

## Telemetry Skills Checklist

Name:  Date:  Experience Since:

**Please indicate your experience with the following patient care areas, equipment and procedures.**

	Comfortable With	Done Occasionally	No Experience
<b>Cardiovascular</b>			
Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure / Non-invasive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse / Circulation Checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Interpretation of Labs</b>			
Cardiac Enzymes & Isoenzymes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Assist With:</b>			
Central Line Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatic Internal Cardioverter Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatic External Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Monitoring</b>			
Arrhythmia Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lead Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhythm Strip Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>			
External	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological:</b>			
Glasgow Coma Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflex Motor Deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual or Communication Deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Care of the patient with:</b>			
CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DT's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications: - Inderal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- AquaMephton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Kayexelate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Lactulose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Renal / Genitourinary</b>			
Assessment of A/V Fistula/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Fluid Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation of BUN & Creatinine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: Date: 

	Comfortable With	Done Occasionally	No Experience
Insertion & Care of Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supra-pubic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient w/: Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Acute Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Nephrectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Nephrectomy Tube Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- TURP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Urinary Diversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Care of the patient with:</b>			
A.A.A. Repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute M.I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Tamponade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EP Study & Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Commissurotomy, Valve Repair, Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Percutaneous BalloonValvuloplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Rotoblade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre / Post Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre / Post Cardiac Cath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medications:</b>			
Amiodarone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atropine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bretylium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digoxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diltiazem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dobutamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dopamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epinephrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metoprolol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procainamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TPA (Aleptase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine / Metabolic:</b>			
Interpretation of Blood Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Drug Overdose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Wound Management:</b>			
Assess for Skin Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess for Stasis Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess Surgical Wound Healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Comfortable With	Done Occasionally	No Experience
Perform Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform Wound Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient w/ - Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Decubitus Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Surgical Wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Phlebotomy / I.V. Therapy</b>			
Administration of: Cryoprecipitate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
: Packed RBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
: Plasma / Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of Whole Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Draw from Central Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Draw of Venous Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Start I.V. Angiocath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Start I.V. Butterfly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Start Heparin Lock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient w/ - Broviac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Groshong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Hickman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Portacath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Peripheral Line Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pain Management:</b>			
Assessment of Pain Level /Tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient w/ - Epidural Anesthesia / Analgesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- IV Conscious Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Patient Controlled Analgesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Signature

\_\_\_\_\_  
Date

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Agency Representative Signature

\_\_\_\_\_  
Date