOGIC REFLEXES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. REFLEX/MOTOR DEFICITS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. VISUAL OR COMMUNICATION DEFICITS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. EQUIPMENT &amp; PROCEDURES:</b>				
A. ASSIST WITH LUMBAR PUNCTURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
B. HALO TRACTION/CERVICAL TONGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. INTRACRANIAL PRESSURE MONITORING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. NERVE STIMULATORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. ROTATING BED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. SEIZURE PRECAUTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. SPINAL PRECAUTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. STRYKER FRAME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. USE OF HYPER/HYPOTHERMIA BLANKET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. CARE OF THE PATIENT WITH:</b>				
A. ANEURYSM PRECAUTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. BASAL SKULL FRACTURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. CLOSED HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. COMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. DTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. ENCEPHALITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. EXTERNALIZED VP SHUNTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. INCREASED ICP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. LAMINECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. MENINGITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. METASTATIC TUMOR/INTRACRANIAL TUMOR RESECTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. MULTIPLE SCLEROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. SPINAL CORD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. VENTRICULOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. MEDICATIONS:</b>				
A. BARBITURATE INDUCED COMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. DECADRON (DEXAMETHASONE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. DILANTIN (PHENYTOIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. EPIDURAL ADMINISTRATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PHENOBARBITAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. VALIUM (DIAZEPAM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. GASTROINTESTINAL</b>				
<b>1. ASSESSMENT:</b>				
A. ABDOMINAL/BOWEL SOUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. NUTRITIONAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. INTERPRETATION OF LAB RESULTS:</b>				
A. SERUM AMMONIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. SERUM AMYLASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. LFTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. EQUIPMENT &amp; PROCEDURES:</b>				
A. ADMINISTRATION OF TUBE FEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. BALLOON TAMPONADE (SENGSTAKEN BLAKEMORE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. FEEDING PUMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: \_\_\_\_\_

	1	2	3	4
D. FLEXIBLE FEEDING TUBE (I.E., CORPAK, DOBHOFF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. GRAVITY FEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. ICED SALINE LAVAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. MANAGEMENT OF:				
1) GASTROSTOMY TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) JEJUNOSTOMY TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) T-TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) TPN AND LIPIDS ADMINISTRATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) PPN (PERIPHERAL PARENTERAL NUTRITION)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. PLACEMENT OF NASOGASTRIC TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. SALEM SUMP TO SUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CARE OF THE PATIENT WITH:				
A. BLUNT TRAUMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. BOWEL OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. COLOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. ERCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. ESOPHAGEAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. GI BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. GI SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. ILEOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. INFLAMMATORY BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. LIVER FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. LIVER TRANSPLANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. PANCREATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. PARALYTIC ILEUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. PENETRATING TRAUM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. MEDICATIONS:				
A. AQUAMEPHYTON (VITAMIN K)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. INDERAL (PROPRANOLOL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. KAYEXELATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. LACTULOSE (CEPHULAC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PITRESSIN (VASOPRESSIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. RENAL/GENITOURINARY				
1. ASSESSMENT:				
A. A-V FISTULA/SHUNT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. FLUID BALANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. INTERPRETATION OF LAB RESULTS:				
A. BUN & CREATININE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. SERUM ELECTROLYTES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. EQUIPMENT & PROCEDURES:				
A. BLADDER IRRIGATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. INSERTION & CARE OF STRAIGHT AND FOLEY CATHETER:				
1) 3-WAY FOLEY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) FEMALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) MALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
C. SUPRA-PUBIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CARE OF THE PATIENT WITH:				
A. ACUTE RENAL FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. CAVH DIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. HEMODIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. NEPHRECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PERITONEAL DIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. RENAL REJECTION SYNDROME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. RENAL TRANSPLANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. TURP A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. URINARY DIVERSION (ILEAL CONDUIT NEPHROSTOMY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. URINARY TRACT INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. ENDOCRINE/METABOLIC				
1. INTERPRETATION OF LAB RESULTS:				
A. BLOOD GLUCOSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. THYROID STUDIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. EQUIPMENT & PROCEDURES:				
A. BLOOD GLUCOSE MEASURING DEVICE: TYPE: _____				
B. BLOOD GLUCOSE MONITORING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. PERFORMING FINGER STICK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CARE OF THE PATIENT WITH:				
A. DIABETES MELLITUS CATHETER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. DIABETIC KETOACIDOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. DISORDERS OF ADRENAL GLAND (E.G., ADDISON'S DISEASE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. DISORDERS OF PITUITARY GLAND (E.G., DI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. DRUG OVERDOSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. HYPERTHYROIDISM (GRAVE'S DISEASE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. HYPOTHYROIDISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. INSULIN SHOCK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. THYROIDECTOMY - DISORDERS OF THYROID GLAND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. MEDICATION:				
A. INSULIN PUMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. WOUND MANAGEMENT				
1. ASSESSMENT:				
A. SKIN FOR IMPENDING BREAKDOWN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. STASIS ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. SURGICAL WOUND HEALING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. EQUIPMENT & PROCEDURES:				
A. AIR FLUIDIZED, LOW AIRLOSS BEDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. STERILE DRESSING CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. WOUND CARE/IRRIGATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CARE OF THE PATIENT WITH:				

NAME: \_\_\_\_\_

- |                                     |                          |                          |                          |                          |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                     | <b>1</b>                 | <b>2</b>                 | <b>3</b>                 | <b>4</b>                 |
| A. BURNS                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. PRESSURE SORES                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. STAGED DECUBITUS<br>ULCERS       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. SURGICAL WOUNDS WITH<br>DRAIN(S) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. TRAUMATIC WOUNDS                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                |                          |                          |                          |                          |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                | <b>1</b>                 | <b>2</b>                 | <b>3</b>                 | <b>4</b>                 |
| 1) BROVIAC                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) GROSHONG                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) HICKMAN                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PORTACATH                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) PERIPHERAL<br>LINE/DRESSING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**H. PHLEBOTOMY/IV THERAPY**

**1. EQUIPMENT & PROCEDURES:**

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| A. ADMINISTRATION OF<br>BLOOD/BLOOD<br>PRODUCTS |                          |                          |                          |                          |
| 1) CRYOPRECIPITATE                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) PACKED RED BLOOD<br>CELLS                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) PLASMA/ALBUMIN                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) WHOLE BLOOD                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DRAWING BLOOD FROM<br>CENTRAL LINE           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DRAWING VENOUS<br>BLOOD                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. STARTING IVS:                                |                          |                          |                          |                          |
| 1) ANGIOCATH                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) BUTTERFLY                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) HEPARIN LOCK                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**2. CARE OF THE PATIENT WITH:**

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| A. CENTRAL<br>LINE/CATHETER/<br>DRESSING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|

**I. PAIN MANAGEMENT**

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT OF PAIN<br>LEVEL/TOLERANCE: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE PATIENT WITH:              |                          |                          |                          |                          |
| A. EPIDURAL<br>ANESTHESIA/ANALGESIA       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. IV CONSCIOUS SEDATION                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. PATIENT CONTROLLED<br>ANALGESIA        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**J. MISCELLANEOUS**

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. CARE OF THE PATIENT WITH:                          |                          |                          |                          |                          |
| A. ANAPHYLACTIC SHOCK                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DISSEMINATED<br>INTRAVASCULAR<br>COAGULATION (DIC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. HYPOVOLEMIC SHOCK                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. MULTI-SYSTEM ORGAN<br>FAILURE                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. ORGAN/TISSUE<br>DONATION                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. SEPTIC SHOCK                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**AGE SPECIFIC PRACTICE CRITERIA:**

PLEASE CHECK THE BOXES BELOW FOR EACH AGE GROUP FOR WHICH YOU HAVE EXPERTISE IN PROVIDING AGE-APPROPRIATE NURSING CARE.

A. NEWBORN/NEONATE (BIRTH - 30 DAYS)	D. PRESCHOOLER (3 - 5 YEARS)	G. YOUNG ADULTS (18 - 39 YEARS)
B. INFANT (30 DAYS - 1 YEAR)	E. SCHOOL AGE CHILDREN (5 - 12 YEARS)	H. MIDDLE ADULTS (39 - 64 YEARS)
C. TODDLER (1 - 3 YEARS)	F. ADOLESCENTS (12 - 18 YEARS)	I. OLDER ADULTS (64+)

- |  |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <b>A</b>                 | <b>B</b>                 | <b>C</b>                 | <b>D</b>                 | <b>E</b>                 | <b>F</b>                 | <b>G</b>                 | <b>H</b>                 | <b>I</b>                 |
| ABLE TO ADAPT CARE TO INCORPORATE NORMAL GROWTH AND DEVELOPMENT.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ABLE TO ADAPT METHOD AND TERMINOLOGY OF PATIENT INSTRUCTIONS TO THEIR AGE, COMPREHENSION AND MATURITY LEVEL. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CAN ENSURE A SAFE ENVIRONMENT REFLECTING SPECIFIC NEEDS OF VARIOUS AGE GROUPS.                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: \_\_\_\_\_

CERTIFICATION:	EXP DATE:	CERTIFICATION:	EXP DATE:
<input type="checkbox"/> BCLS		<input type="checkbox"/> CNRN	
<input type="checkbox"/> ACLS		<input type="checkbox"/> TNCC	
<input type="checkbox"/> BTLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> CCRN		<input type="checkbox"/> OTHER	

MY EXPERIENCE IS PRIMARILY IN:  
(PLEASE INDICATE NUMBER OF YEARS.)

- MEDICAL \_\_\_\_\_ YEAR(S)
- SURGICAL \_\_\_\_\_ YEAR(S)
- TRAUMA \_\_\_\_\_ YEAR(S)
- CARDIOVASCULAR \_\_\_\_\_ YEAR(S)
- CARDIOTHORACIC \_\_\_\_\_ YEAR(S)
- OTHER \_\_\_\_\_ (YEARS)

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS CRITICAL CARE SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE