Specialty Clinic Visit
Resident Self Evaluation:
Hospital For Special Care

Resident's Name:__________________

Date of Visit:______________________

Contact Person:____________________

1. Do any patients receive early intervention or special education services in the hospital? ❑ Yes ❑ No

2. Do any patients attend school in the community during their stay at the hospital? ❑ Yes ❑ No

3. Did this visit enhance your understanding of issues children face in an intermediate care facility? ❑ Yes ❑ No

4. Do you understand more about the challenges faced by families whose children are in an intermediate care facility? ❑ Yes ❑ No

5. Did this visit provide you with an understanding of how the clinical team processes, shares, and uses information? ❑ Yes ❑ No

6. Did you learn more about the benefits of professional collaboration in the care of children with disabilities? ❑ Yes ❑ No

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

8. Did you see examples of doctors integrating medical, educational, and social services for the children? ❑ Yes ❑ No

9. Were you satisfied with the preparation given for this clinic experience? ❑ Yes ❑ No

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

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

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

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

Please return this form to:
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