HHP 321 COMPETENCIES/PROFICIENCIES INSTRUCTED (I) AND EVALUATED (E)

DIAGNOSIS

DI-C8	Describe the nature of diagnostic tests of the neurological function of cranial nerves, spinal nerves, and peripheral nerves using myotomes, dermatomes, and reflexes. (I, E)
DI-C9	Assess neurological status, including cranial nerve function, myotomes, dermatomes and reflexes, and circulatory status. (I, E)
DI-P2	Perform inspection/observation of the clinical signs associated with common injuries including deformity, posturing and guarding, edema/swelling, hemarthrosis, and discoloration. (I, E)
DI-P4	Palpate the bones and soft tissues to determine normal or pathological characteristics. (I, E)
DI-P7	Apply appropriate stress tests for ligamentous or capsular stability, soft tissue and muscle, and fractures. (I, E)
DI-P8	Apply appropriate special tests for injuries to the specific areas of the body as listed above. (I, E)
DI-P9	Assess neurological status, including cranial nerve function, myotomes, dermatomes and reflexes, and circulatory status. (I, E)
DI-CP1	Demonstrate a musculoskeletal assessment of upper extremity, lower extremity, head/face, and spine (including the ribs) for the purpose of identifying (a) common acquired or congenital risk factors that would predispose the patient to injury and (b) a musculoskeletal injury. This will include identification and recommendations for the correction of acquired or congenital risk factors for injury. At the conclusion of the assessment, the student will diagnose the patient's condition and determine and apply immediate treatment and/or referral in the management of the condition. Effective lines of communication should be established to elicit and convey information about the patient's status. While maintaining patient confidentiality, all aspects of the assessment should be documented using standardized record-keeping methods.
DI-CP1.1	Foot and Toes (E)
DI-CP1.2	Ankle (E)
DI-CP1.3	Lower Leg (E)
DI-CP1.4	Knee (tibiofemoral and patellofemoral) (E)
DI-CP1.5	Thigh (E)
DI-CP1.6	Hip/Pelvis/Sacroiliac Joint (E)
DI-CP1.7	Lumbar Spine (E)
DI-CP1.8	Thoracic Spine (E)
DI-CP1.9	Ribs (E)
DI-CP1.10	Cervical Spine (E)
DI-CP1.11	Shoulder Girdle (E)
DI-CP1.12	Upper Arm (E)
DI-CP1.13	Elbow (E)
DI-CP1.14	Forearm (E)
DI-CP1.15	Wrist (E)
DI-CP1.16	Hand, Fingers & Thumb (E)
DI-CP1.17	Head and Face (E)
DI-CP1.18	Temporomandibular Joint (E)

MEDICAL CONDITIONS

MC-C4	Describe and know when to refer common eye pathologies from trauma and/or localized infection (e.g., conjunctivitis, hyphema, corneal injury, stye, scleral trauma). (I, E)
MC-C5	Describe and know when refer common ear pathologies from trauma and/or localized infection (e.g., otitis, ruptured tympanic membrane, impacted cerumen). (I, E)
MC-C6	Describe and know when to refer common pathologies of the mouth, sinus, oropharynx, and nasopharynx from trauma and/or localized infection (e.g., gingivitis, sinusitis, laryngitis, tonsillitis, pharyngitis). (I, E)
MC-C17	Describe and know when to refer common neurological medical disorders from trauma, anoxia, drug toxicity, infection, and congenital malformation (e.g., concussion, postconcussion syndrome, second-impact syndrome, subdural and epidural hematoma, epilepsy, seizure, convulsion disorder, meningitis, spina bifida, cerebral palsy, chronic regional pain syndrome [CRPS], cerebral aneurysm). (I, E)
MC-C21	Describe and know when to refer common injuries or conditions of the teeth (e.g., fractures, dislocations, caries). (I, E)
MC-P3	Palpate the bones and soft tissues, including the abdomen, to determine normal or pathological characteristics. (I, E)
MC-CP1	Demonstrate a general and specific (e.g., head, torso and abdomen) assessment for the purpose of (a) screening and referral of common medical conditions, (b) treating those conditions as appropriate, and (c) when appropriate, determining a patient's readiness for physical activity. Effective lines of communication should be established to elicit and convey information about the patient's status and the treatment program. While maintaining confidentiality, all aspects of the assessment, treatment, and determination for activity should be documented using standardized record-keeping methods.
MC-CP1.1	Derma (E)
MC-CP1.2	Head, including the Brain (E)
MC-CP1.3	Face, including the Maxillofacial Region (E)
MC-CP1.4	Thorax, including the heart and lungs (E)
MC-CP1.5	Abdomen, including the abdominal organs, the renal and urogenital systems (E)
MC-CP1.6	Eyes (E)
MC-CP1.7	Ear, Nose, and Throat (E)

ACUTE CARE

AC-C19	Identify the signs and symptoms of head trauma, including loss of consciousness, changes in standardized neurological function, cranial nerve assessment, and other symptoms that indicate underlying trauma. (I, E)
AC-C21	Define cerebral concussion, list the signs and symptoms of concussions, identify the methods for determining the neurocognitive status of a patient who sustains a concussion and describe contemporary concepts for the management and return-to-participation of a patient who sustains a concussion. (I, E)
AC-C22	Identify the signs and symptoms of trauma to the cervical, thoracic and lumbar spines, the spinal cord, and spinal nerve roots, including neurological signs, referred symptoms, and other symptoms that indicate underlying trauma and pathology. (I, E)
AC-P2	Perform an initial assessment to assess the following, but not limited to:
AC-P2d	Level of consciousness (I, E)

EXERCISE

EX-P1	Assess a patient to determine specific therapeutic exercise indications, contraindications, and precautions. (I, E)