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**OPERATING ROOM NURSE PROFICIENCY SKILLS CHECKLIST**

**Please accurately complete the following checklist. After printing your name and the date, please write the appropriate letter (C, S, B, or N) in the column that best describes your experience level with each skill.**

**EXPERIENCE** **EXPERIENCE LEVELS**

C = Circulate 1 Perform without assistance

S = Scrub 2 Require some assistance

B = Both 3 Require considerable assistance

N = Neither 4 No experience

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL SURGERY** | **1** | **2** | **3** | **4** | **ORTHOPAEDIC** | **1** | **2** | **3** | **4** |
| A.P. Resection |  |  |  |  | Amputation of limb |  |  |  |  |
| Adrenalectomy |  |  |  |  | Arthroscopy |  |  |  |  |
| Bowel Resection |  |  |  |  | Appl. external fix. |  |  |  |  |
| Cholecystectomy (open) |  |  |  |  | Hip replacement |  |  |  |  |
| Cholecystectomy (lap) |  |  |  |  | ORIF of fractures |  |  |  |  |
| Gastrectomy |  |  |  |  | Spinal fusion |  |  |  |  |
| Herniorrohaphy |  |  |  |  | Insertion Spinal Rods |  |  |  |  |
| Stripping Varicose Veins |  |  |  |  | **NEUROSURGERY** | **1** | **2** | **3** | **4** |
| Splenectomy |  |  |  |  | Burr Holes |  |  |  |  |
| Thyroidectomy |  |  |  |  | Craniotomy |  |  |  |  |
| Tracheostomy |  |  |  |  | Laminectomy |  |  |  |  |
|  |  |  |  |  | Shunt procedures |  |  |  |  |
| **GYNECOLOGY** | **1** | **2** | **3** | **4** | **PLASTICS** | **1** | **2** | **3** | **4** |
| Caesarean Section |  |  |  |  | Reduction Mammoplasty |  |  |  |  |
| D & C |  |  |  |  | Rhinoplasty |  |  |  |  |
| Hysterectomy (abdo) |  |  |  |  | Scar Revisions |  |  |  |  |
| Hysterectomy (vag) |  |  |  |  | Skin grafts |  |  |  |  |
| Laparoscopy |  |  |  |  |  |  |  |  |  |
| Tubal reconstruction |  |  |  |  |  |  |  |  |  |
| **G.U.** | 1 | 2 | 3 | 4 | **OPTHALMIC** | **1** | **2** | **3** | **4** |
| Circumcision |  |  |  |  | Cataract extr. |  |  |  |  |
| Cystectomy |  |  |  |  | Corneal transplant |  |  |  |  |
| Nephrectomy |  |  |  |  | Enucleation |  |  |  |  |
| Prostatectomy (open) |  |  |  |  | I.O.L. Implants |  |  |  |  |
| Ureterolithotomy |  |  |  |  | Vitrectomy |  |  |  |  |
| T.U.R.P. |  |  |  |  |  |  |  |  |  |
| Vasectomy |  |  |  |  |  |  |  |  |  |
| **E.N.T.** | **1** | **2** | **3** | **4** | **THORACIC** | **1** | **2** | **3** | **4** |
| Caldwell Luc |  |  |  |  | Chest Tube Insertion |  |  |  |  |
| Laryngectomy |  |  |  |  | Hiatal Hernia |  |  |  |  |
| Mastoidectomy |  |  |  |  | Lobectomy |  |  |  |  |
| Radical Neck |  |  |  |  | Pneumectomy |  |  |  |  |
| Ts and As |  |  |  |  |  |  |  |  |  |
| **CARDIO-VASCULAR** | **1** | **2** | **3** | **4** | **ENDOSCOPY** | **1** | **2** | **3** | **4** |
| A-V Fistula |  |  |  |  | Bronchoscopy |  |  |  |  |
| Aortic graft |  |  |  |  | Gastroscopy |  |  |  |  |
| Aorto-fem. graft |  |  |  |  | Colonoscopy |  |  |  |  |
| Fem. Pop. Bypass |  |  |  |  | Hysteroscopy |  |  |  |  |
| In situ fem. graft |  |  |  |  |  |  |  |  |  |
| Pacemaker insertion |  |  |  |  | **ANAESTHETICS** | **1** | **2** | **3** | **4** |
| Endarterectomy |  |  |  |  | Familiar with Boyles |  |  |  |  |
| Embolectomy |  |  |  |  | Machine |  |  |  |  |
|  |  |  |  |  | Arterial / CVP set up |  |  |  |  |

**Please indicate the number of years experience in each:**

Circulate \_\_\_\_\_\_ Scrub \_\_\_\_\_\_ Adult \_\_\_\_\_\_ Pediatric \_\_\_\_\_\_ Both \_\_\_\_\_\_

Additional Skills: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Qualifications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Personal Objections to:**

Therapeutic Abortions:\_\_\_\_\_Yes \_\_\_\_\_\_No

Salpingectomies: \_\_\_\_\_Yes \_\_\_\_\_\_No

Others (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_