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?** |