

DETROIT EAST MEDICAL CONTROL AUTHORITY

PARAMEDIC EVALUATION FORM FOR SERVICE ENDORSEMENT

GOALS & OBJECTIVES:

The goal of the physician shadow time is to establish whether or not the paramedic possesses a minimum competency to function within DEMCA. This is NOT intended to be a time for primary education, although we encourage discussion and education as it fits the clinical context. The paramedic is expected to have working knowledge of DEMCA protocols and be able to apply them in the clinical setting. We also expect them to be able to take a focused history and physical and communicate their findings in an organized way to other healthcare providers.

SITE CONTACTS:

Detroit Receiving Hospital

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Henry Ford Hospital

Dr. Howard Klausner-hklausner@gmail.com

Sinai-Grace Hospital

Dr. Erin Brennan-sghem@wayne.edu

St John Hospital

Evan Pile-Evan.Pile@ascension.org

Information

| | | | |
|-----------------------|--|-----------------------|--|
| Paramedic Name | | Date | |
| Agency | | Physician Name | |

Evaluation

| | Performs Consistently | Does Not Perform Consistently | N/A |
|--|--|--|--------------------------|
| Patient Assessment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Elicits a focused chief complaint, history of present illness and pertinent past medical history including medications.</i> | | | |
| Differential Diagnosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Develops a list of 1-2 life threatening diagnoses.</i> | | | |
| Protocol Identification | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Identifies the appropriate DEMCA protocol to utilize for patient treatment.</i> | | | |
| Intervention Identification | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Identifies the appropriate major interventions as indicated by DEMCA protocol.</i> | | | |
| Communication Skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Concisely summarizes patient information in an oral presentation.</i> | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overall Assessment | <i>Recommended for Service Endorsement</i> | <i>NOT Recommended for Service Endorsement</i> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |

Comments

Verification of Review

| | | | |
|----------------------------|--|-------------|--|
| Physician Signature | | Date | |
|----------------------------|--|-------------|--|