



# MABAS DIVISIONS 4 & 5 SRT

## Dive Checklist / Rapid Field Neuro (Water Rescue & Recovery)

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

### DIVE CHECKLIST

Diver Name: \_\_\_\_\_ Department: \_\_\_\_\_

Tender: \_\_\_\_\_ Dive No: \_\_\_\_\_

- Hood
- Full Face Mask
- Drysuit Zipped
- Harness/Carabineer/Shackle
- Buoyancy Compensator
- Regulator
- Depth Gauge/Pressure Gauge
- Octopus/Alternate Air
- Compass
- Gloves
- 2 Cutting Tools
- Weight System \_\_\_\_\_ lbs.
- Ankle Weights
- Fins
- Review Objectives
- Establish Initial Pattern
- Review Found Object Protocol
- Comm. Check/Review Line Signals
- Review Diver in Distress Protocol
- Review Emergency Procedures

Starting Tank Pressure (PSI): \_\_\_\_\_

Start Dive Time: \_\_\_\_\_

Max. Depth for Dive: \_\_\_\_\_

Tank Pressure: \_\_\_\_\_ PSI 5 Minutes

Tank Pressure: \_\_\_\_\_ PSI \_\_\_\_\_ Minutes

Tank Pressure: \_\_\_\_\_ PSI \_\_\_\_\_ Minutes

Ending Tank Pressure: \_\_\_\_\_

End Dive Time: \_\_\_\_\_

Max. Depth: \_\_\_\_\_

Total Dive Time: \_\_\_\_\_

Rapid Field Neuro Exam:  Pos  Neg

\_\_\_\_\_  
Tender Signature

\_\_\_\_\_  
Dive Supervisor Signature

Additional Notes/Observations:



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### RAPID FIELD NEURO

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

		PRE-DIVE		POST-DIVE	
<b>MENTAL STATUS</b> (Does the Diver Know...)	Their Name	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Where They Are	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Time of Day	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Most Recent Activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Speech is Clear & Correct	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>SIGHT</b>	Correctly Counts Fingers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Vision is Clear	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>EYE MOVEMENTS</b>	Move All 4 Directions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nystagmus Absent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Teeth Clench, OK	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>FACIAL MOVEMENTS</b>	Able to Wrinkle Forehead	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Tongue Moves in All 4 Directions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Smile Symmetrical	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>HEAD/SHOULDER MOVEMENTS</b>	Swallow / "Adams's Apple" Moves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Shoulder Shrug Normal, Equal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Head Movements Normal, Equal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>HEARING</b>	Normal for the Diver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Equal in Both Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>SENSATIONS</b> (Present, Normal & Symmetrical)	Face	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Abdomen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Arms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Buttocks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>MUSCLE TONE</b> (Present, Normal & Symmetrical)	Arms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hand Grips	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>BALANCE &amp; COORDINATION</b>	Romberg, OK?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heel/Shin Side, OK?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Alternating Hand Movements, OK?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>VITAL SIGNS</b>	B/P _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pulse/Respirations _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No