ENLOE MEDICAL CENTER
INVASIVE PROCEDURE PROCTORING FORM

Individual: ___________________________
Proctor: ___________________________
Date of Review: _______________________
Medical Record #: ___________________

Diagnosis: ___________________________

Procedure (if any): ___________________

Direct/Concurrent Review: [ ]
Retrospective Review: [ ]
Setting: [ ] Inpatient [ ] Clinic [ ] Emergency [ ] ICU

You have been requested to proctor this physician to evaluate the quality of care provided. As such, it is your responsibility to report any poor or significant substandard performance made by the physician immediately to the Chair of the Division/Department.

Evaluate in terms of completeness and accuracy:

Acceptable Mariginal (explain) Not Acceptable (explain) N/A

I. PRE-OPERATIVE WORK UP:

H&P is complete/accurate: [ ]

Consent(s) appropriate/signed: [ ]

Lab and X-rays are appropriate: [ ]

Indications for procedure: [ ]

II. INTRAOPERATIVE PHASE:

Surgical/Procedural Technique:

Manual dexterity, approach to procedure: [ ]

Management of any complications: [ ]

SURGICAL JUDGMENT:

Completeness and degree/extent of:

Resections/Procedures; degree to which procedure conforms to accepted practices: [ ]

ACCURACY OF DIAGNOSIS:

Pre-op DX compares with post-op: [ ]

Procedures appropriate to consent signed: [ ]

Procedure justified by the findings: [ ]

III. RETROSPECTIVE OBSERVATIONS:

Operative reports/prognosis notes are appropriate and timely: [ ]

Chart reflects discharge plans, including instructions to the patient: [ ]

Length of stay within accepted standards: [ ]

Complications appropriately documented and managed: [ ]

Procedure was justified by the path reports: [ ]

IV. OVERALL PERFORMANCE:

Interactions with colleagues and staff: [ ]

Appropriate use of consultants: [ ]

Interactions with patient: [ ]

Care provided meets community standards: [ ]

Is there any aspect of this evaluation and treatment with which you are uneasy or uncomfortable (marginal) or unacceptable evaluations? [ ] NO [ ] YES

IF YES, PLEASE EXPLAIN ON REVERSE SIDE OF THIS FORM.

Proctor's Signature ___________________________ Date _______________________
Chair's Signature ___________________________ Date _______________________

A copy of this report may be provided to the individual proctored pursuant to proctoring guidelines.

Supplement #14, June 2005

ENLOE MEDICAL CENTER
NON-INVASIVE PROCEDURE PROCTORING FORM

Individual: ___________________________
Proctor: ___________________________
Date of Review: _______________________
Medical Record #: ___________________

Diagnosis: ___________________________

Procedure (if any): ___________________

Direct/Concurrent Review: [ ]
Retrospective Review: [ ]
Setting: [ ] Inpatient [ ] Clinic [ ] Emergency [ ] ICU

You have been requested to proctor this physician to evaluate the quality of care provided. As such, it is your responsibility to report any poor or significant substandard performance made by the physician immediately to the Chair of the Division/Department.

Evaluate in terms of completeness and accuracy:

Acceptable Mariginal (explain) Not Acceptable (explain) N/A

1. The H&P is complete, accurate and on the chart.
   Comments: ___________________________

2. The diagnosis is consistent with the H&P.
   Comments: ___________________________

3. The orders are appropriate.
   Comments: ___________________________

4. Daily progress evaluations appropriate to clinical findings.
   Comments: ___________________________

5. Consultation is used appropriately.
   Comments: ___________________________

6. Ancillary services are used appropriately.
   Comments: ___________________________

7. Abnormal lab results recognized/followed up.
   Comments: ___________________________

8. Complications managed appropriately.
   Comments: ___________________________

9. Case management is consistent with the problem.
   Comments: ___________________________

10. Drug & Therapeutic regimen meet accepted standards.
    Comments: ___________________________

11. Plans for follow-up are documented.
    Comments: ___________________________

12. Interactions with colleagues and staff.
    Comments: ___________________________

13. Interactions with patient.
    Comments: ___________________________

Is there any aspect of this evaluation and treatment with which you are uneasy or uncomfortable (marginal) or unacceptable evaluations? [ ] NO [ ] YES

IF YES, PLEASE EXPLAIN ON REVERSE SIDE OF THIS FORM.

Proctor's Signature ___________________________ Date _______________________
Chair's Signature ___________________________ Date _______________________

A copy of this report may be provided to the individual proctored pursuant to proctoring guidelines.

Supplement #14, June 2005
**PROCTORING FORM**

**Procedure Performed:**

Was this practitioner the primary operator? _YES_ _NO_

Who will be responsible for post-procedure management?

<table>
<thead>
<tr>
<th>CHECK A BOX FOR EACH RESPONSE:</th>
<th>Acceptable</th>
<th>Unacceptable</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>1. Clinical Indications</td>
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<td>2. Pre - Procedures</td>
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<td>A. Clinical Management</td>
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<td>B. Documentation</td>
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<td>C. Communications (Patient/Family)</td>
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<td>3. Procedure</td>
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<td>A. Approach - Modality and Equipment Selection</td>
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<td>B. Technical Skills</td>
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<td>C. Clinical Management</td>
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<td>D. Documentation</td>
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<td>E. Communication (Technical Staff)</td>
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<td>4. Post - Procedure</td>
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<td>A. Clinical Management</td>
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<td>B. Documentation</td>
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<tr>
<td>C. Communication (Patient/Family)</td>
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<td>5. Complications (if any):</td>
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6. Recommendation:

_ Practitioner satisfactorily performs the procedure.
_ Practitioner could benefit from additional proctoring of such cases.
_ Practitioner should not attempt further procedures like this without additional training.

(Please use back of form for additional comments, if any.)

The next page is 1-49.

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Courtesy of Swedish Medical Center, Seattle, Washington.

1-4:8.2 _MEDICAL STAFF MANAGEMENT_
RADIATION ONCOLOGY PROCTORING FORM

<table>
<thead>
<tr>
<th>Proctor's Name:</th>
<th>Please Print</th>
<th>Surgeon's Name:</th>
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<tbody>
<tr>
<td>Date:</td>
<td>Time:</td>
<td>Hrs.</td>
<td>Chart #:</td>
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<tr>
<td>Pre-Op Diagnosis:</td>
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<tr>
<td>Post-Op Diagnosis:</td>
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<td>Procedure(s) Performed:</td>
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<td><strong>SURGICAL H&amp;P OR CONSULTATION</strong></td>
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<tr>
<td>1. Appropriate and Complete Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>2. Pre-Op Laboratory (Blood, EKG, X-Ray, Etc.) Appropriate [ ] Inappropriate [ ]</td>
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<td>3. Pre-Op Management Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>4. Clinical Judgment Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>5. Surgical Technique Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>6. General Handling of Case Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>7. Demeanor during Case Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>8. Appropriate Consent Documentation (Including GANN Amendment) Yes [ ] No [ ]</td>
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<td>11. Did Pre-Op Diagnosis Coincide with OP Findings? Yes [ ] No [ ]</td>
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<td>12. Appropriateness of Procedure Appropriate [ ] Inappropriate [ ]</td>
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<tr>
<td>13. Complications during Procedure (list):</td>
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<tr>
<td>14. OP Report Reflects OP Findings and Technique? Yes [ ] No [ ]</td>
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<td><strong>POST OPERATIVE CARE</strong></td>
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<tr>
<td>1. Availability Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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<td>2. Appropriateness of Management Satisfactory [ ] Unsatisfactory [ ] Questionable [ ]</td>
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CONCLUSION: Acceptable [ ] Unacceptable [ ] Questionable [ ]
Acceptable with the following recommendation/limitations:

COMMENTS:

Signature of Proctor: ___________________________ Date: ____________
Reviewed by Division Chief: ______________________ Date: ____________
Reviewed by Pediatric Dept. Chair: __________________ Date: ____________

Courtesy of Children's Hospital, San Diego, California.
### Department of Surgery Proctoring Report continued

3. Post-Operative Laboratory (Blood, EKG, X-Ray, etc.)  
   - Appropriate [ ]  
   - Inappropriate [ ]

4. Complications (if any, list):

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5. Adequacy of Record (Chart) Notes  
   - Satisfactory [ ]  
   - Unsatisfactory [ ]  
   - Questionable [ ]

6. Use of Consultants  
   - Satisfactory [ ]  
   - Unsatisfactory [ ]  
   - Questionable [ ]

7. Was Patient Seen At Least Daily?  
   - Yes [ ]  
   - No [ ]

8. Overall Rating  
   - Satisfactory [ ]  
   - Unsatisfactory [ ]  
   - Questionable [ ]

9. Additional Remarks:

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Proctor's Signature __________________________ Date ____________

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### RELEASE OF OBSERVATION REPORTS

I hereby authorize John C. Lincoln Hospital and Health Center and its representatives to release to the following hospital(s) and its representatives, all observation report forms originated at John C. Lincoln Hospital and Health Center which are contained in my credential file.

**LIST HOSPITAL(S):**

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<th>Hospital</th>
<th>Contact Person</th>
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I release from legal liability and hold harmless John C. Lincoln Hospital and Health Center and its representatives from any and all claims, suits, actions, and legal liability by providing the requested reports to the hospital(s) and its representatives listed above.

Physician's Name (please print) __________________________ Date ____________

Physician's Signature __________________________ Date ____________

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- For Medical Staff Services Use Only -

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Courtesy of Cedars-Sinai Medical Center, Los Angeles, California.

Supplement #1, April 1996