University of Kansas Respiratory Care Education

Shadow Documentation and Summary Form

Note: this form is not required of Degree-Completion Program applicants with valid RRT or CRT credential

Name ____ SS# ________________________________

Facility ____

____
City State Zip

Date of Observation _____________________________ # Hours Observed __________________________

Please check below the type of patient/setting/procedure you observed. If your observation was a different nature, please Describe it in the comment section below.

Type of Patient Observed:

______ Adult

______ Child/Adolescent

______ Geriatric

Type of Setting Observed:

______ Inpatient Acute

______ Outpatient

______ School

______ Rehab (in/out patient)

______ Residential Care

Procedures Observed:

______ Routine Therapeutic Procedures

______ Adult Ventilator Management

______ Chest Physiotherapy

______ EKG's

______ Pulmonary Functions

______ Arterial Blood Gases/Arterial Line

______ Pediatric Experience

______ Neonatal Experience

______ Airway Management

______ CPR

Summary of Observation Experience:

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Signature of Registered Respiratory Therapist observed: ______________________________________

Date: ______________________________________

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Student Name: ____

Health Care Facility: ____

Date(s) of observation: ____

Total Hours of observation: ____

Signature of RT observed: ____Date: _______________________

STUDENT:

In the space provided, please summarize your observation experience. Include procedures or examinations seen, types of patients seen, and your personal reaction(s) to this observation experience (utilize back of sheet, also, if necessary).

Student signature: ____ Date: _______________