



Provider: _____

Medical Record Number: _____ Date of Procedure: _____

Procedure Done: _____

Please rate the practitioner on the following:

A. INDICATION	Satisfactory	Needs Improvement	Unsatisfactory	N/A
Informed Consent				
History Documentation				
Pre-Procedure Lab				
Clinical Judgement				
B. DIAGNOSTIC CORRELATION				
C. TECHNIQUE				
Attention to anatomy				
Surgical Skill				
Use of time				
Management of complication				

_____ OF _____ REQUIRED

CONCLUSIONS & EVALUATION OF CARE

Signature of Proctor *date*

Printed Name