Health Science Career Technology

EMT-Basic Course

Spring, 2009

This Packet Belongs To

_____

If Found Contact Jim McKee, LP at 903.880.6125

EMS Internship Documentation Form

Name: _____

Address: _____

Social Security Number _____

Location: _____

☐ EMT-B ☐ EMT-I ☐ EMT-P

Use separate form for Ambulance and Hospital Internship

☐ Clinical Site or ☐ Ambulance Internship Site

A. _____

B. _____

C. _____

School Number: _____

Coordinator: _____

Clinical Area/Site	Date	Time In	Time Out	Number Of Hours	Description of Patient Management	Staff Signature

Total Hours This Sheet: _____ Total Hours All Sheets:_____ Coordinator's Signature: _____

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Trinity Valley Community College EMS Program ~ Ambulance Internship Evaluation

Student Name: _____ EMS Unit/Station: _____ Date: _____

During ambulance internship, the student shall practice under the supervision of an Ambulance crew member.
Please evaluate each skill performed by the student according to the legend below.
Please mark all evaluations "n/a" if the skill was not attempted.
Evaluations of less than "2" require an explanation on the back of this form.
PLEASE FEEL FREE TO MAKE ANY COMMENTS CONCERNING THE STUDENT ON THE BACK OF THIS FORM.

ALL LEVELS			
Area of Evaluation	**# of Skills**	**Evaluation**	**Comments**
Professionalism		1 2 3 4 N/A	
Professionalism Appearance		1 2 3 4 N/A	
Initiative		1 2 3 4 N/A	
Overall Attitude		1 2 3 4 N/A	
Infection Control		1 2 3 4 N/A	
Interaction with Patient		1 2 3 4 N/A	
Interaction with Crew/Staff		1 2 3 4 N/A	
Scene Survey		1 2 3 4 N/A	
Present History		1 2 3 4 N/A	
Past History		1 2 3 4 N/A	
Vital Signs		1 2 3 4 N/A	
Breath Sounds		1 2 3 4 N/A	
Triage		1 2 3 4 N/A	
Physical Exam		1 2 3 4 N/A	
Control Bleeding		1 2 3 4 N/A	
Bandaging		1 2 3 4 N/A	
Splinting		1 2 3 4 N/A	
Traction Splint		1 2 3 4 N/A	
MAST Trousers		1 2 3 4 N/A	
AED		1 2 3 4 N/A	
CPR		1 2 3 4 N/A	
Bag-Valve-Mask		1 2 3 4 N/A	
Basic Airway Management		1 2 3 4 N/A	
Oxygen Therapy		1 2 3 4 N/A	
Spinal Immobilization		1 2 3 4 N/A	
Medication Administration		1 2 3 4 N/A	
Paramedic Clinical I, II, III			
Peripheral IV Insertion		1 2 3 4 N/A	
IV Piggy Back		1 2 3 4 N/A	
Draw Blood Sample		1 2 3 4 N/A	
Endotrachial Intubation		1 2 3 4 N/A	
IV Medication Administration		1 2 3 4 N/A	
IM Medication Adminstration		1 2 3 4 N/A	
SQ Medication Administration		1 2 3 4 N/A	
EKG Interpretation		1 2 3 4 N/A	
Defibrillation		1 2 3 4 N/A	
Cardioversion		1 2 3 4 N/A	
Pacing		1 2 3 4 N/A	
Needle Decompression		1 2 3 4 N/A	

Average Score: _____

Preceptor Signature: _____ Instructor Signature: _____

Crew Member Signature: _____ Student Signature: _____

Crew Member Name: _____ Date Submitted: _____

Legend:
1 – Rarely meets requirements;
2 – Meets some requirements;
3 – Meets and exceeds some requirements;
4 – Meets and exceeds most requirements;
N/A – Not applicable

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Ambulance Internship Form Date: ____/____/____ Clinical Site_____ Run Number 1 2 3 4 5 Basic / Advanced

Chief Complaint:

Past Medical History:

Allergies

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.):_____

_____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ____ Appropriate ____ Inappropriate

Airway:_____ Breathing:_____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT:_____

BACK: _____

NEURO:_____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

_____

EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

☐ Oral ☐ Nasal Equal B/S: ☐ Yes ☐ No Good Compliance: ☐ Yes ☐ No

Cords Visualized: ☐ Yes ☐ No Tube Size: _____

Reassessment En Route:

_____

_____

Safety Devices:

☐ N/A ☐ None

☐ Airbag ☐ Helmet

☐ Seatbelt / Shoulder

☐ Child Restraints

Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

☐ Passenger ☐ Ejected ☐ Motorcycle ☐ Pedestrian

☐ Electrocution ☐ Burn ☐ GSW ☐ Stab/P ☐ Bicycle

☐ Farm ☐ Crush ☐ Fall _____ ft ☐ Industry

☐ Home ☐ Road / Highway ☐ Other_____

Damage to Vehicle: ☐ N/A

☐ Steering Wheel ☐ Windshield ☐ Rollover

☐ Compartment ☐ Major Damage Exterior

☐ Intrusion ☐ Minor Damage

Care Prior to Arrival?: : ☐ Yes ☐ No ☐ N/A

Provided By: ☐ 1st Responder ☐ Fire ☐ Police

☐ Citizen ☐ Hospital / ED

Type of Aid: ☐ CPR ☐ AED ☐ Splinting

☐ Bleeding Control

GCS / TS:

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

Vitals:

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

Preceptor Signature:_____ Date _____/_____/_____ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date _____/_____/_____

Instructor Signature: _____ Date _____/_____/_____

Ambulance Internship Form Date: ____/____/____ Clinical Site_____ Run Number 1 2 3 4 5 Basic / Advanced

Chief Complaint:

Past Medical History:

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On-going Assessment (Document all findings – positive and pertinent negatives:

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Cords Visualized: ☐ Yes ☐ No Tube Size: _____

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Safety Devices:

☐ N/A ☐ None

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Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

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Damage to Vehicle: ☐ N/A

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Provided By: ☐ 1st Responder ☐ Fire ☐ Police

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☐ Bleeding Control

GCS / TS:

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B/P____/____ P:_____(R I) R:_____ Time_____

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B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

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Preceptor Signature:_____ Date _____/_____/_____ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date _____/_____/_____

Instructor Signature: _____ Date _____/_____/_____

Ambulance Internship Form Date: ____/____/____ Clinical Site_____ Run Number 1 2 3 4 5 Basic / Advanced

Chief Complaint:

Past Medical History:

Allergies

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.):_____

_____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ____ Appropriate ____ Inappropriate

Airway:_____ Breathing:_____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT:_____

BACK: _____

NEURO:_____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

_____

EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

☐ Oral ☐ Nasal Equal B/S: ☐ Yes ☐ No Good Compliance: ☐ Yes ☐ No

Cords Visualized: ☐ Yes ☐ No Tube Size: _____

Reassessment En Route:

_____

_____

Safety Devices:

☐ N/A ☐ None

☐ Airbag ☐ Helmet

☐ Seatbelt / Shoulder

☐ Child Restraints

Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

☐ Passenger ☐ Ejected ☐ Motorcycle ☐ Pedestrian

☐ Electrocution ☐ Burn ☐ GSW ☐ Stab/P ☐ Bicycle

☐ Farm ☐ Crush ☐ Fall _____ ft ☐ Industry

☐ Home ☐ Road / Highway ☐ Other_____

Damage to Vehicle: ☐ N/A

☐ Steering Wheel ☐ Windshield ☐ Rollover

☐ Compartment ☐ Major Damage Exterior

☐ Intrusion ☐ Minor Damage

Care Prior to Arrival?: : ☐ Yes ☐ No ☐ N/A

Provided By: ☐ 1st Responder ☐ Fire ☐ Police

☐ Citizen ☐ Hospital / ED

Type of Aid: ☐ CPR ☐ AED ☐ Splinting

☐ Bleeding Control

GCS / TS:

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

Vitals:

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

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Chief Complaint:

Past Medical History:

Allergies

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Airway:_____ Breathing:_____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

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PELVIS: _____

UPPER EXT: _____

LOWER EXT:_____

BACK: _____

NEURO:_____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

_____

EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

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☐ Oral ☐ Nasal Equal B/S: ☐ Yes ☐ No Good Compliance: ☐ Yes ☐ No

Cords Visualized: ☐ Yes ☐ No Tube Size: _____

Reassessment En Route:

_____

_____

Safety Devices:

☐ N/A ☐ None

☐ Airbag ☐ Helmet

☐ Seatbelt / Shoulder

☐ Child Restraints

Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

☐ Passenger ☐ Ejected ☐ Motorcycle ☐ Pedestrian

☐ Electrocution ☐ Burn ☐ GSW ☐ Stab/P ☐ Bicycle

☐ Farm ☐ Crush ☐ Fall _____ ft ☐ Industry

☐ Home ☐ Road / Highway ☐ Other_____

Damage to Vehicle: ☐ N/A

☐ Steering Wheel ☐ Windshield ☐ Rollover

☐ Compartment ☐ Major Damage Exterior

☐ Intrusion ☐ Minor Damage

Care Prior to Arrival?: : ☐ Yes ☐ No ☐ N/A

Provided By: ☐ 1st Responder ☐ Fire ☐ Police

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Type of Aid: ☐ CPR ☐ AED ☐ Splinting

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GCS / TS:

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

Vitals:

B/P____/____ P:_____(R I) R:_____ Time_____

B/P____/____ P:_____(R I) R:_____ Time_____

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Chief Complaint:

Past Medical History:

Allergies

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ASSESSMENT: _____

TREATMENT: _____

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EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
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☐ Oral ☐ Nasal Equal B/S: ☐ Yes ☐ No Good Compliance: ☐ Yes ☐ No

Cords Visualized: ☐ Yes ☐ No Tube Size: _____

Reassessment En Route:

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Safety Devices:

☐ N/A ☐ None

☐ Airbag ☐ Helmet

☐ Seatbelt / Shoulder

☐ Child Restraints

Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

☐ Passenger ☐ Ejected ☐ Motorcycle ☐ Pedestrian

☐ Electrocution ☐ Burn ☐ GSW ☐ Stab/P ☐ Bicycle

☐ Farm ☐ Crush ☐ Fall _____ ft ☐ Industry

☐ Home ☐ Road / Highway ☐ Other_____

Damage to Vehicle: ☐ N/A

☐ Steering Wheel ☐ Windshield ☐ Rollover

☐ Compartment ☐ Major Damage Exterior

☐ Intrusion ☐ Minor Damage

Care Prior to Arrival?: : ☐ Yes ☐ No ☐ N/A

Provided By: ☐ 1st Responder ☐ Fire ☐ Police

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Type of Aid: ☐ CPR ☐ AED ☐ Splinting

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GCS / TS:

GCS_____ TS_____ Time_____

GCS_____ TS_____ Time_____

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Vitals:

B/P____/____ P:_____(R I) R:_____ Time_____

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Past Medical History:

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ASSESSMENT: _____

TREATMENT: _____

_____

EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
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☐ N/A ☐ None

☐ Airbag ☐ Helmet

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Mechanism of Injury: ☐ N/A ☐ Auto ☐ Driver

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Damage to Vehicle: ☐ N/A

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ASSESSMENT: _____

TREATMENT: _____

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EKG MONITORING: Rhythm:_____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
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