



Echocardiography Skills Checklist

Name _____ Date _____

Years of Experience - Adult _____ Pediatric _____ Combined _____

Signature: _____

Please rate your experience / frequency (within the last year) using the following scale (check the appropriate boxes below):

Experience Scale:

- 0 - No Experience / Theory Only
- 1 - Limited Experience / Need Review
- 2 - Frequent Experience / May Need Some Review
- 3 - Experienced / Perform Well

Frequency Scale:

- 0 - Observed Only / Never Done
- 1 - Rarely Done (<6 times/year)
- 2 - Occasionally Done (1-2 times/month)
- 3 - Frequently Done (daily or weekly)

Experience Frequency

ADULT ECHOCARDIOGRAPHY

2-D	0	1	2	3	0	1	2	3
M-Mode	0	1	2	3	0	1	2	3
Pulsed Wave Doppler	0	1	2	3	0	1	2	3
Continuous Wave Doppler	0	1	2	3	0	1	2	3
Color Doppler	0	1	2	3	0	1	2	3
Pied Off Probe	0	1	2	3	0	1	2	3

PEDIATRIC ECHOCARDIOGRAPHY

2-D	0	1	2	3	0	1	2	3
M-Mode	0	1	2	3	0	1	2	3
Pulsed Wave Doppler	0	1	2	3	0	1	2	3
Continuous Wave Doppler	0	1	2	3	0	1	2	3
Color Doppler	0	1	2	3	0	1	2	3
Pied Off Probe	0	1	2	3	0	1	2	3

STRESS ECHOCARDIOGRAPHY

Exercise	0	1	2	3	0	1	2	3
Pharmacological	0	1	2	3	0	1	2	3
Other:					0	1	2	3
Other:					0	1	2	3
Stress EKG with Treadmill Testing	0	1	2	3	0	1	2	3
Dobutamine Stress Echocardiography	0	1	2	3	0	1	2	3
2-D	0	1	2	3	0	1	2	3
Pulsed Wave Doppler	0	1	2	3	0	1	2	3
Continuous Wave Doppler	0	1	2	3	0	1	2	3
Color Doppler	0	1	2	3	0	1	2	3
Pied Off Probe	0	1	2	3	0	1	2	3