Appendix – Forms

DEPARTMENT OF UROLOGY
RESIDENT RESEARCH PROGRESS FORM

Resident Name: Date:_____
PGY-1 Start Date: _____ U-4 completion date: _____
Basic Science Research Mentor:_____
Clinical Research Mentor:_____
Research Title and Brief Description:

U-1 Year: Research Idea Completed (IRB, Funding, Lab, etc.)
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-2 Year: Research Initiated
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-3 Year: Research Project Update: In Progress Completed Meeting Abstract Publication
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-4 Year: Research Project Update: Completed Meeting Abstract Publication
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

DEPARTMENT OF UROLOGY
RESIDENT QUALITY IMPROVEMENT PROGRESS FORM

Resident Name: Date:_____
PGY-1 Start Date: _____ U-4 completion date: _____
Quality Improvement Mentor:_____
QI Project Title and Brief Description:

U-1 Year: QI Idea Completed
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-2 Year: Project Initiated
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-3 Year: Project Update: In Progress, Completed, Meeting, Abstract, Publication.
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

U-4 Year: Project Update: Completed, Meeting, Abstract, Publication,
Mentor Signature: _____ Date:_____
Resident Signature: _____ Date:_____

UTHSCSA Department of Urology
Minor Procedure Verification Log

Residents are required to perform five (5) procedures in the presence of faculty or senior resident before being certified to perform these procedures without direct supervision (progression to independent practice).

Procedure:
- ☐ Cystoscopy
- ☐ Transrectal Ultrasound with Biopsy
- ☐ Circumcision
- ☐ Vasectomy
- ☐ Genital Biopsy
- ☐ Suprapubic Tube Placement
- ☐ Other:

Competency with these procedures is based upon observation of adequate performance with respect to the following:
Patient selection, appropriate indication, pre-procedure evaluation, informed consent process, compliance with patient safety standards (Time-Out, etc), Positioning, Preparation, local anesthesia administration, Performance of the procedure, post procedure communication, treatment planning, continuity of care (follow-up) planning, documentation and coding.

I certify that Dr. _____ has demonstrated competence in all above areas for the procedure indicated.

_____, MD Date: ____/____/_____

_____, MD Date: ____/____/_____

_____, MD Date: ____/____/_____

_____, MD Date: ____/____/_____

_____, MD Date: ____/____/_____

Based upon the above documentation by the teaching faculty at UTHSCSA Department of Urology, I certify that the resident named above is capable of performing the indicated procedure without direct supervision (independent practice).

Joseph W. Basler, PhD, MD _____ Date: ___/___/_____
Program Director

Minor Procedure Verification Worksheet

Resident: _____MD Staff: _____

Date: ___/___/_____ Patient ID:

Procedure:
- ☐ Cystoscopy
- ☐ Transrectal Ultrasound with Biopsy
- ☐ Circumcision
- ☐ Vasectomy
- ☐ Genital Biopsy
- ☐ Suprapubic Tube Placement
- ☐ Other:

Evaluation Criteria:

☐ Patient selection,
☐ Appropriate indication,
☐ Pre-procedure patient evaluation,
☐ Informed consent process,
☐ Compliance with patient safety standards (Time-Out, etc),
☐ Positioning,
☐ Preparation,
☐ Administration of Local anesthesia,
☐ Performance of the procedure,
☐ Post procedure communication,
☐ Treatment planning,
☐ Continuity of care (follow-up) planning,
☐ Documentation
☐ Coding.

Attach a copy of the note from the patient's record (de-identified)

Staff Comments and Recommendations:

I have observed and evaluated the resident who performed this procedure.

Staff Signature: _____

eTOD Reporting Form

UTHSCSA Department of Urology

Date: ___/___/_____

Resident requiring eTOD: _____
Circumstances necessitating request for eTOD:

Category of eTOD: (circle)
1- Continuation of OR, post-op care

2- Continuation of ward, ER, UCC, Consultation care

3- Preparation time for patient care conferences (GU Tumor, Pre-op)

4- Other –

Note: Any '**other'** purpose must be reviewed ***prospectively*** for eligibility by the PD or Department Chair. If denied, resident should go home to complete the non-qualifying activity and in any case will not count subsequent on-site hours against the 80hr week or 10HR.

Chief Resident _____

Signature: _____

Resident: _____

Signature: _____

Attending, Local PD, Dept Chair: _____

Signature: _____

Resident Portfolio Evaluation Checklist

Resident_____ Date_____

Please have your portfolio organized with all documentation in place. **All items in bold print are required!**

How will your portfolio be evaluated?
You will review your portfolio with the program director as part of your semi-annual review. It will be scored according to the following criteria:

Beginning: partial demonstration of required exhibits
Advancing: substantial demonstration of required exhibits
Competent: satisfactory demonstration of required exhibits
Above Competence: outstanding demonstration of required exhibits

Though not a surrogate for the Milestones, you can see that these evaluations dovetail into the Milestones process and may be considered in the overall Milestones evaluation.

Patient Care

____Invasive procedure/case log, up-to-date/ACGME Minimum Numbers
____Rotational faculty evaluations
____Direct observation by faculty of invasive procedures, including obtaining consent, site confirmation, time-out, and advising patients regarding adverse events or outcomes; with faculty evaluation (see form in handbook)
____Blood-borne Pathogens Safety Training Course (UTHSCSA, VA)
____Radiation & Laser Safety Training Course (UTHSCSA, VA)

Medical Knowledge

____In-service examination scores
____Extracurricular Urology conferences, Urology courses, Progression through the AUA Curriculum and Urology self-assessment (SASP) modules.
____Participation in the formal Curriculum including: Presentations (include a copy of all presentations), case discussions (include a brief discussion summary with references and outcomes) and analysis of scientific journal articles with written critique (include copy of articles)
____Research project, including manuscript, exhibit and presentation.

Practice-based Learning & Improvement

____Urology self-assessment modules (e.g. SASP)
____Quality Improvement project, including manuscript, exhibit and presentation.
____Documentation of participation in hospital QI/QA and regulatory activities____Case presentations at conferences: preparation and presentation (include .ppt or other files)
____Participation in interdepartmental Internal Review, with short personal analysis of process. See Program Coordinator for upcoming Internal Reviews.

Interpersonal Communication Skills

____Institutional Core Competencies Sessions (Informed Consent, Conflict Resolution, Crafting Apologies, Delivering Difficult News, etc) with documentation of attendance.
____Multidisciplinary oncology conference; preparation and moderation (show dates and patient lists)
____Direct observation by faculty of invasive procedures, including obtaining consent, site confirmation, time-out, and advising patients regarding adverse events or outcomes; with faculty evaluation.
____Residents as Teachers Course and related activities (UTHSCSA)

Professionalism

____Conference attendance record
____Online modules: "Patient Confidentiality", "Ethics" Include documentation of completion.
____Institutional Core Competencies (Impaired Physicians, HIPPA instruction). Include documentation of attendance.
____U.T. Risk Management Course
____Medicare Compliance Ethics Instruction (CDT certificate)
____Membership & Activity in professional societies

System-based Practice

____Multidisciplinary conference; preparation and moderation (show dates and patient lists)
____Quality Improvement Project - Resident analysis of systems-based problem; with data, solution and implementation, if applicable.
____Billing and Documentation Instruction (CDT certificate)
____ Departmental Planning Retreat (Usually Chief Residents)
____Hospital / school / department committee service
____Participation in interdepartmental Internal Review, with short personal analysis of process. See Program Coordinator for upcoming Internal Reviews.

For reviewer use only:

Overall assessment of progress**:**

Beginning	____
Advancing	____
Competent	____
Above Competence	____

Deficiencies (if applicable) _____
_____
Plan of action _____
_____
_____

Reviewer signature_____Date_____

After signing, copy this entire form and give to resident for inclusion in portfolio.
Keep one copy in departmental file.

*You also have a training file that includes the following components; Demographic Summary, Application Documents, Contracts and Professional Liability Insurance, Credentialing Documents, Record of Training and General Correspondence

**Confidential Evaluations and In-Service Scores are kept separate from either of these files.

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Resident Education Portfolio –
Individual Learning Plan by Resident

This form will be placed in your portfolio as your self directed Individual Learning Plan (ILP). You will complete this annually and make adjustments as you attain each goal.

Name:
PGY Level:
Date:

Goals for current PGY year:
1.
2.
3.

Objectives to reach PGY year goals:
1.
2.
3.

Goals for Urology Residency:
1.
2.
3.

Objectives to reach Urology Residency goals:
1.
2.
3.

In-Service Exam Problem Areas:

Plan of Action to resolve ISE problem areas:

What do you consider to be your strengths?

What do you consider to be your weakness?

What are the threats to your education & career?

What Opportunities lie ahead that should be pursued?

Urology Spot-check Hand-off Form

Observer: _____Date: _____**Time:** _____

Service: __UH, __VA, __SRMC, __Meth, __Peds, __SLB

On Call Resident: _____**Level**: __U-1, __U-2,__U-3,__U-4

	Adequate	**Inadequate**
Could name residents and faculty on-call		
Had information on all inpatients		
Had information on all consults, ER patients		
Index patient query:		
Clarity of index patient presentation		
Clarity of index patient safety concerns		
Clarity of index patient actions required		
Clarity of index patient care plan		
Understanding of rationale behind treatment		

Overall Understanding of the patients.	Poor – unable to articulate or express understanding.	Acceptable – missed a few things but not important issues	Excellent – on top of patient info, details & treatment plan.

Comments:

Urology Observation of Transition Evaluation Form

Observer: _____Date: _____**Time: _____**

Service: __UH, __VA, __SRMC, __Meth, __Peds, __SLB

Check-out Res.: _____**Recipient**: _____

	Adequate	**Inadequate**
Structure		
Clarity of patient presentation		
Clarity of safety concerns		
Clarity of actions that are required		
Clarity of residents and faculty who are on-call		
Clarity of care plan		
Recipient was able to express questions/concerns		

Length	Appropriate	Too Short	Too Long

Comments:

Handbook Receipt Certification

I hereby certify that I have received a copy of the **2016-2017** Edition of the University of Texas Health Science Center Department of Urology Residency Handbook, and have familiarized myself with its content.

_____

Name (please print)

_____

Signature

_____

Date

House Staff Physician's Leave Form

FUNDING: ☐ UHS ☐ VAH ☐ UTHSC ☐ Military ☐ Santa Rosa

NAME: _____
(Last/First/Middle)

DEPARTMENT/DIVISION: Urology

MONTH/YEAR: _____ **ASSIGNED LOCATION**: _____

DAY																															
DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
CODE																															

CODES: V=Vacation S=Sick M=Meeting L=Leave of Absence NC=No Call/No Late Stay RC= Request Call AR=Authorized Rotation O=Other

☐ **MEETING/CONFERENCE/SEMINAR (type and location):**

_____

_____

_____

☐ **AUTHORIZED ROTATION (name and address of facility):**

_____

_____

☐ **OTHER (specify – licensure exam, board exam, jury duty, military reserves and location):**

_____

_____

☐ **LEAVE OF ABSENCE (temporary disability, maternity, personal – accompanied by memo of explanation by Program Director)**

_____

_____ _____

House Staff Physician's Signature and Date Program Director's Signature and Date

_____

University Hospital System Official and Date

DISTRIBUTION: UHS Physician Affairs Office,
UT House Staff Coordinator,
UH or VA Secretary
House Staff Member