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