

2012 CBT 450-EMT 12 Endocrine Emergencies EMERGENCY MEDICAL SERVICES (11/21/2011) MH			SKILLS CHECKLIST FOR RECERTIFICATION		
NAME	ID #	DATE			
Objective: Given a partner, appropriate equipment and a patient with an endocrine emergency, demonstrate appropriate assessment and treatment as outlined in CBT 450-EMT 12 and EMT Patient Care Guidelines.					
SCENE SIZE-UP (must verbalize)					
<input type="checkbox"/> BSI	<input type="checkbox"/> Scene Safety	<input type="checkbox"/> Determines MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources	
INITIAL ASSESSMENT (must verbalize)					
<input type="checkbox"/> Mental Status	<input type="checkbox"/> Airway	<input type="checkbox"/> Breathing	<input type="checkbox"/> Circulation	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK
<input type="checkbox"/> Chief complaint	<input type="checkbox"/> C-spine		<input type="checkbox"/> Bleeding	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK
SUBJECTIVE (FOCUSED HISTORY)					
<input type="checkbox"/> Establishes rapport with patient (reassures and calms) and obtains consent to treat (implied/actual) <input type="checkbox"/> Determines patient's chief complaint and follows SAMPLE and OPQRST investigation <input type="checkbox"/> Determines time of onset of complaint, signs or symptoms <input type="checkbox"/> Obtains names/dosages of current medications and were any taken					
OBJECTIVE (PHYSICAL EXAM)					
<input type="checkbox"/> Records and documents baseline vital signs - confirms patient's ability to swallow (as indicated) <input type="checkbox"/> Performs appropriate medical / trauma exam – exposes/checks for bleeding and/or injuries <input type="checkbox"/> Performs blood glucometry and records findings (if trained to do so) <input type="checkbox"/> Obtains second set of vital signs and compares to baseline					
ASSESSMENT (IMPRESSION)					
<input type="checkbox"/> Verbalizes impression (i.e.: hypoglycemia) <input type="checkbox"/> Determines if ALS is needed — states rationale _____					
PLAN (TREATMENT)					
GENERAL CARE (Check all that apply)			CRITICAL (FAIL) CRITERIA		
<input type="checkbox"/> Indicates need for ALS and/or immediate transport (SICK)			DID NOT... <input type="checkbox"/> Take/verbalize BSI <input type="checkbox"/> Appropriately provide/manage airway, breathing, bleeding control, treatment of shock <input type="checkbox"/> Properly administers oxygen <input type="checkbox"/> Indicate need for ALS and/or immediate transport (SICK)		
<input type="checkbox"/> Reports APS to Dispatch					
<input type="checkbox"/> Administers appropriate rate and delivery of oxygen (as indicated)					
<input type="checkbox"/> Properly positions patient					
<input type="checkbox"/> Performs blood glucometry records: (findings/time [Pre/Post])					
<input type="checkbox"/> Provides oral glucose (if indicated)					
<input type="checkbox"/> Monitors patient vital signs					
<input type="checkbox"/> Considers Index of Suspicion					
<input type="checkbox"/> Oximetry					
<input type="checkbox"/> Follows proper " after-care " procedures (if indicated)					
<input type="checkbox"/> Performs pt. reassessment					
COMMUNICATION AND DOCUMENTATION					
<input type="checkbox"/> Delivers timely and effective short report (if indicated)			<input type="checkbox"/> YES <input type="checkbox"/> NO 2nd ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Completes SOAP narrative portion of incident response form					
PRINT EVALUATOR'S NAME		EVALUATOR'S SIGNATURE		EVALUATOR ID #	
IF NO EXPLAIN					

