CbD

To be completed and signed by the evaluator

VED _____ GDC No. _____

Evaluator _____ GDC No. _____

Date of CbD

Description of case / encounter

Please grade the following areas using the scale 1 - 6	Needs Improvement		Borderline	Acceptable		Above expectations	Not observed
	1	2	3	4	5	6	
Patient record keeping	❒	❒	❒	❒	❒	❒	❒
Investigation / referrals	❒	❒	❒	❒	❒	❒	❒
Clinical Diagnosis	❒	❒	❒	❒	❒	❒	❒
Treatment planning	❒	❒	❒	❒	❒	❒	❒
Follow up and patient management	❒	❒	❒	❒	❒	❒	❒
Professionalism	❒	❒	❒	❒	❒	❒	❒
Overall clinical judgment	❒	❒	❒	❒	❒	❒	❒
Case presentation skills	❒	❒	❒	❒	❒	❒	❒
After feedback given on the assessment please rate: **VED's insight into own performance**	❒	❒	❒	❒	❒	❒	

Areas of good performance

Areas for development	
Minutes spent observing	
Minutes spent giving feedback	

Tick the clinical competencies met by this CbD	
Patient examination & diagnosis	❒
Replacement of teeth	❒
Restoration of teeth	❒
Management of developing dentition	❒
Non-surgical management of the hard & soft tissues of the head & neck	❒
Hard & soft tissue surgery	❒
Periodontal therapy & management of soft tissue	❒
Anaesthesia, sedation, pain & anxiety control	❒
Medical & dental emergencies	❒
Health promotion & patient management	❒
Treatment planning and patient	❒

Questions asked	
Evaluator notes	
VED's comments, if any	
Signature of Evaluator	Please be sure that this form is complete before you place your signature as once it is signed it will be locked and no addition or alteration can be made.