OOH Session Recording and Feedback Form

**GP Trainee Name:**

**GP ES Name:**

**Contact Details for Practice:**

|  |  |  |
| --- | --- | --- |
| **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?** | | |