PROCEDURAL/SURGICAL PROCTOR/PRECEPTOR EVALUATION FORM

Practitioner's Name: ____________________________________

Clinical Service: ____________________________________

Procedure/Surgery Performed at: (circle): **ASC** **BGMC** **DMH** **MFS** **WCHOB**

Date of Procedure/Surgery: ____/____/____

Procedure/Surgery:

Medical Record Number: ____________________

Start Time: ___________ Duration of Surgery/Procedure: ________hours_______minutes

EVALUATION:

Please evaluate each item with a letter choice. A comment is required if you indicate I, B or N:

I = Improvement needed **B = Borderline (additional training needed)** **N = Not competent**
C = Competent (meets standards) **E = Excels (high level performance)** **NA = Not Applicable**

Medical Expertise:

___Followed appropriate selection criteria for patient and procedure: ___________________________
____

___Performed a comprehensive pre-operative evaluation: ___________________________
appropriate for the specific procedure and patient: ___________________________
____

___Adequately prepared patient and procedural/surgical site: ___________________________
____
____

Technical Expertise:

___Demonstrated familiarity with instrumentation/dexterity: ___________________________
____

___Demonstrated appropriate procedural/surgical skills: ___________________________
____

___Tissue manipulation: ___________________________
____

___Tissue dissection/transection: ___________________________
____

___Suturing: ___________________________
____

Practitioner's Name: ___________________________________

Judgement:

___Demonstrated appropriate clinical judgement: ____________________________
____

___Completed procedure in a safe, expeditious manner: ____________________________
____

___Completed procedure without complications: ____________________________
____

___Detailed a comprehensive post-operative plan; appropriate to patient and procedure: ____________________________
____

CONCLUSION: (Please choose one, use reverse side for additional comments)

Practitioner has demonstrated he/she is technically competent to perform this procedure independently (obtained all C/E for above items) include comments:

Practitioner shows improvement yet more training is needed
(obtained I in above review) include comments/recommendations:

Practitioner has not yet demonstrated he/she is competent to perform this procedure
(obtained B/N in above review) include comments/recommendations:

Proctor's Name: ____________________________________

Signature: ____________________________________ **Date: _____/_____/____**

******A separate form is to be completed after each case.**

Send completed form to: KH Central Verification Office, 1028 Main Street, 3rd Floor, Buffalo, NY 14202, Attn: Barbara Sharples