Columbia St. Mary's Medical Staff Proctor
Form: Gynecologic Cystoscopy

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
Preoperative evaluation				
Diagnostic judgment				
Operative technique				
Quality of medical record documentation				

Operative time was:	☐	Reasonable	☐	Excessive
Use of technology was:	☐	Warranted	☐	Excessive
Was there unnecessary risk to patient?	☐	Yes	☐	No
Were there any complications?	☐	Yes	☐	No
In your opinion, does this surgeon need further proctoring?	☐	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"

New: 06.25.12