Resident Self Evaluation: Observation of an Individual Assessment or Intervention

Resident's Name:_____

Name of Clinic/Program/Agency:_____
_____

Date of Visit:_____

Contact Person:_____

1. Did the family members have a clear understanding of the reason for the evaluation/intervention, their role, and the expected outcomes? ❑ Yes ❑ No

2. Was there role release? ❑ Yes ❑ No ❑ NA
If yes, please give an example.

3. What type of team works with this child? (circle one) Interdisciplinary Multidisciplinary Transdisciplinary

4. Were the parents and other family members involved in the assessment/intervention process? ❑ Yes ❑ No

5. Was the pediatrician involved in this assessment/intervention process? ❑ Yes ❑ No

6. Do you understand more about this professional's specific role with children as a result of this observation? ❑ Yes ❑ No

7. Do you have a better understanding of the assessment process and assessment methods as a result of this observation? ❑ Yes ❑ No

8. Do you have a clearer understanding of how parents can be encouraged to be full participants and partners in assessment/intervention? ❑ Yes ❑ No

9. Were you satisfied with the preparation you were given for this experience during the Team Based Service Models didactic session? ❑ Yes ❑ No

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

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

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

Please return this form to:
Physicians Training Project Coordinator
University of Connecticut
A.J. Pappanikou Center for Excellence
in Developmental Disabilities
263 Farmington Ave., MC 6222
Farmington, CT 06030
Fax: (860) 679-1571