Specialty Clinic Visit Resident Self Evaluation: Adaptive Equipment

Resident's Name:_____

Date of Visit:_____

Contact Person:_____

Choose one child:

1.	Were concerns or needs identified for this patient by the family or caregiver?	❑ Yes	❑ No	
2.	Were concerns or needs identified by the patient directly?	❑ Yes	❑ No	❑ NA
3.	Were these concerns the same for everyone on the team?	❑ Yes	❑ No	
4.	Were treatment options given to the patient and family or caregiver, such as adaptation of equipment, color or style of equipment, etc.?	❑ Yes	❑ No	
5.	Were the family or caregiver and patient equal partners in the decision-making process, including suggested treatments or ways to address the identified problems?	❑ Yes	❑ No	
6.	Were efforts made to get feedback from the patient regarding comfort or effectiveness of the adaptations?	❑ Yes	❑ No	
7.	Did you have an opportunity to see any pieces of adaptive equipment that you had never seen before?	❑ Yes	❑ No	
8.	Were insurance and/or Medicaid issues addressed during any of these appointments?	❑ Yes	❑ No	
9.	Were there any evident limitations or restrictions imposed by insurance/Medicaid regulations? If yes, please describe.	❑ Yes	❑ No	
10.	Did this visit allow you to understand more about the challenges faced by patients and families related to adaptive equipment needs?	❑ Yes	❑ No	
11.	Do you understand more about the challenges faced by patients and families as they schedule and attend clinic visits?	❑ Yes	❑ No	
12.	Did you learn more about the benefit of families and professionals collaborating in the care of children with disabilities?	❑ Yes	❑ No	

13. Did you see examples of the clinic team working with the family to integrate medical, educational, and social services for this child? ❑ Yes ❑ No

14. Did this visit allow you to discover new ways in which a physician might be helpful to families and children? ❑ Yes ❑ No

15. Were you satisfied with the preparation you were given for this experience? ❑ Yes ❑ No

16. Was this visit beneficial to you as a physician? ❑ Yes ❑ No

17. Were you satisfied with the experience and knowledge gained from this clinic visit? ❑ Yes ❑ No

18. What might you do differently in your practice as a result of this experience?

19. Did you have any difficulties during this experience? If yes, please describe. ❑ Yes ❑ No

Please return this form to:
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