

St. David's South Austin Medical Center
Proctoring Evaluation Form

Please note:

All consents, H&Ps, etc. must be completed according to policy, prior to procedure.

Form to be turned in to Medical Staff Office upon completion.

Section I: To be completed by physician being proctored:

Physician Name, printed: _____

Name of Procedure: _____

Indications for procedure: _____

Date of Procedure: _____

Medical Record Number: _____

Consent Complete? YES NO

Section II: To be completed by proctor:

Assessment of Procedural Skills: Excellent Good Fair Poor

Additional Comments: _____

Assessment of Clinical Judgment: Excellent Good Fair Poor

Additional Comments: _____

Are there appropriate indications for procedure? Yes No (*please explain*): _____

Were there any complications? Yes No (*please explain*): _____

Recommendation for continued proctoring? Yes No (*please explain*): _____

Additional Comments / Recommendations, if any: _____

Completed by: _____ (*proctor printed name*)

Signature of Proctor

Date

Section III To be completed by Medical Staff Office:

Date Received in MSO: _____

Proctored case # _____ of _____ required

Notes: _____