



Name of Resident _____

Dates of Service _____

Service Name _____

| | | | | | |
|------------------|---|---|----|----|----|
| PGY 2,3,4 | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 |
| Rotation # | | | | | |

Resident Performance Evaluation

Please rate Resident based upon function and knowledge while working on your service or under your supervision. Base this evaluation upon knowledge and performance comparable to peers, with regard for level of training and time of year.

N/A = Not Applicable
 Not part of this rotation

1, 2 = Unacceptable
 Does not meet minimal skill or knowledge objectives

3, 4 = Marginal
 Needs improvement, would benefit from remediation

5, 6 = Average
 Customary and usual acceptable performance and knowledge

N/O = Not Observed
 Did not observe

7, 8 = Above Average
 Performance or knowledge Somewhat above that of peers.

9 = Superior
 Performance or knowledge Exceeds expectations

10 = Outstanding
 Far exceeds expectations in performance or knowledge.

| # | Category of Review | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | N/O | N/A |
|------------|--|---|---|---|---|---|---|---|---|---|----|-----|-----|
| I | ADMIN RESPONSIBILITY | | | | | | | | | | | | |
| A | Case Management Skills | | | | | | | | | | | | |
| B | Organizational Skills and Paperwork | | | | | | | | | | | | |
| C | Attendance and Participation | | | | | | | | | | | | |
| D | Understanding of Dept/Service Operations | | | | | | | | | | | | |
| E | Other () | | | | | | | | | | | | |
| II | PSYCHIATRIC KNOWLEDGE | | | | | | | | | | | | |
| A | Therapy and Psychodynamic Issues | | | | | | | | | | | | |
| B | Psychopharmacology and Somatic Therapies | | | | | | | | | | | | |
| C | Diagnosis in Psychiatry and the DSM IV | | | | | | | | | | | | |
| D | Other () | | | | | | | | | | | | |
| III | PATIENT CARE SKILLS | | | | | | | | | | | | |
| A | Psychiatric Assessment | | | | | | | | | | | | |
| B | Interviewing Skills | | | | | | | | | | | | |
| C | Physical Diagnosis Skills | | | | | | | | | | | | |
| D | Medical Management of Patients | | | | | | | | | | | | |
| E | Use of Psychiatric Medications | | | | | | | | | | | | |
| F | Procedures (LP, suture, ECT, other) | | | | | | | | | | | | |
| G | Patient Presentations | | | | | | | | | | | | |
| H | Other () | | | | | | | | | | | | |
| IV | TEAMWORK | | | | | | | | | | | | |
| A | Interpersonal skills | | | | | | | | | | | | |
| B | Ability to work as part of a team | | | | | | | | | | | | |
| C | Flexibility and response to feedback | | | | | | | | | | | | |
| D | Attitude toward work | | | | | | | | | | | | |
| E | Other () | | | | | | | | | | | | |
| V | SUPERVISORY ABILITIES | | | | | | | | | | | | |
| A | Works effectively with medical students | | | | | | | | | | | | |
| B | Supervision /support of lower residents | | | | | | | | | | | | |
| C | Other () | | | | | | | | | | | | |
| VI | OVERALL ASSESSMENT | | | | | | | | | | | | |

Comments:

I have reviewed this evaluation with the resident named above.

Supervising Physician Name / Signature

Resident Initials

RETURN THIS FORM WITHIN 5 DAYS TO:
RESIDENCY COORDINATOR
PSYCHIATRIC MEDICINE
KIM MANN, HSC, BOX 623