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: _______________
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:  ____/____/______
___________________________, 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.
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

<table>
<thead>
<tr>
<th>Could name residents and faculty on-call</th>
<th>Adequate</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had information on all inpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had information on all consults, ER patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Overall Understanding of the patients.</th>
<th>Poor – unable to articulate or express understanding.</th>
<th>Acceptable – missed a few things but not important issues</th>
<th>Excellent – on top of patient info, details &amp; treatment plan.</th>
</tr>
</thead>
</table>

Comments:
# Urology Observation of Transition Evaluation Form

**Observer:** ____________________  **Date:** __________  **Time:** ______________

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

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

<table>
<thead>
<tr>
<th></th>
<th>Adequate</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of patient presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of safety concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of actions that are required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of residents and faculty who</td>
<td></td>
<td></td>
</tr>
<tr>
<td>are on-call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recipient was able to express</td>
<td></td>
<td></td>
</tr>
<tr>
<td>questions/concerns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Length</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate</td>
<td></td>
</tr>
<tr>
<td>Too Short</td>
<td></td>
</tr>
<tr>
<td>Too Long</td>
<td></td>
</tr>
</tbody>
</table>

**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 | 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 |
|-----|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

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