

**Columbia St. Mary's Medical Staff
Clinical Service of Heart and Vascular
Proctor Form: Interventional Procedures**

Name of Surgeon Being Proctored: _____

Patient Health Record Number: _____ Patient's Age: _____

Procedure Performed: _____

EVALUATION OF PATIENT CARE: Please check (✓) appropriate box

	Excellent	Standard	Unacceptable	Unable to Evaluate
Pre-procedure evaluation				
Diagnostic judgment				
Operative technique				
Quality of medical record documentation				

Procedure time was: Reasonable Excessive

Blood Loss was: Reasonable Excessive

Was there unnecessary risk to patient? Yes No

Were there any complications? Yes No

In your opinion, does this surgeon need further education/training beyond required proctorship? Yes No

If yes, please explain below: _____

Proctor printed name _____ Signature of Proctor _____ Date _____

Please submit completed Proctor Form to:
CSM Central Credentials
4425 N. Port Washington Road, Suite 327, Glendale, WI 53212
Fax: (414) 326-1728
E-mail: centralcred@columbia-stmarys.org

"Health Care Services Review, privileged and confidential, protected from disclosure pursuant to Wis. Stats. 146.37 and 146.38"