OOH Session Recording and Feedback Form

**GP Trainee Name:**

**GP ES Name:**

**Contact Details for Practice:**

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| **Date of session:** | **Time: Daytime 🞎 Evening 🞎 Overnight 🞎** **Weekday 🞎 Weekend 🞎** |
| **Session activities: (Tick all that apply)****Primary Care Centre 🞎 Visiting Doctor 🞎 Telephone Triage 🞎****Minor Injuries Centre 🞎 Other:** |
| **Name of Supervising Clinician:**  |
| **Level of supervision:****All patients reviewed by Supervising Clinician or joint consulting 🞎****Close supervision, case management discussed when required 🞎****Mainly consulting independently with end debrief 🞎** **Remote (telephone) supervision 🞎** |
| **Debriefing notes from Supervising Clinician:****Signature of Clinical Supervisor ………………………….. Date ……………..** |
| **Communication Box: Educational Supervisor <> Supervising Clinician**  |
| **Cumulative OOH completed by the end of this session:** |  |
| **Curriculum Headings Chosen:** |
| **What did you learn?****Include relevant cases seen and/or significant events (these may or may not be medical) and what you learned from these.****State which capabilities have been demonstrated.** |
| **What will you do differently in future?** |
| **What future learning needs did you identify?** |
| **How will you address these?** |