# OOH Session Recording and Feedback Form

**GP Trainee Name:**

**GP ES Name:**

**Contact Details for Practice:**

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| --- | --- | --- |
| **Date of session:** | **Time:** Daytime 🞎 Evening 🞎 Overnight 🞎  Weekday 🞎 Weekend 🞎 | |
| **Session activities: (Tick all that apply)**  Primary Care Centre 🞎 Visiting Doctor 🞎 Telephone Triage 🞎  Minor Injuries Centre 🞎 Other: | | |
| **Name of Supervising Clinician:** | | |
| **Level of supervision:**   |  |  | | --- | --- | | All patients reviewed by Supervising Clinician or joint consulting | 🞎 | | Close supervision, case management discussed when required | 🞎 | | Mainly consulting independently with end debrief | 🞎 | | Remote (telephone) supervision | 🞎 | | | |
| **Debriefing notes from Supervising Clinician:**  **Signature of Clinical Supervisor ………………………….. Date ……………..** | | |
| **Communication Box: Educational Supervisor <> Supervising Clinician** | | |
| **Cumulative OOH completed by the end of this session:** | |  |
| **Curriculum Headings Chosen:** | | |
| **What did you learn?**  **Include relevant cases seen and/or significant events (these may or may not be medical) and what you learned from these.**  **State which capabilities have been demonstrated.** | | |
| **What will you do differently in future?** | | |
| **What future learning needs did you identify?** | | |
| **How will you address these?** | | |