

**Department of Medicine
Division of Respiratory Medicine**

ITER

ROTATION – REHABILITATION

Please return this form to: Karen Rimmer, Peter Lougheed Hospital

Resident: _____ PGY: _____

Rotation: Rehabilitation Site/Location: _____

Block ____ From: _____ To: _____, 20____

Name(s) of person(s) consulted in preparing the evaluation:

Requirement	FAIL		PASS			Not Applicable
	Rarely Meets	Inconsistently	Almost Always Meets	Sometimes Exceeds	Consistently Exceeds *	
	0	1	2	3	4	

* Performs at the level of a staff respirologist.

MEDICAL EXPERT						
Demonstrates knowledge of the components of a successful rehab program:						
• Patient selection (inclusion/exclusion criteria)	0	1	2	3	4	N/A
• Baseline assessment	0	1	2	3	4	N/A
• Exercise prescription	0	1	2	3	4	N/A
• Definition of overall benefit	0	1	2	3	4	N/A
• Definition of expected benefits in terms of exercise	0	1	2	3	4	N/A
Demonstrates use of Stage II exercise to develop an exercise prescription	0	1	2	3	4	N/A

Requirement	FAIL		PASS			Not Applicable
	Rarely Meets	Inconsistently	Almost Always Meets	Sometimes Exceeds	Consistently Exceeds *	
	0	1	2	3	4	N/A

* Performs at the level of a staff respirologist.

MEDICAL EXPERT continued						
Demonstrates knowledge of the evidence for rehabilitation in respiratory disease	0	1	2	3	4	N/A

COMMUNICATOR						
Communication skills (both written and verbal)	0	1	2	3	4	N/A

COLLABORATOR						
Works with a multi-disciplinary team to achieve the rehab goals.	0	1	2	3	4	N/A

MANAGER						
Demonstrates knowledge of resource constraints and utilization in the area of rehab	0	1	2	3	4	N/A

HEALTH CARE ADVOCATE						
Brings rehabilitation to patients in a community setting	0	1	2	3	4	N/A

PROFESSIONAL						
Attitudes, values and ethics	0	1	2	3	4	N/A

OVERALL	FAIL		PASS			Not applicable
	Rarely Meets	Inconsistently	Almost Always Meets	Sometimes Exceeds	Consistently Exceeds*	
	0	1	2	3	4	N/A

* Performs at the level of a staff respirologist.

General Comments:

Identify any special strengths or weaknesses that have been brought to the attention of the resident:

Date: _____

Evaluator's Signature

Resident's Signature