Clinical Packet

Clinical Packet Assigned To:

EMT Student Name: _______________________________ ID# ___________
Course Section Number: ________ Semester: __________ Year: __________

Updated: 01/2020
**PATIENT ASSESSMENT**

1. Evaluate the ill or injured patient  
2. Obtain diagnostic signs to include, but not limited to:  
   a. respiratory rate  
   b. pulse rate  
   c. skin signs  
   d. blood pressure  
   e. level of consciousness  
   f. pupil status  
   g. pain  
   h. pulse oximetry (if available)

**TRAUMA CARE**

1. Provide initial prehospital emergency trauma care including, but not limited to:  
   a. tourniquets for bleeding control  
   b. hemostatic dressings  
   (State EMSA approved dressings only)  
   c. extremity splints  
   d. traction splints

2. Use spinal motion restriction devices

**ASSIST PATIENTS WITH PRESCRIBED EMERGENCY MEDICATIONS**

1. Assist patients with the administration of their physician-prescribed emergency devices and medications to include but not limited to:  
   a. Sublingual nitroglycerin  
   b. Aspirin  
   c. Bronchodilator inhaler or nebulizer  
   d. Epinephrine device (autoinjector)  
   e. Patient-operated medication pump

**PATIENT TRANSPORT AND MONITORING BY AN APPROVED EMS PROVIDER**

1. Transport and monitor patients in the prehospital setting and/or during an inter-facility transfer by an approved EMS Provider (Fire Department or a licensed Los Angeles County Ambulance Provider)  
2. Transport patients with one or more of the following medical devices:  
   a. nasogastric (NG)  
   b. orogastric tube (OG)  
   c. gastrostomy tube (GT)  
   d. saline/heparin lock  
   e. foley catheter  
   f. tracheostomy tube  
   g. ventricular assist device (VAD)  
   h. surgical drain(s)  
   i. medication patches  
   j. indwelling vascular lines  
    i. pre-existing vascular access device (PVAD)  
    ii. peripherally inserted central catheter (PICC)  
   k. patient-operated medication pump

3. Monitor, maintain at a preset rate or turn off if necessary, the following intravenous (IV) fluids:  
   a. glucose solutions  
   b. isotonic balanced salt solutions (normal saline)  
   c. ringer’s lactate

**ADDITIONAL THERAPIES REQUIRING APPROVAL BY THE LA COUNTY EMS AGENCY**

EMS Providers (Fire Department or a licensed Los Angeles County Ambulance Provider) may apply for approval of select additional therapies and medications

Authority: California Code of Regulations, Title 22, Section 100063
EMT Student Field Performance Evaluation
(To be completed by Ambulance Preceptor)

Student: _____________________________  Preceptor: ____________________________  Date: __________

1. EMT student documented at least ten (10) patient contacts
   YES  NO

2. EMT student conducted themselves professionally and maturely
   YES  NO

3. EMT student arrived in uniform (including watch and stethoscope)
   YES  NO

4. EMT student arrived on time
   YES  NO

5. EMT student completed full clinical experience (12 hours)
   YES  NO

6. Comments: ___________________________________________________________________________
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Student Signature: _______________________________________________________________________________   Date: ___________________

Preceptor Signature: ______________________________________________________  Date: ___________________
Ambulance Preceptor Evaluation
(To be completed by EMT Student)

Student: _____________________________  Preceptor: ____________________________  Date: __________

1. Preceptor served as an advocate and role model    YES  NO
2. Preceptor helped make the transition from the classroom to the field    YES  NO
3. Preceptor supervised during the clinical experience    YES  NO
4. Preceptor oriented candidate to all applicable company policies    YES  NO
5. Preceptor oriented candidate to all applicable equipment    YES  NO
6. Preceptor helped practice assessment/therapeutic communication skills    YES  NO
7. Preceptor provided alternative experiences if patient volume was low    YES  NO
8. Preceptor completed the Candidates Clinical Evaluation    YES  NO
9. Preceptor provided constructive feedback and positive reinforcement    YES  NO

10. Describe your experience:  _______________________________________________________________
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Student Signature: _______________________________________________________________________________   Date: ___________________
EMT Student Field Performance Evaluation
(To be completed by Hospital Preceptor)

Student: _____________________________  Preceptor: ____________________________  Date: __________

1. EMT student documented at least ten (10) patient contacts   YES  NO
2. EMT student conducted themselves professionally and maturely   YES  NO
3. EMT student arrived in uniform (including watch and stethoscope)   YES  NO
4. EMT student arrived on time   YES  NO
5. EMT student completed full clinical experience (12 hours)   YES  NO

6. Comments: ___________________________________________________________________________
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Student Signature: _______________________________________________________________________________   Date: ___________________

Preceptor Signature: ______________________________________________________  Date: ___________________
Hospital Preceptor Evaluation
(To be completed by EMT Student)

1. Preceptor served as an advocate and role model
   YES  NO
2. Preceptor helped make the transition from the classroom to the field
   YES  NO
3. Preceptor supervised during the clinical experience
   YES  NO
4. Preceptor oriented candidate to all applicable company policies
   YES  NO
5. Preceptor oriented candidate to all applicable equipment
   YES  NO
6. Preceptor helped practice assessment/therapeutic communication skills
   YES  NO
7. Preceptor provided alternative experiences if patient volume was low
   YES  NO
8. Preceptor completed the Candidates Clinical Evaluation
   YES  NO
9. Preceptor provided constructive feedback and positive reinforcement
   YES  NO

10. Describe your experience:

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Student Signature: ________________________________________________ Date: ____________
ECC EMT Student Patient Summary Form  
(Must completely document 10 patient interactions below)

EMT Student Name: ___________________________ Course Section: _________ Year: _________

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