KALEIDA HEALTH

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