Family Medicine

Clerkship Survival Guide

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Dear Student,

Welcome to your Family Medicine Clerkship rotation!

During the next 4 amazing weeks, you be in locations all over the state of Texas in a truly unique primary care rotation experience. You will have the opportunity to examine, diagnose, and treat patients with a broad range of healthcare needs and from every patient demographic from "womb to tomb."

Because of the breadth of practice in Family Medicine, it is more important than ever that you take full advantage of your non-clinical time to study core concepts pertinent not only to Family Medicine but all other domains of medical care.

This is our updated 2019-2020 Family Medicine Clerkship Survival Guide. This provides you the calendar of when things are due, a clerkship checklist of requirements, and numerous study tips. This Survival Guide will give you the necessary tools for a superior clerkship experience. While it is not a substitute for becoming familiar with the Family Medicine Clerkship Syllabus, it is shorter and easier to use.

We invite your feedback about the Survival Guide and the Syllabus both.

A custom designed resource in the Guide is the "Top 30" which provides a core, foundational knowledge base about the most common diagnoses seen in Family Medicine. The synoptic organization of the "Top 30" will be a high yield use of your study time and will improve your clinical experience and skills.

For those students who wish to garner Honors in Family Medicine as well as those with a score under the 20th percentile on the practice NBME exam, we STRONGLY recommend utilizing the "Top 30" as a guide to study and reading. We advise at least 2 hours of reading daily, including weekends. See the suggested calendar to cover the most common problems you will see in clinic based on frequency.

Here is a reminder of core objectives your clerkship:

- Recognize the value of primary care as an integral part of the health care system
- Achieve competency in the evaluation and initial management of acute presentations commonly seen in the office setting.
- Achieve competency in the management of chronic illnesses that are commonly seen in the office setting.
- Achieve competency in conducting a wellness visit for a patient of any age or gender.
- Describe the principles of family medicine care and medical home.

If we as the Medical Student Education Program in Family Medicine can do anything to improve your learning experiences during this clerkship, we are always available at the contacts listed.

Work, study hard, and especially have fun. This month is a really deep dive into the heart of medicine.

Warm regards,

Victor S. Sierpina, MD
Co-Director
Family Medicine Clerkship

Jennifer Raley, MD
Co-Director
Family Medicine Clerkship

WORDS TO THE WISE!

- ☐ **Please check your email daily – information is sent regularly!**
- ☐ Family Medicine adheres to the UTMB School of Medicine Student Absence Policy (see OCE Universal Clerkship Syllabus for more info.)
- ☐ Do not contact your preceptor regarding your final evaluation – doing so will result in an early concern note for violation of professionalism.
- ☐ If you have a special date where you need to be out (SCOPE, PHT, wedding, childbirth, other major personal or family event, etc.), please give the coordinator a MINIMUM of 30 days to adjust your schedule.

FAMILY MEDICINE CLERKSHIP TIMELINE

SUN	MON	TUES	WED	THURS	FRI	SAT
				Confirm location and time with site for reporting on Monday	End of previous clerkship	**Read the family medicine syllabus and clerkship survival guide**
Travel to your clinical site if placed at a distance location.	**1st Day FM Clerkship**	Ortho Exam Modules (1-3) DAC	Lumps, Bumps, and Rashes DAC	Difficulty Breathing - Adult DAC	Well Woman Exam/Follow up on Dysuria DAC **NBME FM Practice exam available**	
Week 1 NI Patient encounter logbook due	**NBME FM Practice exam Due by Midnight**		Mid-clerkship Evaluation with Preceptor	Complete CRI Week 2 Assignment **IRAT Assignment opens in Blackboard**	**Mid-clerkship eval due to Layne Dearman, Clerkship Coordinator**	**IRAT Closes @ noon** **GRAT Opens @ noon**
Week 2 NI patient encounter logbook due	**GRAT group response due to faculty by midnight**		GRAT activities graded by faculty	Complete CRI Week 3 Assignment GRAT faculty response to blackboard		
Week 3 NI patient encounter logbook due		Complete CRI Week 4 Assignment	**Upload all CRI's and DAC rubrics to Blackboard**	**Week 4 NI patient encounter logbook due** ***Travel Day***	**FM shelf exam 8:30 am check-in**	

If an activity is in bolded font, it is a required due date for the activity

PRO TIPS! -

PUT THESE DATES IN YOUR CALENDAR OR TAKE A PICTURE.

CHECK YOUR EMAIL DAILY!!!!!

DAY BY DAY CHECKLIST FOR SUCCESSFUL COMPLETION OF THE CLERKSHIP

For successful completion of your FM clerkship by week:

Prior to starting your Rotation:

- ☐ THURSDAY PRIOR – Contact your site and confirm time and location to report to clinic on Monday.
- ☐ SATURDAY PRIOR –
  - o **READ THE SYLLABUS!** You will be held to it, no exceptions. FM Clerkship Syllabus
  - o The ***Universal Clerkship Syllabus*** can be found on the Office of Clinical Education webpage: OCE Universal Clerkship Syllabus
  - o Wash and press your lab coat! Professional presentation matters.

- ☐ SUNDAY -
    - Arrive at your housing site if you are at an away location so that you are ready and on time Monday morning. Get a good night's rest, clinics are busy!
    - **Begin your NIGHTLY reading assignments – See study calendar**

Week ONE:

- ☐ TUESDAY – Recommended Completion of Ortho Exam Modules (1-3) Design-A-Case (Knee, Shoulder, and Back) - Remember to do the rubrics (back required, plus shoulder OR knee) with your preceptor as they will be required to turn in by the end of the rotation. Do at least one of these weekly.
- ☐ WEDNESDAY – Recommended Completion of Lumps, Bumps, and Rashes Design-A-Case
- ☐ THURSDAY - Recommended Completion of Difficulty Breathing - Adult Design-A-Case
- ☐ FRIDAY
    - Recommended Completion of Well Woman Exam/Follow up on Dysuria Design-A-Case
    - **Practice Exam– Available first Friday via a voucher sent to you by email, due by Monday midnight**

Week TWO:

- ☐ **SUNDAY - New Innovations (NI) Case Logger documentation – 25 cases minimum DUE**
- ☐ **MONDAY - NBME Practice Exam is due by midnight – Please review your score as this will give you specific areas to supplement your studying. If you are under the 20th percentile, please make sure that you use your time wisely because you are identified as at-risk. Top 30 is ESSENTIAL reading if you are in this category (see above) – **Remediation and Study Plans are required for anyone identified as having failed the practice exam or at risk of failure – if you fall into this category, you will be contacted by faculty****
- ☐ **WEDNESDAY – Complete a mid-clerkship evaluation form with your preceptor. Please request written comments about performance. Make sure you review your log book diagnosis summary for areas for your preceptor to target in clinic.**
- ☐ THURSDAY
    - Clinical Reasoning Instrument (CRI) #1 - upload form to Blackboard course – **check Blackboard for full instructions for how Family Medicine uses this form differently**
    - **IRAT opens at noon. You have until the following Saturday at 11:59am to complete.**
- ☐ **FRIDAY – Mid-Clerkship Evaluation Form DUE – fax or scan to coordinator - must also document feedback in New Innovations – STUDENT IS REPSONSIBLE FOR TURNING THIS IN**
- ☐ **SATURDAY – IRAT closes at 11:59am and GRAT opens at noon. You must contribute to the discussion board – 1) your clinical reasoning for your chosen answer and 2) how it applies to the principles of Family Medicine. Each group will designate a person to submit a final and agreed upon answer and response to their assigned faculty. GRAT responses are due to faculty by email Monday at midnight. Make sure to copy the coordinator!**

Week THREE:

- ☐ **SUNDAY - New Innovations (NI) Case Logger documentation DUE – 50 cases minimum DUE**
- ☐ MONDAY – **GRAT responses due to assigned faculty by midnight. Make sure to copy the coordinator!**

- ☐ THURSDAY - Clinical Reasoning Instrument (CRI) #2 - upload form to Blackboard course
- ☐ THURSDAY – Faculty responses to GRAT will be posted in Blackboard. Please review.

Week FOUR:

- ☐ **SUNDAY - New Innovations (NI) Case Logger documentation DUE– 75 cases minimum DUE**
- ☐ TUESDAY - Clinical Reasoning Instrument (CRI) #3 - upload all forms to Blackboard course
- ☐ **WEDNESDAY –**
    - o **DAC Rubrics (2) DUE – Back and Knee *OR* Shoulder upload all forms to Blackboard course**
    - o **Clinical Reasoning Instrument (CRI) forms (3) - upload all forms to Blackboard course**
- ☐ **THURSDAY - New Innovations (NI) Case Logger documentation DUE – 100 cases minimum DUE**
- ☐ **FRIDAY –**
    - o **NBME Family Medicine Exam - Final Friday of Rotation – Scores are available when the grades are posted. If you scored below the 10th percentile, you will be notified within the week.**
    - o **Evaluations DUE – Complete in New Innovations**
    - o **Bring a draft thank you note to the exam to send to your preceptor but leave it in your locker until you've completed the exam – the coordinator will provide cards and mail for you.**

SUMMARY CHECKLIST OF REQUIREMENTS!

For successful completion of your FM clerkship:

- ☐ NBME Practice Exam – Available 1st Friday, due 2nd Monday by midnight
- ☐ IRAT Assignment – Available Week 2 Thursday, due Week 2 Saturday by noon
- ☐ GRAT Assignment – Available Week 2 Saturday, group response due Week 3 Monday by midnight
- ☐ New Innovations (NI) Case Logger documentation for a minimum of one case for every required diagnosis and a minimum of 100 patient encounters
- ☐ Mid-Clerkship Evaluation Form – fax or scan to coordinator by Friday of Week 2 – must also document feedback in NI
- ☐ Design A Case (DAC) Assignments - Well Woman Exam/Follow up on Dysuria, Ortho Exam Modules (1-3), Lumps, Bumps, and Rashes, Difficulty Breathing - Adult due final Friday 3 PM
- ☐ Clinical Reasoning Instrument (CRI) forms (3) - upload all forms to Blackboard course by final Friday 3 PM
- ☐ DAC Rubrics (2) – Back and Knee *OR* Shoulder upload all forms to Blackboard course by final Friday 3 PM
- ☐ Evaluations - 2 open the final week in NI; one for rotation; one for site/preceptor
- ☐ NBME Family Medicine Exam - Final Friday of Rotation

FAMILY MEDICINE STUDY CALENDAR

SUN	MON	TUES	WED	THURS	FRI	SAT
					End of previous clerkship	READ THE FAMILY MEDICINE SYLLABUS and Clerkship Survival Guide
Health Promotion and Prevention	Diabetes Mellitus	Hypertension	Back Pain and Neck Pain	Obesity	Anxiety and Depression	Abdominal Pain
Arthritis	Cough & Upper Respiratory Symptoms	Abdominal Pain	Chest Pain	Coronary Artery Disease	Joint/Limb Pain and Injury	Hyperlipidemia and Leg Swelling
Dysuria & Men's Urinary Symptoms	Substance Abuse and Dependency	Fever	COPD	Headache	Hypo and Hyperthyroidism	Asthma and Dyspnea
Dizziness	Women's Health and Abnormal Vaginal Bleeding	Dementia and Delirium	Pregnancy	Skin Lesions & Skin Rashes	FM Shelf Exam 8:30 AM Check-In	

TOP 30 DIAGNOSES READING MATERIALS HERE:
http://guides.utmb.edu/fmclerkship/conditions

Studying should not be cramming information at the last moment before your exam. It should be a well thought out and intentional process. If you follow our suggested reading and incorporate some of the following resources into a regular study routine, chances of a very successful NBME exam score are much more likely. You should be studying at a minimum 1-2 hours per night in addition to seeking information throughout the day to help your patients. We strongly encourage this study program for all students, especially those who did poorly on the self-assessment.

Additional resources you may wish to use:

- **AAFP Question Bank**
- **Case Files Family Medicine**
- **NBME Practice Tests**
- **UWORLD (Internal Medicine, Pediatrics, Dermatology)**
- **Step Up 2 Medicine**
- **US Preventive Services Task Force Recommendations**
- **Blueprints FM**
- **OnlineMedEd Videos**
- **Swanson's Family Medicine Review**

Helpful Apps:

- **Epocrates – medication dosage, side effects, tables, and guidelines**
- **AHRQ ePSS – Age and gender-based recommendations from USPSTF**
- **Shots by AAFP and STFM**
- **Preg Wheel**

ALSO:

Bookmark common online resources: There are some things that you need to always be ready to know. Immunization guidelines, antibiotic ladders, diabetes management, and hypertension control are some common ones. Quick accessibility in clinic is extremely helpful.

Consolidate your patient's problems (limit them to 3-5): If you are at a clinic where the patients are regulars, expect them to come in with a laundry list of issues. Seeing their doctor only once a year reminds them of every rash/ache they have. It is your job as the student to help prioritize the list of concerns. Which are important to address today? Which can you hold off until the next visit?

Efficiency is key: A family medicine clinic is usually quite busy. Most patient appointments are scheduled every 15-20 minutes. Have a template for a quick head to toe exam you always do so you can use the parts of the exam needed based on the patients concerns for that visit. Be sure to provide extra attention to the areas of concern. For example, if the patient has shoulder pain make sure you do all the maneuvers you can think of to narrow your differential. YOU DO NOT NEED TO AND SHOULD NOT DO A COMPLETE ROS OR PHYSICAL ON EVERY PATIENT EXCEPT FOR FULL PHYSICALS AND ANNUAL EXAMS.

GRADING

Final grades are assigned as follows:	
Honors:	MUST HAVE ALL - a final grade of 91 or above, no documented concerns related to **professionalism AND** a score at or above the 75th percentile on the NBME
High Pass:	BOTH a final grade of 87 to 90 **AND** in the 50th to 75th percentile on the NBME
Pass:	Any final grade of 70 to 100 **WITH** a score of 5th to 49th percentile on the NBME
In Progress (IP) or Fail:	One or more of the following: a final calculated grade below 70, a FM NBME percentile less than the 5th percentile, or an unsatisfactory rating for Professionalism in any aspect of the course

Required Components for Student's Grade	**Weight**
Clinical Performance Evaluation - completed by Preceptor(s) online. If more than one form is completed, scores are averaged.	50%
NBME Subject Exam – Family Medicine	25%
Professionalism – All assignments must be completed to receive the grade points – All completed on time or zero points • DAC 6 Cases - (completed and submitted): o Well Woman Exam/Follow up on Dysuria o Ortho Exam Modules (1-3) o Lumps, Bumps, and Rashes o Difficulty Breathing - Adult • CRIs 3 completed and submitted in Blackboard • Diagnostic Requirements in NI Logbook (NI Rotation Requirements Summary) • Patient Encounter Requirements in NI Logbook (NI Case Logger) • Rubrics DAC Ortho to Blackboard (Back required, plus either Shoulder or Knee)	10%
IRAT/GRAT Assignments (IRAT 40%/GRAT 60%) IRAT – 8 questions – scored at ½ point each – scored in Blackboard GRAT – 2 questions – each question is 3 points each and will be scored by faculty • 1 point for having the correct answer • 1 point for clinical reasoning • 1 point for including family medicine principles	10%
Practice NBME Exam – 5 percentage points toward final grade - Scores 18 and lower are at risk of failing the NBME Scaled Score of: • 30-25 = 5% pts • 24-19 = 4% pts • 18-13 = 3% pts • 12-6 = 2% pts • 5-0 = 1% pt	5%

GRADE APPEALS

See Syllabus for details.

The **electronic Grade Appeal Form** to use for a grade appeal is posted in our Forms tab in the Black Board course and on our website in the Forms section. The completed form is automatically submitted to the course Co-Directors with a copy to the Clerkship Coordinator.

Do not contact your preceptor after the clerkship regarding your grade.

TIPS ON OUTPATIENT PRESENTATIONS

1. General Description – Giving an oral presentation in the clinic is an important skill for medical student to learn. It is medical reporting which is terse and rapidly moving. After collecting the data, you must then be able to both document it in a written format and transmit it clearly to other health care providers. In order to do this successfully, you need to understand the patient's medical illnesses, the psychosocial contributions to their HPI and their physical findings. You then need to compress them into a concise, organized recitation of the most essential facts. The listener needs all of the relevant information without the extraneous details and should be able to construct his/her own differential diagnosis as the story unfolds. Consider yourself an advocate who is attempting to persuade an informed, interested judge the merits of your argument, without distorting any of the facts. Depending on the purpose of the presentation, different parts of the database are included. In taking your history, you have gathered more information than you will include in your write-up and likewise, your write-up contains more information than you will include in an oral presentation. Your oral presentation must include all essential information including a differential diagnosis and plan of evaluation and treatment.

2. Basic principles - An oral case presentation is NOT a simple recitation of your write-up. It is a concise, edited presentation of the most essential information. Length – this will vary depending on your service. A full patient presentation in clinic should generally be under 5 minutes. (see Oral Case Presentation Rating Scale)

3. Similarities and differences between written and oral presentations
    a. Both are an organized reconstruction of the patient's narrative into a coherent HPI, not a random assortment of facts.
    b. Both follow the same organizational format
    c. Separation of subjective data – derived from the patient, family and medical record and objective data which includes your physical exam and today's lab/radiographic data

4. Organization and content of case presentation

    a. Identifying Information/Chief Complaint (II/CC) – you want flesh out the bare bones enough to make your presentation engage the listener and give them a feel for the patient as a person.
        i. Structure: "Mr./Mrs./Ms. ___ is a ___year-old man/woman who presents with a chief complaint of ___ (or who was seen for evaluation of ___, or who comes in to clinic for follow up of _____)".
        ii. Only include the race or ethnicity of the patient if it is relevant and will make your listener weigh diagnostic possibilities differently.
        iii. To orient your listener, the identifying information should include the patient's relevant active medical problems, of which you would list 4 or less most relevant. You will list these problems here by diagnosis only, and will elaborate on them later in the "HPI" or "other medical problems."

    b. Content of history of present illness - specifically characterize the major presenting symptoms including patient attributions (what the patient thinks is causing the symptoms), any prior episodes, and complications and the relevant ROS questions (these include symptoms related to the major and adjacent organ systems, constitutional complaints such as fever and weight loss and

epidemiological risk factors or exposures. If there was any evaluation of the chief complaint prior to hospital admission, this should be included. Use the OLD CARTS mnemonic to ensure you present all the information. The following is a another useful mnemonic to make sure all those bases are covered:

- C character, circumstances
- L location – deep or superficial, well or poorly localized
- E exacerbating factors
- A alleviating factors
- R radiation of pain
- A associated symptoms
- S severity on a 1-10 scale
- T temporal features - timing (intermittent/constant), duration, frequency, changes over time (progressive, stable or improving)

c. In the case presentation, avoid presentation of irrelevant diagnoses. What is irrelevant is not always obvious to you at your level of training and improves with your clinical experience. Consultation with your facilitator and preceptor will help you make this determination. "gonorrhea in 1945, malaria in 1940, cataract extraction in 1972, and tinea pedis" are probably not relevant during presentation of the diabetic with angina.
    - You must know all of the patient's problems and include them in your write-up, but presentation of problems, which are not relevant to the current active problems, only distracts your listener.
    - Medications, Allergies, Substance Use - Provide a list of all prescribed medications and a list of any relevant non-prescription medications. Unless you have the chance to review the patient's chart, you will only be able to give as much detail about medications as the patient can give you. You should also include any supplements or integrative therapies the patient may be using.
    - Report any relevant drug allergies and the type of reaction (for example, "the patient developed a skin rash approximately 20 years ago after receiving penicillin and carries the diagnosis of penicillin allergy").

d. Summarize substance use not already mentioned in HPI. However, if it has been mentioned in the HPI, do not repeat it.
    ii. **Social History (brief)** – we are more than our habits and marital status. Please don't try and reduce patients to these facts alone. Summarize their social history into a brief (2-3 sentences) paragraph commenting on their current life situation including work, living situation, and support systems, stress level, and any ongoing social issues of note. *This is an essential part of the biopsychosocial model of care in Family Medicine.*
    iii. **Physical Examination** - General description – be colorful, allow the listener to visualize the patient. "The patient was short of breath" is inferior to "the patient was sitting on the edge of the bed, leaning forward and gasping for breath." Vital signs should always be mentioned initially, including postural changes if relevant. Mention only the relevant positive findings and relevant negative findings. An example of the latter includes (in the dyspneic patient) "the exam is remarkable for clear lungs bilaterally." Use concise but complete descriptions of positive findings.

- **NOTE**: It is not necessary to say I auscultated the abdomen and the bowel sounds were normal active, I palpated the abdomen and I didn't feel any masses and she wasn't tender. Instead – abdomen normal active bowel sounds, soft non-tender.
- **NOTE:** ALWAYS examine the system the patient complains of , e.g, Neurological for headache, MSK for back or joint pain
- **NOTE:** CV/Resp exam is not always needed, e.g, knee pain, UTI, injury, skin complaint
- **NOTE:** DO NOT use the phrase "Normal" or "within normal limits" when presenting. Inform your preceptor of what you see, hear, and feel

iv. **Assessment and Plan** = This takes the following form: "…the patient's major presenting problem is ____ (best positive statement you can make; say "chest pain" and avoid statements like "rule-out myocardial infarction"). The differential diagnosis includes ____, _____, and _____. The diagnosis of _____appears to be the most likely of these because _____. You should also include your plan for further evaluation and management of the problem, which would usually include patient education and/or health promotion.

Common Mistakes in Oral Presentation

1. Struggle with organization and pace
2. Not enough detail in HPI
3. Editorializing in the middle of the presentation
4. Use of negative statements instead of positive statements.
5. Repetition of previously stated information
6. Disorganization – such as switching between history and assessment
7. Physical findings presented without proper terminology, not reporting physical exam, or not examining the appropriate system for the patients concern. That said, it not necessary to perform a complete exam – everything ever learned in POM1 for each patient. Only examine the parts of the patient relevant to presenting concerns and to help narrow the differential diagnosis. If you spend time doing things you don't need to do, you will not have time for what is most important to help the patient.
8. Diagnoses used instead of descriptions in the physical examination
9. Not presenting clinical reasoning and assessment, therapeutic plan

ORAL CASE PRESENTATION RATING SCALE

Student

Evaluator

Date

HISTORY

1	2	3	4	5	Questions/Comments
No introductory statement or cc		Included cc and most pertinent information		Painted a clear picture of patient	

1. Introductory statement includes patient's age, sex, and chief complaint or reason for admission in one sentence without extra information

1	2	3	4	5	Questions/Comments
Sequence unclear		Major events sequenced		All events sequenced	

2. HPI is organized so that chronology of important events is clear

1	2	3	4	5	Questions/Comments
Information not clearly connected to problems		Active medical problems adequately described		Active problems completely & concisely described	

3. The PMH, FH, SH, and ROS include only elements related to active medical problems

PHYSICAL EXAM AND DIAGNOSTIC STUDY RESULTS

1	2	3	4	5	Questions/Comments
General statement poor or missing; vitals inappropriately incomplete		Mostly clear general statement with VS mostly complete		Succinct general statement; VS appropriately given	

4. Begins with a general statement and vital signs (and growth parameters if patient is a child):

1	2	3	4	5	Questions/Comments
Either too much or too little information given		Most important information is given		All important elements of PE given	

5. Includes a targeted physical exam stating the positive and negative findings that distinguish the diagnoses under consideration and any other abnormal findings

1	2	3	4	5	Questions/Comments
Irrelevant test results apresented or significant results omitted		Either minor omissions or a few extra results included		All relevant results relevant presented	Check here if no labs/tests available: ☐

6. Organizes lab data and results of other diagnostic tests to distinguish between possible diagnoses.

ASSESSMENT AND PLAN

1	2	3	4	5	Questions/Comments
No differential diagnoses are given and/or focuses on trivial problems		A ddx with several possibilities is given for major problems and the most important problems are appropriately prioritized		Extensive ddx for all problems given, problems all appropriately prioritized	

7. Provides an appropriate differential diagnosis for each problem, appropriately prioritizes problems

1	2	3	4	5	Questions/Comments
Patient plan is not described or is unrelated to the problem list		Plan for the patient addresses most important issues, may omit active but lower priority problems		Patient plan is complete and relates directly to the problem list; all active issues are included	

8. States the diagnostic/therapeutic plan that targets each problem; each item in the plan relates to something listed on the prob list

CLINICAL REASONING/SYNTHESIS OF INFORMATION

1	2	3	4	5	Questions/Comments
Much ambiguity remained		The picture was clear for the major issue(s)		The picture was complete and all issues were clear	

9. At the end of the presentation I had a clear picture of this patient's situation

GENERAL ASPECTS

1	2	3	4	5	Questions/Comments
Difficult to understand		Mostly understandable and engaging		Understandable and engaging speaking style	

10. Speaking style:

1	2	3	4	5	Questions/Comments
Unable to answer questions		Moderately able to answer questions		Answers questions fully and responsively	

11. Able to answer questions during and immediately following presentation

1	2	3	4	5
Needs significant help	Needs some help	Mostly on target	Above expectations	Well above expectations

12. Overall assessment of presentation:

Additional Comments:

Reviewed with Student? ___ Yes No