HOSPITAL ROTATION FORMS

THESE FORMS ARE TO BE COMPLETED WHEN YOU ATTEND YOUR HOSPITAL ROTATION.

FAUQUIER CO. DEPT OF FIRE, RESCUE, & EMERGENCY SERVICES
TRAINING AND LOGISTICS DIVISION
210 HOSPITAL DRIVE, SUITE 100
WARRENTON, VA 20186
(540) 347-6930

EMT-ENHANCED CLINICAL/FIELD ROTATION SUMMARY REPORT

STUDENT INFORMATION:
NAME: _____ DATE: _____

UNIT: _____ # HOURS: _____ PRECEPTOR: _____

COMPETENCIES:	REQUIRED:	TOTAL THIS ROTATION:
SKILLS		
MEDICATION ADMINISTRATION	15	
ORAL INTUBATION	0	
IV ACCESS	10	
VENTILATE NON-INTUBATED PATIENT		
ADULT ASSESSMENT	12	
PEDIATRIC ASSESSMENT	5	
GERIATRIC ASSESSMENT	5	
TRAUMA ASSESSMENT	5	
PSYCHIATRIC ASSESSMENT	2	
CHEST PAIN ASSESSMENT	5	
RESPIRATORY/DYSPNEA ASSESSMENT	5	
ABDOMINAL COMPLAINTS ASSESSMENT	5	
ALTERED MENTAL STATUS	5	
TEAM LEADER ON EMS UNIT	5	

*****PRECEPTORS: PLEASE DO NOT LEAVE ANY BOXES EMPTY. IF AN ITEM WAS NOT COMPLETED DURING THE ROTATION, PLEASE WRITE "NONE" IN THE BOX AND INITIAL.****

STUDENT SIGNATURE: _____

PRECEPTOR SIGNATURE: _____

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(540) 422-8811

PATIENT HISTORY & PHYSICAL EXAMINATION FORM

STUDENT'S NAME _____ PRECEPTOR'S NAME _____ DATE _____

TEAM LEADER Y N TYPE OF CALL: _____

PATIENT INFORMATION:

AGE: _____ SEX: _____ RACE: _____ WEIGHT: _____

S: _____

A: _____

M: _____

P: _____

L: _____

E: _____

VITAL SIGNS ASSESSMENT:

TIME:	AVPU:	GCS:	RESP.	PULSE:	B/P:	SKIN:	PUPILS:	SaO2	GLUCOSE:	EKG (ATTACH STRIP TO SHEET)

TREATMENT:

IV ATTEMPT	TIME:	OBS/PERF	SUCCESSFUL?	LOCATION:	SIZE:	BLOOD DRAWN?:	FLUID TYPE:	RATE:

OXYGEN THERAPY:	TIME:	OBS/PERF:	TYPE OF DEVICE:	FLOW RATE:	EFFECTS ON PATIENT:

AIRWAY ADJUNCTS:	TIME:	OBS/PERF:	DEVICE/PROCEDURE:	LEVEL OF DIFFICULTY:	EFFECTS ON PATIENT:

INTUBATION ATTEMPTS:	TIME:	OBS/PERF:	ROUTE:	METHOD:	SIZE:	SUCCESSFUL?:	METHOD OF CONFIRMATION:

TREATMENT:

CRICOTHYRODOTOMY	TIME:	OBS/ PERF	SURGICAL/NEEDLE	TUBE SIZE:	SUCCESSFUL?	COMMENTS:

CHEST DECOMPRESSION	TIME:	OBS/PERF:	LOCATION:	NEEDLE SIZE:	SUCCESSFUL?	COMMENTS:

MEDICATION ADMINISTRATION:	TIME:	OBS/PERF:	MEDICATION:	DOSE:	ROUTE:	EFFECT:

DEFIBRILLATION CARDIOVERSION PACING	TIME:	OBS/PERF:	RHYTHM TREATED:	ENERGY:	RATE: (PACING)	RESULTING RHYTHM:

OTHER INTERVENTIONS:	TIME:	OBS/PERF:	ADDITIONAL INFORMATION:	RESULT OF INTERVENTION:	COMMENTS:

NARRATIVE:

STUDENT SIGNATURE: _____

FTO SIGNATURE: _____