



NEONATAL INTENSIVE CARE SKILLS CHECKLIST

- 1 = No Experience
 2 = Perform infrequently (would require some supervision)
 3 = Able to perform without any supervision

Name: _____

Date: _____

	1	2	3
General			
Gestational Assessment			
Physical Assessment			
Assessment of Heart Sounds			
Assessment of Lung Sounds			
TPR (Temp/Pulse/Resp)			
Blood Pressure			
Intra-Arterial Monitor			
Cardiac Monitor			
Transcutaneous Monitor			
Use of Various Ventilators			
Oxyhood			
Bag/Mask			
Infant CPR			
Ambubagging by Hand During Infant CPR			
Suctioning - Oral			
Suctioning - Nasal			
CPAP Application			
Humidification			
Chest PT/Neonatal Procedure			
Utilization of Bilimeter			
Phototherapy			
Infant Stimulation			
Infant Destimulation			

	1	2	3
Oral/Nipple Feeding			
OGT/Insertion and Feeding			
Continuous OGT Feed			
Intermittent OGT			
Breast Milk Collection/Storage			
Baby at Breast			
Drawing Blood Samples for ABG's			
Working Knowledge of Neonate Lab Values			
Documentation of all Infant Reactions			
Responses to any Therapy/Medication			
Administration and Monitoring of Blood & Blood Products			
Care of Infant With:			
Respiratory Distress Syndrome			
Chest Tubes			
Hypothermia			
Colostomy			
Ileostomy			
Prematurity			
Perforation Sepsis			
Vessel Occlusion			
Hemorrhage			
Patent Ductus Arteriosus			
Tetrology of Fallot			

NEONATAL INTENSIVE CARE SKILLS CHECKLIST

	1	2	3
Utilization of Radiant Warmers			
Utilization of Air-Shields			
Maintenance of Neutral-Thermal Environment			
Administration & Monitoring of Medications Given:			
Oral			
IM			
IV			
SP			
Initiating and Maintaining IV Therapy			
Use of Infusion Pumps			
Use of IVAC Control Pumps			
Use of IVAC Syringe			

	1	2	3
Tracheal-Esophageal Fistula			
AIDS			
Hyperthermia			
Knowledge of Infectious Disease			
Precautions			
Providing Family Teaching Regarding Infant's Treatment & Progress			
Assessment of Family Emotional Needs & Appropriate Intervention Needed			
Infant Death			
Assisting Family with Grieving Process			
Charting Within the Legal Aspects of Law			
Charge Nurse Experience			
Team Leader Experience			

NUMBER OF YEARS EXPERIENCE:

NICU _____ **NURSERY** _____

CERTIFICATIONS:

CPR _____ **EXP DATE:** _____

NRP _____ **EXP DATE:** _____

NALS _____ **EXP DATE :** _____

OTHER _____ **EXP DATE:** _____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Premier Nursing Service to release this list to its client health care facilities.

Signature Date

Authentication By Agency:

DON Signature Date