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?** | | |