PROCEDURAL/SURGICAL PROCTOR/PRECEPTOR EVALUATION FORM

Practitioner's Name: ____________________________________

Clinical Service: _______________________________________

Procedure/Surgery Performed at: (circle): **BGMC DMH MFS OCH KLEIN ROAD ASC SOUTHTOWNS ASC**

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/transsection: __________________________
____

___Suturing: __________________________
____

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: __________________________

Practitioner's Name: ____________________________________

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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 Medical Staff Office, 1028 Main Street – 3rd Floor, Buffalo, NY 14202; Attn: Supervisor/Medical Staff Office