



# MEDICAL/SURGICAL 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. ASSESSMENT:
  - A. AUSCULTATION (RATE, RHYTHM)      1    2    3    4
  - B. BLOOD PRESSURE/NON-INVASIVE
  - C. DOPPLER
  - D. HEART SOUNDS/MURMURS
  - E. PULSES/CIRCULATION CHECKS
2. EQUIPMENT & PROCEDURES:
  - A. TELEMETRY
    - 1) BASIC 12 LEAD INTERPRETATION
    - 2) BASIC ARRHYTHMIA I INTERPRETATION
    - 3) LEAD PLACEMENT
  - B. PACEMAKER         
    - 1) PERMANENT
    - 2) TEMPORARY
3. CARE OF THE PATIENT WITH:
  - A. ABDOMINAL AORTIC BYPASS
  - B. ANEURYSM
  - C. ANGINA
  - D. CARDIAC ARREST
  - E. CARDIOMYOPATHY
  - F. CAROTID ENDARTERECTOMY
  - G. CONGESTIVE HEART FAILURE (CHF)
  - H. FEMORAL-POPLITEAL BYPASS
  - I. MYOCARDITIS
  - J. POST ACUTE MI (24-48 HOURS)
  - K. POST ANGIOPLASTY
  - L. POST CARDIAC CATH
  - M. POST CARDIAC SURGERY
  - N. THROMBOPHLEBITIS
4. MEDICATIONS:
  - A. HEPARIN DRIP
  - B. ORAL ANTICOAGULANTS
  - C. ORAL & IVP ANTIHYPERTENSIVES
  - D. ORAL & TOPICAL NITRATES

## B. PULMONARY

- |                                                                     | 1                        | 2                        | 3                        | 4                        |
|---------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT:                                                      |                          |                          |                          |                          |
| A. CHEST/LUNGS: INSPECTION<br>PALPATION,PERCUSSION,<br>AUSCULTATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BREATHING<br>PATTERNS/RATE/SOB                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. COUGH/SECRETIONS/<br>HEMOPTYSIS                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PAINS (CHEST)                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. SKIN (COLOR)                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB<br>RESULTS:                                |                          |                          |                          |                          |
| A. BLOOD CHEMISTRY                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BLOOD GASES                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES:                                          |                          |                          |                          |                          |
| A. AIRWAY MANAGEMENT<br>DEVICES/SUCTIONING:                         |                          |                          |                          |                          |
| 1) ENDOTRACHEAL<br>TUBE/SUCTIONING                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) NASAL AIRWAY/SUCTIONING                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) OROPHARYNGEAL/<br>SUCTIONING                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) SPUTUM SPECIMEN<br>COLLECTION                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) TRACHEOSTOMY/SUCTIONING                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ASSIST WITH INTUBATION                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ASSIST WITH THORACENTESIS                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. CARE OF THE PATIENT WITH A<br>CHEST TUBE:                        |                          |                          |                          |                          |
| 1) ASSIST WITH SET-UP &<br>INSERTION                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) MEASURING AND EMPTYING                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) REMOVAL                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. CHEST PHYSIOTHERAPY                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. INCENTIVE SPIROMETRY                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. O <sup>2</sup> THERAPY & MEDICATION<br>DELIVERY SYSTEMS          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) BAG AND MASK                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) EXTERNAL CPAP                                                    | <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"/> |
| 4) INHALERS                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

	1	2	3	4
5) NASAL CANNULA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) PORTABLE O <sup>2</sup> TANK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) TRACH COLLAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. OXIMETRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. CARE OF THE PATIENT WITH:</b>				
A. BRONCHOSCOPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. FRESH TRACHEOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. LOBECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PNEUMONECTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. PULMONARY EMBOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. THORACOTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. NEUROLOGICAL</b>				
<b>1. ASSESSMENT:</b>				
A. MENTAL STATUS/LOC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. GLASGOW COMA SCORE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. MOTOR MOVEMENT/ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. STRENGTH COORDINATION	<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"/>
B. 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. MENINGITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. NEUROMUSCULAR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. POST CRANIOTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. SPINAL CORD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. ADMINISTRATION OF ANTICONVULSANTS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. ORTHOPEDICS</b>				
<b>1. ASSESSMENT:</b>				
A. CIRCULATION CHECKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. JOINTS-INSPECTION/PALPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. MOBILITY/GAIT/ POSITIONING/ TRANSFERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. POSTURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. SKIN -INSPECT/PALPATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. EQUIPMENT &amp; PROCEDURES:</b>				
A. CONTINUOUS PASSIVE MOTION DEVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. SUPPORT DEVICES				
1) CANE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) CERVICAL COLLAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
3) GAIT BELT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) PROSTHETIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) SLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) TRANSFER BOARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) WALKER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) WHEELCHAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. TRACTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. CARE OF THE PATIENT WITH:</b>				
A. AMPUTATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. ARTHROSCOPIC SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. CAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. PINNED FRACTURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. RHEUMATIC/ARTHRITIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. TOTAL HIP REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. TOTAL KNEE REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. MEDICATIONS</b>				
A. DILANTIN (PHENYTOIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. MANNITOL (OSMITROL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. PHENOBARBITAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. SOLU-MEDROL (METHYLPREDNISOLONE SODIUM SUCCINATE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. GASTROINTESTINAL</b>				
<b>1. ASSESSMENT:</b>				
A. ABDOMINAL/BOWEL SOUNDS	<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"/>
C. NUTRITIONAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. EQUIPMENT &amp; PROCEDURES:</b>				
A. ADMINISTRATION OF TUBE FEEDING				
1) FEEDING PUMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) GRAVITY FEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) SALINE LAVAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. FLEXIBLE FEEDING TUBE (I.E., CORPAK, DOBHOFF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. 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"/>
D. PLACEMENT OF NASOGASTRIC TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. SALEM SUMP TO SUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. CARE OF THE PATIENT WITH:</b>				
A. BOWEL OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. COLOSTOMY/ILEOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. GI BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. GI SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. INFLAMMATORY BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. INVASIVE DIAGNOSTIC TESTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. LIVER FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. PARALYTIC ILEUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**F. RENAL/GENITOURINARY**

- |                                                        | 1                        | 2                        | 3                        | 4                        |
|--------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>1. ASSESSMENT:</b>                                  |                          |                          |                          |                          |
| A. ARTERIO VENOUS FISTULA/<br>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"/> |
| <b>2. INTERPRETATION OF LAB RESULTS:</b>               |                          |                          |                          |                          |
| A. BUN & CREATIVE                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ELECTROLYTES                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. EQUIPMENT &amp; PROCEDURES:</b>                  |                          |                          |                          |                          |
| A. INSERTION & CARE OF STRAIGHT<br>AND FOLEY CATHETER: |                          |                          |                          |                          |
| 1) FEMALE                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) MALE                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) CHILD FEMALE                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) CHILD MALE                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CATHETER CARE:                                      |                          |                          |                          |                          |
| 1) 3-WAY FOLEY                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) SUPRA-PUBIC                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. BLADDER IRRIGATIONS:                                |                          |                          |                          |                          |
| 1) CONTINUOUS                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) INTERMITTENT                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. SPECIMEN COLLECTION                                 |                          |                          |                          |                          |
| 1) ROUTINE                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) 24 HOUR                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4. CARE OF THE PATIENT WITH:</b>                    |                          |                          |                          |                          |
| A. HEMODIALYSIS                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. NEPHRECTOMY                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. PERITONEAL DIALYSIS                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. RENAL FAILURE                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RENAL TRANSPLANT                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. TURP                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. URINARY DIVERSION/ILEAL<br>CONDUIT NEPHROSTOMY      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. URINARY TRACT INFECTION                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**G. ENDOCRINE/METABOLIC**

- |                                                         |                          |                          |                          |                          |
|---------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>1. ASSESSMENT:</b>                                   |                          |                          |                          |                          |
| A. S/S DIABETIC COMA                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. S/S INSULIN REACTION                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>2. EQUIPMENT &amp; PROCEDURES:</b>                   |                          |                          |                          |                          |
| A. BLOOD GLUCOSE MONITORING:                            |                          |                          |                          |                          |
| 1) ELECTRONIC MEASURING<br>DEVICE: TYPE                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) PERFORMING FINGER STICK                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) VISUAL BLOOD GLUCOSE<br>STRIPS                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) INDWELLING INSULIN PUMP                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. CARE OF THE PATIENT WITH:</b>                     |                          |                          |                          |                          |
| A. DIABETES MELLITUS                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DISORDERS OF ADRENAL GLAND<br>(ADDISON'S DISEASE)    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DISORDERS OF PITUITARY GLAND<br>(DIABETES INSIPIDUS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. HYPERTHYROIDISM (GRAVE'S<br>DISEASE)                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. HYPOTHYROIDISM                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. THYROIDECTOMY                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4. MEDICATIONS (ADMINISTRATION AND TEACHING):</b>    |                          |                          |                          |                          |
| A. INSULIN                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- |                       | 1                        | 2                        | 3                        | 4                        |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| B. ORAL HYPOGLYCEMICS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. STEROIDS           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. THYROID            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**H. WOUND MANAGEMENT**

- |                                       |                          |                          |                          |                          |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>1. ASSESSMENT:</b>                 |                          |                          |                          |                          |
| A. SKIN FOR IMPENDING<br>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"/> |
| <b>2. EQUIPMENT &amp; PROCEDURES:</b> |                          |                          |                          |                          |
| A. AIR FLUIDIZED, LOW AIRLOSS<br>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"/> |
| <b>3. CARE OF THE PATIENT WITH:</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 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"/> |

**I. ONCOLOGY/HEMATOLOGY**

- |                                                                                                                |                          |                          |                          |                          |
|----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>1. ASSESSMENT:</b>                                                                                          |                          |                          |                          |                          |
| A. PERSONAL/FAMILY HISTORY/<br>MENTAL STATUS                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. MOTOR RESPONSES /ROM/<br>STRENGTH/ ENDURANCE                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. NODULES /TUMORS<br>/DEFORMITIES                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. GI/GU – N/V, URINE, STOOLS,<br>NUTRITION                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. SKIN – LESIONS/ TUMORS,<br>COLOR                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. PAIN CONTROL                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>2. EQUIPMENT &amp; PROCEDURES:</b>                                                                          |                          |                          |                          |                          |
| A. LABS – BLOOD DRAWS/<br>INTERPRETATIONS                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BIOPSIES                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. BONE MARROW ASPIRATION                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. REVERSE ISOLATION                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. CARE OF THE PATIENT WITH:</b>                                                                            |                          |                          |                          |                          |
| A. BONE MARROW TRANSPLANT                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. FRESH ONCOLOGIC SURGERY                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. INPATIENT CHEMOTHERAPY                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. INPATIENT HOSPICE                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. LEUKEMIA                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. RADIATION IMPLANT                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4. MEDICATIONS: CHEMOTHERAPY CERTIFICATION?</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                          |                          |                          |                          |

**J. INFECTIOUS DISEASES**

- |                                                    |                          |                          |                          |                          |
|----------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>1. ASSESSMENT:</b>                              |                          |                          |                          |                          |
| A. MANIFESTATIONS OF INFECTIONS<br>ON BODY SYSTEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>2. EQUIPMENT &amp; PROCEDURES:</b>              |                          |                          |                          |                          |
| A. ISOLATION/UNIVERSAL<br>PRECAUTIONS              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- |                                                                 | 1                        | 2                        | 3                        | 4                        |
|-----------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| B. BLOOD CULTURES (OBTAINING SPECIMEN)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. SPUTUM CULTURES (OBTAINING SPECIMEN)                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. STOOL CULTURES (OBTAINING SPECIMEN)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. WOUND CULTURES (OBTAINING SPECIMEN)                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. CSF CULTURES (OBTAINING SPECIMEN)                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. CBC WITH DIFFERENTIAL                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH:                                    |                          |                          |                          |                          |
| A. ABSCESSES                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BACTEREMIA/SEPTIC SHOCK                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. SYSTEMIC FUNGAL DISEASE/RICKETTSIAL DISEASE                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PARASITIC INFECTION                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. VIRAL INFECTION                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. HIV                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. SEXUALLY TRANSMITTED DISEASE                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. MEDICATIONS – ADMINISTRATION/TEACHING                        |                          |                          |                          |                          |
| A. IMMUNOGLOBULIN/ANTITOXINS                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. IMMUNIZATIONS – MMR, TETANUS, HEP B, INFLUENZA, PNEUMOCOCCAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ANTIBACTERIAL DRUGS                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. ANTIVIRAL DRUGS/HIV DRUGS                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. PHLEBOTOMY / IV THERAPY                                      |                          |                          |                          |                          |
| 1. EQUIPMENT & PROCEDURES:                                      |                          |                          |                          |                          |
| A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS:                      |                          |                          |                          |                          |
| 1) ALBUMIN                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                       | 1                        | 2                        | 3                        | 4                        |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2) CRYOPRECIPITATE                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) PACKED RED BLOOD CELLS             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PLASMA                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) WHOLE BLOOD                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DRAWING BLOOD FROM CENTRAL LINE    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DRAWING VENOUS BLOOD               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. STARTING IVS:                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 LINE/CATHETER/DRESSING:    |                          |                          |                          |                          |
| 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) QUINTON                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. PERIPHERAL LINE/DRESSING           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. PAIN MANAGEMENT                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. ASSESSMENT OF PAIN LEVEL/TOLERANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE PATIENT WITH:          |                          |                          |                          |                          |
| A. EPIDURAL 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. NARCOTIC ANALGESIA                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PATIENT CONTROLLED ANALGESIA       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. PCA PUMP                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

MEDICAL/ SURGICAL \_\_\_\_\_ YEAR(S)

NEUROLOGY \_\_\_\_\_ YEAR(S)

TELEMETRY \_\_\_\_\_ YEAR(S)

OB/GYN \_\_\_\_\_ YEAR(S)

ORTHOPEDICS \_\_\_\_\_ YEAR(S)

PSYCHIATRY \_\_\_\_\_ YEAR(S)

PEDIATRICS \_\_\_\_\_ YEAR(S)

ONCOLOGY \_\_\_\_\_ YEAR(S)

REHABILITATION \_\_\_\_\_ YEAR(S)

LTC \_\_\_\_\_ (YEARS)

OTHER \_\_\_\_\_ (YEARS)

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

**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"/>

CERTIFICATION:	EXP DATE:	CERTIFICATION:	EXP DATE:
<input type="checkbox"/> BCLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> ACLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> PALS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> OTHER		<input type="checkbox"/> OTHER	

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

\_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE**