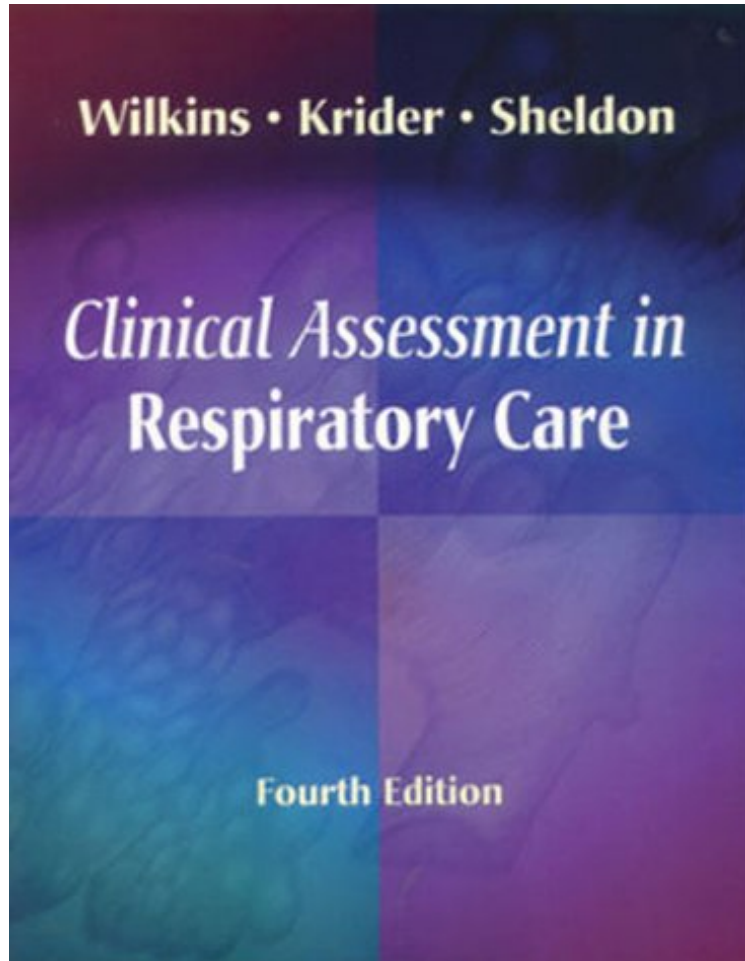


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## Clinical Assessment in Respiratory Care, 4e

*Robert L. Wilkins PhD RRT FAARC, Susan Jones Krider RN MS, Richard L. Sheldon MD FACP FCCP*  
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This thoroughly revised and updated classical text teaches assessment techniques from the most basic skills for the student learning the process of patient care, to the more advanced skills for the student or practitioner involved with patients in the intensive care unit. An entirely new section teaches students and practitioners the skills necessary to record patient cases using the SOAP format (Subjective, Objective, Assessment, Plan). An extremely useful and versatile Instructors Manual and Test Bank replaces the Quick Reference Guide, allowing instructors to customise their approach to assessment.Covers the basics of patient assessment from the first encounter, including how to

initially approach, interview, monitor, and examine the patient in a professional and sensitive manner. Teaches the student to recognize basic and life ECG patterns that may occur in the cardiopulmonary patient. Discusses the unique situations that apply to neonatal and pediatric patients, differences in assessment, and how to document the young patient's history and interpret test results. Covers monitoring patients with sleep-related breathing disorders by discussing normal sleep patterns and the causes and effects of some of the more common sleep disorders, such as sleep apnea. Includes learning objectives, outlines, overviews, summaries, and outstanding review questions in each chapter. Covers special assessment techniques for caring for the adult patient, including reducing communication barriers, the effects of vision and hearing loss on assessment, age-related structural and physiological changes, and specific diagnostic tests. Features a new chapter describing the use of the fiberoptic bronchoscope, including important technical aspects, complications, risks, patient preparation, and some of the most frequent indications for use. Uses case studies to address how respiratory therapists should document the patient history and physical examination using the SOAP (Subjective, Objective, Assessment, Plan) format as they develop a care plan for their patients. Incorporates Simply Stated boxes to summarize key points, so students can easily identify and locate the most important information. Provides an Instructors Manual/Test Bank with valuable suggestions on effectively using the text within a curriculum, and includes a ready selection of test questions. Free with qualified adoptions.