QIC ACADIAN AMBULANCE PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. Which of the following conditions is among those where the closest hospital is the definitive care hospital?

A. Stroke

B. Seizure

C. Fractured ankle

D. Cardiac arrest

2. Which item is included in the Standardized Call Report items?

A. Last Set of VS & Trends Noted, including ETCO2, SPO2, and CBG

B. Patient's dietary preferences

C. Weather conditions at scene

D. Computing time of arrival

3. A definitive care hospital for non-traumatic pediatric patients is a hospital with what capability?

A. 24/7 PICU/NICU capabilities

B. Pediatric ER staffed 24/7

C. Pediatric ICU only

D. 24/7 PICU/NICU capabilities

4. Which of the following is a trauma secondary finding (status 2)?

A. Laceration to scalp

B. Contusion to thigh

C. Pelvic fracture

D. Fracture of the clavicle with no neuro compromise

5. In field management of postpartum hemorrhage when possible, which step is essential?

A. Establish airway and breathing, secure IV access, monitor vitals, and provide rapid transport per protocol; uterine massage if directed.

B. Immediately transport without starting IV or airway management to save time.

C. Only perform uterine massage; no airway or IV.

D. Withhold airway management unless speech is impaired.

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6. What is the primary reason for airway patency in prehospital care?

A. To ensure adequate oxygenation and ventilation.

B. To expedite transport with minimal on-scene time.

C. To minimize suctioning.

D. To avoid using oxygen.

7. Which scenario is a DOA criterion?

A. Pulse present and stable

B. Underwater submersion >60 minutes

C. Rigor mortis absent

D. Decapitation or gross dismemberment

8. What is the correct EMS approach when delivery occurs en route or at scene?

A. Delay delivery until arrival of an obstetrician

B. Prepare for delivery, maintain warmth, support the head, assess APGAR, dry and stimulate, clamp and cut umbilical cord when appropriate, and transport

C. Administer labor-inducing medications

D. Move the patient to hospital and perform delivery there only

9. Scene time goal for status 1 patients?

A. Less than 7 minutes

B. Less than 9 minutes

C. Less than 12 minutes

D. Less than 10 minutes

10. When a patient regains decision-making capacity during EMS transport, clinicians should:

A. Continue treatment without consent

B. Stop all treatment

C. Obtain informed consent for ongoing treatment

D. Seek consent from legal guardians only

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Answers

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1. D
2. A
3. D
4. C
5. A
6. A
7. D
8. B
9. D
10. C

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Explanations

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1. Which of the following conditions is among those where the closest hospital is the definitive care hospital?

A. Stroke

B. Seizure

C. Fractured ankle

D. Cardiac arrest

In this scenario, the key idea is that some emergencies are time-critical and require rapid, life-saving actions right away. Cardiac arrest demands immediate CPR and defibrillation, so the fastest route to advanced care is to get to the nearest emergency department. Once circulation is restored, the patient can receive definitive post-arrest care at the hospital, but every minute counts during the arrest, making the closest hospital the best initial destination. Other conditions have different pathways: stroke often benefits from going to a stroke-center with specialized neuroimaging and treatments; seizures and fractures aren't treated primarily by rushing to a single type of center, so they don't rely on the closest hospital as the definitive care facility.

2. Which item is included in the Standardized Call Report items?

A. Last Set of VS & Trends Noted, including ETCO2, SPO2, and CBG

B. Patient's dietary preferences

C. Weather conditions at scene

D. Computing time of arrival

In standardized EMS Call Reports, documenting objective patient data that stays consistent across handoffs is essential. The most important item among these options is the last set of vital signs and trends, including ETCO2, SpO2, and capillary blood glucose. This snapshot captures how the patient's ventilation, oxygenation, and metabolic status are doing at the end of field care, and it provides a clear reference for the receiving clinician and for quality review. ETCO2 reflects ventilation and perfusion status and is especially valuable when airway management or respiratory issues are involved; SpO2 shows how well the patient is oxygenating; and CBG gives a quick measure of blood glucose, which can influence treatment decisions. The other options aren't standard vital-data elements: dietary preferences aren't routinely documented in the call report, weather conditions at the scene aren't typically a standardized data field, and while time of arrival can be recorded, it isn't part of the vital-signs-and-trends section that this item emphasizes.

3. A definitive care hospital for non-traumatic pediatric patients is a hospital with what capability?

A. 24/7 PICU/NICU capabilities

B. Pediatric ER staffed 24/7

C. Pediatric ICU only

D. 24/7 PICU/NICU capabilities

Providing definitive care for non-traumatic pediatric patients means the hospital can deliver comprehensive, ongoing treatment without needing to transfer the child for first-line or definitive care. The essential capability is continuous access to pediatric intensive care and neonatal intensive care units (PICU and NICU). This pairing covers the full pediatric range—from newborns needing neonatal support to older children requiring critical care—with appropriate equipment, monitoring, and specialized staff. A hospital that only has a 24/7 pediatric ER can stabilize a child but may not provide the advanced, ongoing critical care needed for definitive treatment. Similarly, having just a PICU or just a NICU doesn't cover all age groups and conditions. Therefore, a hospital with 24/7 PICU/NICU capabilities is the definitive care facility for non-traumatic pediatric patients.

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4. Which of the following is a trauma secondary finding (status 2)?

A. Laceration to scalp

B. Contusion to thigh

C. Pelvic fracture

D. Fracture of the clavicle with no neuro compromise

The idea being tested is how injuries found during the secondary survey are classified by severity. In trauma care, the primary survey handles life-threatening problems right away, while the secondary survey looks for additional injuries that aren't immediately life-threatening but still require urgent attention. A status 2 secondary finding is a significant injury that suggests potential complications (like hidden blood loss or instability) and needs prompt evaluation and transport, even though it isn't an immediate airway, breathing, or massive circulation threat. A pelvic fracture fits this well. It isn't usually something you treat at once to save the airway or stop an obvious bleed, but it signals a high risk of serious internal bleeding, pelvic instability, and injury to surrounding organs. That combination makes it a classic status 2 finding: important, potentially deteriorating, and requiring rapid but not emergent life-saving action. The other options tend to be either minor or less likely to indicate hidden, life-threatening consequences. A scalp laceration is a superficial wound, a thigh contusion is a soft-tissue injury, and a clavicle fracture without neuro compromise, while painful and requiring immobilization, does not on its own imply the same level of internal risk as a pelvic fracture.

5. In field management of postpartum hemorrhage when possible, which step is essential?

A. Establish airway and breathing, secure IV access, monitor vitals, and provide rapid transport per protocol; uterine massage if directed.

B. Immediately transport without starting IV or airway management to save time.

C. Only perform uterine massage; no airway or IV.

D. Withhold airway management unless speech is impaired.

The key idea is to stabilize the patient first. In field management of postpartum hemorrhage, the priority is to ensure the patient is making it to a facility safely while you address life-sustaining needs. This means securing the airway and ensuring adequate breathing so the patient doesn't become hypoxic, establishing IV access to start fluids or medications, and continuously monitoring vital signs to detect deterioration early. At the same time, initiating rapid transport per protocol gets the patient to definitive care as quickly as possible. Uterine massage is included when directed because a boggy uterus is a common source of postpartum bleeding, and manual massage helps stimulate uterine contraction to help control bleed locally. Having these steps in place—airway/breathing support, IV access, monitoring, and expedited transport—provides both immediate stabilization and a path to definitive treatment, which is essential in PPH. Why not delay these steps? Skipping airway or IV access or delaying transport wastes critical time and can allow shock to worsen. Focusing only on uterine massage without maintaining airway and IV access leaves the patient vulnerable to rapid deterioration, and delaying airway management until speech issues appear is unsafe, as airway compromise can occur before any speech changes.

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6. What is the primary reason for airway patency in prehospital care?

A. To ensure adequate oxygenation and ventilation.

B. To expedite transport with minimal on-scene time.

C. To minimize suctioning.

D. To avoid using oxygen.

Keeping the airway open is essential because it allows air to move into and out of the lungs, enabling oxygen to reach the bloodstream and carbon dioxide to be expelled. In the prehospital setting, this immediate ability to oxygenate and ventilate the patient is the foundation of life-saving care, as hypoxia and rising CO2 can quickly lead to deterioration. Other options miss the point: rapid transport is important, but it doesn't replace the need for a clear airway; suctioning is a tool to help, not the primary aim of airway patency; and avoiding oxygen would remove the very support that airway patency is meant to enable.

7. Which scenario is a DOA criterion?

A. Pulse present and stable

B. Underwater submersion >60 minutes

C. Rigor mortis absent

D. Decapitation or gross dismemberment

In preventing futile resuscitation, a DOA criterion is an obvious, irreversible end to life where continuing efforts aren't appropriate. Decapitation or gross dismemberment is the clearest example: the injury is so catastrophic that life cannot be restored, and initiating or continuing resuscitation would be futile. The other scenarios don't definitively prove death in the field. A pulse that's present and stable means the person is alive and needs care. Prolonged underwater submersion has a very poor prognosis and may lead to death, but it does not by itself automatically declare DOA in all protocols. Absence of rigor mortis isn't a reliable standalone death indicator, since postmortem changes vary and can be inconsistent.

8. What is the correct EMS approach when delivery occurs en route or at scene?

A. Delay delivery until arrival of an obstetrician

B. Prepare for delivery, maintain warmth, support the head, assess APGAR, dry and stimulate, clamp and cut umbilical cord when appropriate, and transport

C. Administer labor-inducing medications

D. Move the patient to hospital and perform delivery there only

Deliveries that happen in the field call for immediate, hands on care to support a safe birth and protect the newborn while arranging rapid transport. The best approach is to prepare for delivery, keep the mother and baby warm, and gently guide the birth as it occurs. As the head crowns, support it without pulling, and clear the airway if needed. After the birth, dry the baby, stimulate breathing if necessary, and maintain warmth to prevent hypothermia. Assess the newborn with APGAR to quickly gauge how well it's adapting and to decide if further resuscitation is needed. Clamp and cut the umbilical cord after the baby is born and per protocol, typically once initial circulation is established and there is no urgent need to delay transport. Throughout, monitor both mother and baby, manage any bleeding, and transport promptly with ongoing care to a facility equipped for delivery.

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9. Scene time goal for status 1 patients?

A. Less than 7 minutes

B. Less than 9 minutes

C. Less than 12 minutes

D. Less than 10 minutes

The main idea is to minimize time spent on scene for a status 1 patient, who needs immediate life-saving care. Because the patient is in a life-threatening condition, the EMS approach prioritizes rapid assessment, essential stabilization, and quick transport to definitive care. A scene time target of under 10 minutes is used because it provides a realistic, achievable goal that still allows critical actions—airway management, hemorrhage control, monitoring, and rapid transport decision—without unnecessary delay. Times shorter than 10 minutes (like under 7 or under 9) can be impractical in many situations; a limit of under 12 minutes is too slow for the most critical cases. Therefore, aiming for less than 10 minutes best balances the need for prompt care with the realities of on-scene stabilization.

10. When a patient regains decision-making capacity during EMS transport, clinicians should:

A. Continue treatment without consent

B. Stop all treatment

C. Obtain informed consent for ongoing treatment

D. Seek consent from legal guardians only

When a patient regains decision-making capacity, they regain the right to decide about their own care and must authorize any ongoing treatment through informed consent. Informed consent means clearly explaining what treatment is being proposed, the risks and benefits, available alternatives, and what happens if they choose not to proceed, then obtaining the patient's voluntary agreement. If they consent, you continue care; if they refuse, you must respect their decision and adjust care accordingly. Guardians or surrogates are involved only when the patient cannot make decisions themselves, not when the patient is capable.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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