



Instructor Slate DCS Field Evaluation



Student Name: _____ **Date:** **Activity Start** _____

Diver (and / or Buddy) Interview

Check One: Air Nitros. Trimix _____ O2%

Any unusual events?		Entanglement
<input type="checkbox"/> Out-of-Air Emergency		Significant Over-Exertion
<input type="checkbox"/> Equipment Malfunction		Loose of Buoyancy Control
<input type="checkbox"/> Buddy Separation		Rapid Ascent
<input type="checkbox"/> Other:		

Any Prior History of DCS? No. Yes (if yes, explain)

Any Other Medical Issues? No. Yes (if yes, explain)

Signs and Symptoms of DCS

<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Hearing Disturbances
<input type="checkbox"/> Tingling or Numbness	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Joint or Limb Pain	<input type="checkbox"/> Slurred Speech
<input type="checkbox"/> Back or Abdominal Pain	<input type="checkbox"/> Distressed Breathing
<input type="checkbox"/> Chest Pain or Discomfort	<input type="checkbox"/> Severe Coughing
<input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Blood or Froth in Mouth
<input type="checkbox"/> Loss of Muscle Strength	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Unconsciousness
<input type="checkbox"/> Disorientating	<input type="checkbox"/> Cardiac Arrest
<input type="checkbox"/> Neck Swelling	<input type="checkbox"/> Rapid or Erratic Pulse
<input type="checkbox"/> Abnormal Sounding Voice	<input type="checkbox"/> Signs of Shock

First Aid for Suspected DCS

<input type="checkbox"/> Administer Oxygen	
<input type="checkbox"/> EMS / Medical Attention	<input type="checkbox"/> Monitor Patient
<input type="checkbox"/> Patient Laying Down (left side)	<input type="checkbox"/> Treat for Shock
<input type="checkbox"/> Provide Fluids (if conscious)	<input type="checkbox"/> CPR when appropriate

5 Minute Field Neurological Evaluation Form

This field neurological exam should be conducted immediately whenever DCS is suspected, and then repeated periodically if medical attention is delayed; record all observations, and note time.

- Look for deviation from the expected norm
- Look for differences, one side versus the other
- Look for any changes over time

Orientation	Ask patient his/her name, age, the location, date, and / or approximate time of day; evaluate overall alertness.
Eyes	Ask patient track your moving finger, evaluate uniform and fluid movement of eyes; also check pupil size and reaction to light; inquire about blurred vision or other visual disturbances.
Forehead	Check sensation, in response to touch; ask patient to raise and lower eyebrows, evaluate uniform movement
Face	Ask patient to whistle, smile and / or clench teeth, evaluate uniform movement, and check for equal tension in jaw muscles.
Ears	With patient's eyes closed, rub your fingers together and determine distance from each ear that patient hears this sound; inquire about ringing in ears or other hearing disturbances.
Gag Reflex	Ask patient to swallow , observe movement of Adam's apple and / or neck muscles, watch for any difficulty.
Tongue	Ask patient to stick out tongue, watch for any drooping or one-sided tendency.
Shoulders	Check sensation, in response to touch; ask patient to raise shoulders against resistance, compare muscle strength.
Arms & Hands	Check sensation, in response to touch, ask patient to move arms against resistance and also ask patient to squeeze your hands, compare muscle strength.
Chest	Check sensation, in response to touch; observe general breathing pattern, and inquire about any difficulty or discomfort
Legs	Check sensation, in response to touch, ask patient to move legs against resistance, compare muscle strength.
Heel-to-toe-Walk	Observe patient's balance and coordination (use caution, or omit this exercise completely, on a moving boat).

Student Signature: _____ Date: Course End _____