# OOH Session Recording and Feedback Form

**GP Trainee Name:**

**GP ES Name:**

**Contact Details for Practice:**

|  |  |
| --- | --- |
| **Date of session:** | **Time:** Daytime 🞎 Evening 🞎 Overnight 🞎 Weekday 🞎 Weekend 🞎 |
| **Session activities: (Tick all that apply)**Primary Care Centre 🞎 Visiting Doctor 🞎 Telephone Triage 🞎Minor Injuries Centre 🞎 Other: |
| **Name of Supervising Clinician:**  |
| **Level of supervision:**

|  |  |
| --- | --- |
| All patients reviewed by Supervising Clinician or joint consulting | 🞎 |
| Close supervision, case management discussed when required | 🞎 |
| Mainly consulting independently with end debrief | 🞎 |
| Remote (telephone) supervision | 🞎 |

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| **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?** |