

## Neonatal Intensive Care Unit Skills Checklist

Level of Proficiency:

- 1. Can function independently**
- 2. Experienced but may need review**
- 3. Limited or no experience**

By accurately filling out this checklist, you will help us match your skills and interest with available assignments. Please select the button in the column that best describes your experience level with each skill.

<b>ASSESSMENT SKILLS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>O2 THERAPY (cont.)</b>	<b>1</b>	<b>2</b>	<b>3</b>
Gestational Age/ Dubowitz Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal CPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apgar scoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bag/Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest tube care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Dimensions/landmarks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Utilization of Emerson Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Utilization of:			
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transcutaneous monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bp2000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bear Cub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infant Star	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Secrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>EXCHANGE TRANSFUSION</b>			
Hip Click	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Set up and use of equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ISOLETTE CARE</b>				Assessment of baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Utilization of Air Shields	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recording of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IISC Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VITAL SIGNS</b>			
Maintenance of Neutral Thermal Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RADIANT WARMERS</b>				BP-Dynamap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Model types used Type:				Intra-arterial/HP Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization of air shields	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breath Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ISC Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MEDICATIONS</b>				Other Monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Emergency Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SUCTIONING</b>			
Administration of IM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral/Nasal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endo-Tracheal Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV THERAPY</b>				DeLee/Mucaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administer Blood/Blood Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOUND CARE</b>			
Utilization of infusion pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cord care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harvard <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IVAC Control pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>TUBE CARE</b>			
IVAC Syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gavage/Lavage Feedings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collect Core Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest tube insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperal procedures		<input type="checkbox"/>	<input type="checkbox"/>	Chest tube maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp Vein Needle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEEDING</b>			
				Nipple/Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Umbilical Artery/Vein Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OGT/Insertion and Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Set-Up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continuous feed OGT/Intermittent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OGT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drawing ABGs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast milk collection/storage/ baby at breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>O2 THERAPY</b>							
Oxyhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infant stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humidification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infant destimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPAP Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Utilization of Bilimeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest PT/Neonatal Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phototherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_