

Department of Medical Education
Multan Medical & Dental College



GENERAL SURGERY CLINICAL LOG BOOK

STUDENT INFORMATION

Paste your Picture

Name: _____

Father's Name: _____

Roll No: _____ Class: _____

Address: _____

UHS Enrollment No: _____

UHS Roll No: _____

MULTAN MEDICAL & DENTAL COLLEGE

MISSION STATEMENT

To Produce Professionally Competent, Research Oriented Health Care Providers, Through Modern Medical Education, Meeting the Local And Global Needs And Committed To Serve Humanity

VISION

Working in Consonance with the vision of UHS, the Federal and provincial Health Authorities to groom best quality Medical Professionals by providing the best quality Education based on Modern Teaching Techniques. Also, committed to develop a strong spectrum of research-oriented activities.

Envisaging an example in eliminating Health disparities faced by the different strata of the society by finding their solution through research and execution of Public Health Programs.

OUTCOMES

By the end of (MBBS/BDS) program the graduates of MM&DC will be able to:

1. Perform various basic Medical/Surgical and Dental procedures independently.
2. Demonstrate Knowledge and comprehension of common Medical/Surgical and Dental procedures.
3. Assist in management of Critically ill patient.
4. Manage common non critical conditions Independently.
5. Demonstrate professional, ethical and culturally appropriate behavior.
6. Advocate health promotion and disease prevention.
7. Involve in research programs.
8. **Quality Outcomes:** Develop a habit of reflection, critical thinking and applying the knowledge to reach the level of Creativity.

MESSAGE FROM PRINCIPAL

Prof. Dr. Shabbir Ahmad Nasir

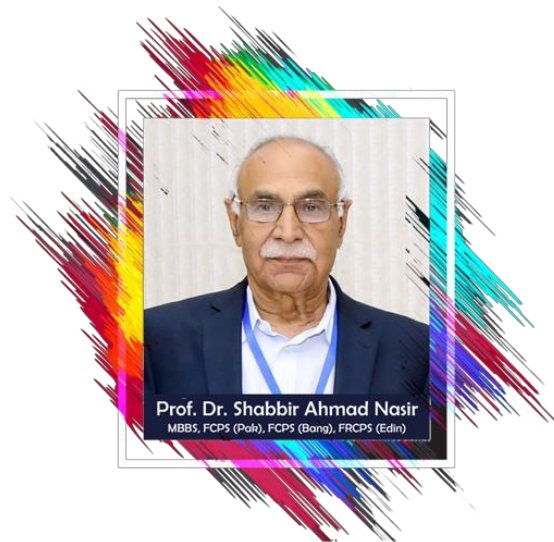
Chief Executive & Principal Multan Medical & Dental College

Avicenna once said “The extraordinary faith put in oneself & in one’s creator, as one takes the very first step for a new journey, shall mark itself as a milestone to one’s eternal glory”. This was my vision and that of my team to provide quality medical education to the students at Multan Medical & Dental College, when we laid the foundation stone of this nascent Alma Mata, seven years ago. This college has come of a small age in terms of years but we feel a genuine pride to see that it is fledgling with powerful wings to embark towards its destination of eternal glory in the field of quality medical education. A journey, which apparently seemed to be less promising at the beginning, has now turned into a story of achievements at every front. It is indeed a matter of immense pleasure to welcome applications for the Seven batch at Multan Medical & Dental College with a mission to impart profound quality medical education.

In consonance with the vision of the Government to extend healthcare to all segments of society and groom the best quality medical professionals, Multan Medical & Dental College has responded positively well to this national cause. We have taken the pledge to keep serving this noble mission and prove our credentials as a beacon so that our nation reposes its full confidence in our commitment to excellence. Besides providing quality education, based on modern teaching techniques, I am sure the college shall also develop a strong spectrum of research-oriented activities. Owing to a top-class faculty, supported by a 600-bedded modern hospital, Ibn-e-Siena Hospital & Research Institute, I am confident that its graduates shall emerge as doctors upholding the highest intellectual, professional & social values.

Institutions are developed through professional acumen and commitment to the cause. My advice to the students & faculty alike is to leave no stone unturned to keep on bringing laurels to themselves and this institution as they have done it in their initial trials. In their endeavors, they shall always find me at their back to provide them a genuine direction and elan to help channel their energies into a glorious outcome.

I wish the best of luck to all those who are associated with this project for the fulfillment of this already being realized dream.



DEPARTMENTS

CLINICAL SCIENCES

- Medicine
- Neurology
- Pulmonology
- Nephrology
- Gastroenterology
- Dermatology
- Surgery
- Orthopedics surgery
- Pediatric surgery
- Neurosurgery
- Plastic Surgery
- Urology surgery
- Thoracic Surgery
- Psychiatry
- Anesthesia
- Pediatrics
- Urology
- ENT
- Obstetrics & Gynecology
- Ophthalmology

Instruction for Log Book Management

1. Write your full name and roll no on the log book.
2. Write on all pages with pen and do not tear any page.
3. Completely fill the patient medical history form & comprehensive examination & treatment plan chart.
4. Get your log book signed by the supervisor on the same day.
5. Write all your daily work in the department indoor patient register.

PREFACE

Purpose of Logbook

The purpose of this logbook is to develop, record, assess and certify student's activities during clinical and other rotations. These desired activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an evidence during assessment of student and evaluation of the overall performance of institution. Record of these activities will ultimately improve patient safety, as the students will be aware of the responsibilities, limits and duties.

Dr. Asad Ali
Head of Department
Medical Education,
Multan Medical & Dental College, Multan

LOGBOOK GUIDE

Rotation in General Surgery is represented into 3 parts; 1st part represents clinical skills and activities like knowledge imparted during rotation and record of history taking and clinical examinations. 2nd part includes attributes of behavior and professionalism. 3rd Part includes assessment. The level of competency is graded and assessed as:

KEY FOR LEVEL CHECKLIST:

O	Observed treatment, been attending treatment
A	Assisted during treatment
B	Beginner, the student fails to perform the treatment correctly without much help and instruction
BL	Beginner/Learner, student needs help and instruction to carry out the treatment
L	Learner, student needs some help and little instruction to carry out the treatment
LC	Learner/Competent, student needs to discuss therapy but can carry out the treatment independently in a competent manner
C	Competent, student can carry out the treatment independently
E	Experienced, student can carry out the treatment independently in a fast and efficient manner

This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year.

GENERAL INFORMATION

The students at the end of the undergraduate training program in the subject of General Surgery, should possess essential knowledge, skills and attitude in order to enable them to:

1. Take comprehensive history, perform detailed physical examination and make a probable diagnosis with a list of differential diagnoses.
2. Devise an investigation plan, interpret the information and apply his knowledge.
3. Suggest a treatment plan for patients.
4. Apprehend and diagnose possible complications.
5. Document all aspects properly and timely.
6. Write and present the cases.
7. Identify medical diseases presenting in out-patients, in-patients and emergency departments.
8. Provide primary health care, at the community level.
9. Perform essential medical emergency and planned procedures.
10. Communicate and counsel effectively with the patient, their families and the community, regarding disease and its relevant issues.
11. Understand medical ethical issues and their application in reference to Internal Medicine.
12. Maintain the confidentiality of the patient.
13. Counsel patients and families regarding common medical problems.
14. Guide the patients and families regarding rehabilitation.
15. Understand the prevalence and prevention of the common Public Health Problems related to Internal Medicine in the community.
16. Understand the principles of medical research including medical writing.
17. Understand the fundamentals of Information Technology and basic computer soft wares.
18. Understands the principles of sterilization and disinfection techniques to prevent infections to the patients and save himself or herself from patients.
19. Be a life-long self-directed learner.
20. Exhibit Professionalism.
21. Competent in Preventive Medicine.

1) Indoor Rotations (Morning Shifts)

Sr.	Date	Patient Initials/ID	Diagnosis	History and Exam Summary	Differential Diagnosis	Management Plan	Supervisor's Signature and Stamp
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

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		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
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8		• Apply Bandage/Splint						
9		• IV Line						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
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What I Need to Improve	
Action Plan	

Signature & Stamp
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Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

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Definial Diagnosis:

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**Signature & Stamp
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General Surgery

Surgical A unit

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(To be filled by the supervisor)

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5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
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What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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Bleeding Disorder _____

Operations _____

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Respiratory System _____

Alimentary _____

Central Nervous System _____

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Pelvic Examination _____

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Definitional Diagnosis:

Investigations:

**Signature & Stamp
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General Surgery

Surgical A unit

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Reflective Practice Record

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Signature & Stamp
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Surgical A unit

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(To be filled by the supervisor)

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U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



IBN-E-SIENA HOSPITAL & RESEARCH INSTITUTE MULTAN

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Tel: 061-6782872-6

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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
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		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
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		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
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9		• IV Line						
10		• CPR						
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12		• Care of Chest Tube						
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14		• Jaw Thrust Maneuver						
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16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
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14		• Jaw Thrust Maneuver						
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16		• Nasopharyngeal Air Way						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor

2) Indoor Rotations (Evening Shifts)

Sr.	Date	Day	Case Summary	Learning Points	Supervisor's Signature and Stamp
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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6		• Foley's Catheter insertion						
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9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
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13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
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18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
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24		• Tourniquet Application						
25		• CVP Line						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
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4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• Nervous system						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Defential Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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Professionalism and Behavior of Student

(To be filled by the supervisor)

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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
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9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor

3) Outdoor (OPD) Rotations:

Sr.	Date	Patient Initials/ID	Diagnosis	Short History	Management Plan	Follow up Review/ Remarks	Supervisor's Signature and Stamp
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
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21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
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5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
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		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
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Reflective Practice Record

Field	Entry
Case Summary	
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Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
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		• Nervous system						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
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Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



IBN-E-SIENA HOSPITAL & RESEARCH INSTITUTE MULTAN

Southren Bypass Jahangirabad Multan.

Tel: 061-6782872-6

E-mail: info@ibne-e-siena.org.pk, Website: ibne-e-siena.org.pk

HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Defential Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
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		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
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15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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8		• Apply Bandage/Splint						
9		• IV Line						
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11		• Care of Tracheostomy Tube						
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16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
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22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

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		Yes	No	Any other point
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2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
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24		• Tourniquet Application						
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26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

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5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• BP						
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		• Respiratory rate						
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		• Respiratory system						
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11		• Care of Tracheostomy Tube						
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13		• Endotracheal Intubation						
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16		• Nasopharyngeal Air Way						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
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13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
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5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
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Professionalism and Behavior of Student

(To be filled by the supervisor)

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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
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Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

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Professionalism and Behavior of Student

(To be filled by the supervisor)

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		Yes	No	Any other point
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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
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Signature & Stamp
of Supervisor

4) Emergency Duties:

Sr.	Date	Duration/Shift	Type of Emergency Case	Role of Student	Procedures	Follow up Review/ Remarks	Learning points
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							



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Postal Address _____

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1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

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P/S _____ P/V _____ P/R _____

Local Examination:

Definitional Diagnosis:

Investigations:

Signature & Stamp
of Supervisor

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
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		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
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7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
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		• BP						
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		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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10		• CPR						
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15		• Ambubag						
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17		• Oropharyngeal Air Way						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
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1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
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16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
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19		• Helmet Removal						
20		• Spine Board						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Defential Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
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5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
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13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
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16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
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23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
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		• Nervous system						
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4		• First Aid						
5		• Nasogastric tube insertion						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
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Reflective Practice Record

Field	Entry
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Signature & Stamp
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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definitional Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
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Professionalism and Behavior of Student

(To be filled by the supervisor)

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Reflective Practice Record

Field	Entry
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Signature & Stamp
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U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Definial Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
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6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
22		• Needle Thoracostomy						
23		• Pressure Dressing						
24		• Tourniquet Application						
25		• CVP Line						
26		• Blood Transfusion						

Professionalism and Behavior of Student

(To be filled by the supervisor)

S. No	Statement	Supervisor Remarks		
		Yes	No	Any other point
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues			
2	Was ready to take responsibility			
3	Maintained an appropriate appearance / dress			
4	Avoided derogatory remarks in the unit			
5	Presentation skills were up to the mark			
6	Overall assessment of professional conduct	A: High		B: Moderate
				C: Low

Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor



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HISTORY SHEET

U.PIN _____

Full Name _____ **Weight** _____

Date & Time _____ **Age** _____ **Ward/Room No.** _____

Postal Address _____

Presenting Complaints _____

1. _____

2. _____

3. _____

History of Present illness _____

Past History _____

Family History _____

Drug Allergy _____

Bleeding Disorder _____

Operations _____

CLINICAL EXAMINATION

General Physical Exam _____ Pulse _____ Temp _____ Resp. _____ B. P. _____

Anaemia _____ Cyanosis _____ Jaundice _____ Clubbing _____ Built & Constitution _____

Lymph Glands _____ Thyroid _____ Oedema Feet _____ Neck Veins _____

Systemic Examination:

Cardiovascular System _____

Respiratory System _____

Alimentary _____

Central Nervous System _____

Musculoskeletal System _____

Pelvic Examination _____

P/S _____ **P/V** _____ **P/R** _____

Local Examination:

Defential Diagnosis:

Investigations:

**Signature & Stamp
of Supervisor**

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A : Observer status B : Assistant status C : Performed part of the procedure under supervision D : Performed whole procedure under supervision E: Independent performance					Supervisor's comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First Aid						
5		• Nasogastric tube insertion						
6		• Foley's Catheter insertion						
7		• Wound care						
8		• Apply Bandage/Splint						
9		• IV Line						
10		• CPR						
11		• Care of Tracheostomy Tube						
12		• Care of Chest Tube						
13		• Endotracheal Intubation						
14		• Jaw Thrust Maneuver						
15		• Ambubag						
16		• Nasopharyngeal Air Way						
17		• Oropharyngeal Air Way						
18		• Cervical Collor						
19		• Helmet Removal						
20		• Spine Board						
21		• Logroll						
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23		• Pressure Dressing						
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Professionalism and Behavior of Student

(To be filled by the supervisor)

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Reflective Practice Record

Field	Entry
Case Summary	
What I Learned	
What I Need to Improve	
Action Plan	

Signature & Stamp
of Supervisor

Professionalism Assessment

Domain	Rating (1-5)	Remarks
Attendance		
Communication		
Teamwork		
Ethics		
Documentation		

End of Rotation Global Assessment

Domain	Score
Clinical Knowledge	
Clinical Skills	
Professionalism	
Communication	
Documentation	

Final Certification

This is to certify that the student has completed required Clinical exposure, emergency duties, procedures and professionalism requirements.

Head of Department Signature: _____

Stamp: _____

Director Medical Education Certification

Signature: _____

Date: _____

Stamp: _____