

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_

**INSTRUCTIONS**

Please provide accurate answers so we can correctly match your abilities to our client job requirements. Please check the level of experience and expertise you have in each skill category, using the following scale:

**#1 = Familiar with procedure but will usually or almost always require some assistance.**

**#2 = Competent and familiar with procedure:** I can perform this procedure with excellence, usually without assistance.

**#3 = Very competent:** I have at least 12 months experience and can perform this procedure with excellence and without assistance.

**NOTE:** Leave blank any procedures which you have **no experience, training or low competence.**

SKILLS:	1	2	3
<b>Renal/Genitourinary (GU)</b>			
1. Assessment of Renal/GU System			
2. Insertion of foley			
<b>3. Care of the patient with:</b>			
Nephrostomy tube			
AV Fistula/ AV Graft			
Tunneled/ Non-Tunneled Catheter			
Ileal Conduit			
Supra-Pubic Catheter			
Chronic Renal Failure			
Acute Renal Failure			
Nephrectomy			
TURP			
Peritoneal Dialysis			
Hemodialysis			
<b>Hemodialysis Skills/Procedures</b>			
<b>1. Experience</b>			
Acute / Inpatient Dialysis			
Chronic/ Outpatient Dialysis			
Dialysis Home Care			
Pediatric Dialysis			
Pedialysis in Nursing Assessment			
Teaching the Dialysis Patient & Family			
<b>2. Set Up/ Initiate Dialysis</b>			
Bicarbonate Dialysate			
Conductivity Testing			
Priming Dialyzer			
Checks for Machine/ Alarm Settings			
Prep Vascular Acces			
Fistula Gortex/ Bovine Graft			

SKILLS:	1	2	3
Dialysis			
Collect Blood Specimens			
Anitcoagulation			
<b>3. Assess Patient &amp; Equipment During Dialysis</b>			
Systems Assessment of Patient			
Volume Status			
Vascular Access Function			
Arterial and Venous Pressures			
Blood Flow Rate			
Subjective Response to Treatment			
Management of Anticoagulation			
Conductivity			
Ultrafiltration Calculation			
Operation of Myron L Meter			
Administration of Mannitol			
Sequential Ultrafiltration/PUF			
Documentation of Dialysis Treatment			
<b>4. Management of the Patient With</b>			
Fluid Overload			
Hypertension			
Hypotension			
Disequilibrium syndrome			
Hyperkalemia			
Seizures			
Muscle Cramps			
Clotted access/ poor blood flow rate from catheter			
Pyrogenic Reaction			
Hemolysis			
Air embolus			
Chest pain			

<b>SKILLS:</b>	<b>1</b>	<b>2</b>	<b>3</b>
Anemia			
Neuropathy			
Pericarditis			
Filter blood leak			
Cardiopulmonary arrest			
<b>5. Machine Alarm Troubleshooting Procedures</b>			
Blood leak alarm			
Arterial pressure alarm			
Venous pressure alarm			
Conductivity alarm			
Ultrafiltration alarm			
High temperature alarm			
Air/foam detector alarm			
Power failure alarm			
Blood pump alarm			
<b>6. Discontinue Dialysis</b>			
Dialysis catheter			
Fistula/vein graft			
Return of blood			
Post treatment access care			
Equipment clean up			
Sterilization procedures			
<b>Age Specific Practice Criteria</b>			
Newborn/Neonate (birth - 30 days)			
Infant (30 days - 1 yr)			
Toddler (1 - 3 yrs)			
Preschooler (3 - 5 yrs)			
School age children (5 - 12 yrs)			
Adolescents (12 -18 yrs)			
Young Adults (18-39 yrs)			
Middle Adults (39 - 64 yrs)			
Older Adults (64+ yrs)			
<b>Care of patient with:</b>			
Able to adapt care to incorporate normal growth and development.			
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.			

<b>SKILLS:</b>	<b>1</b>	<b>2</b>	<b>3</b>
Can ensure a safe environment reflecting specific needs of various groups.			
<b>My experience is primarily in:</b>			
Medical			
Coronary Care			
Surgical			
Neuro			
Trauma			
Burn			
Cardiothoracic			
PACU			
Cardiovascular			
Other:			

Please check the boxes below and indicate the expiration date for each certificate that you hold. If you do not know the exact date, please use the last date of the specific month (e.g., 05/31/2003).

<b>Certification</b>	<b>Expiration Date</b>
<input type="checkbox"/> Arrhythmia	
<input type="checkbox"/> Critical Care	
<input type="checkbox"/> Computerized charting system	
<input type="checkbox"/> Medication administration	
<input type="checkbox"/> ACLS	
<input type="checkbox"/> BCLS	
<input type="checkbox"/> BTLS	
<input type="checkbox"/> CCRN	
<input type="checkbox"/> CNRN	
<input type="checkbox"/> TNCC	
<input type="checkbox"/> Other:	

**Certification:**

I hereby certify all statements and claims as true and that any misrepresentation of the facts on this skills checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

Full Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Retyped name acts as signature, if submitting form by email

Reviewed by \_\_\_\_\_ : Date: \_\_\_\_\_