Resident Name:_____ **Date:** _____
PGY: _____

Psychiatry Clinical Evaluation - Foundations of Psychiatry

1. Interview Process

Item	Expectation	Criterion	Comments
Rapport	Establishes relationship	□ Introduces self □ Explains interview □ Respectful □ Open, explorative beginning	
Rapport	Develops and sustains rapport	□ Remains respectful and non-judgmental □ Genuine interest displayed by verbal and non-verbal responses □ Acknowledges patient's distress with empathic responses	
Control of process	Maintains control of the interview	□ Interrupts politely when required □ Attempts to redirect when required	
Ends the interview	Smoothly closes the interview	□ Attends to timing □ Provides a pertinent closing statement	
Cultural sensitivity	Demonstrates cultural sensitivity	□ Engages patient in a culturally safe manner	

2. Interview technique

Item	Expectation	Criterion	Comments
Information gathering	Maintains an open, explorative process	□ Non-verbal behaviour encourages patient to tell their story □ Listens attentively □ Note taking does not distract from the interview	
	Uses a facilitative questioning style	□ Questioning follows a logical sequence □ Asks clear questions in plain language □ Avoids leading questions	

		□ Avoids stacked (multiple) questions □ Attempts to move between open and closed questions □ Facilitates expression of emotions	
	Pursues important information	□ Appropriately responds to informational and affective cues □ Attempts to pursue and clarify symptom detail	
Maintains Flow	Maintains Flow	□ Reframes when required □ Summarizes when appropriate	

3. Interview Content

Item	Expectation	Criterion	Comments
Elicits a complete, relevant and accurate history	Identifies the person	□ Obtains demographic information	
	Identifies the presenting complaint(s) or problem(s) and its/their history (History of Presenting Complaint)	□ Obtains data on presenting complaint(s) or problem(s) □ Assesses pre-morbid state □ Assesses stressors related to presenting illness □ Inquires about previous illness episodes □ Inquires about past and present treatment interventions and response	
	Screens for symptoms relevant to the differential diagnosis and identification of	□ Screens for symptoms of relevant co-morbid illnesses, including mood, psychotic, and anxiety symptoms	

	co-morbid symptoms	□ Inquires about substance use	
	Ensures safety	□ Completes an appropriate risk assessment (suicidal and homicidal ideation) □ Reviews current medication(s), dosage(s) and response □ Reviews use of over-the-counter products □ Assesses side-effects □ Inquires about allergies	
Elicits a complete, relevant and accurate history	Identifies relevant past history	□ Reviews past medical history including family history of medical disorders □ Reviews past psychiatric history □ Reviews family psychiatric history	
	Identifies the developmental and psycho-social history	□ Reviews family history □ Reviews birth history if relevant □ Inquires about childhood and adolescent development □ Reviews occupational history and current functioning □ Inquires about relationship status □ Inquires about abuse history □ Assesses current supports □ Inquires about other relevant social or cultural factors	
Conducts a formal	Conducts a formal Mental	□ Assesses mood symptoms	

Mental State Examination as indicated	State Examination as indicated	□ Assesses anxiety symptoms □ Assesses psychotic symptoms □ Assesses cognition if relevant □ Considers intellectual function if relevant □ Assesses insight	

4. Case presentation

Item	Expectation	Criterion	Comments
Defines limitations of the data	Identifies issues in the information gathering process	□ Reflects on patient reliability if indicated □ Identifies deficits in the interview and their potential effect on the data collection	
Presentation skills	Provides a coherent, accurate summary of the case	□ Uses descriptive terms correctly (e.g., delusions) □ Presents case in an organized manner that is sufficiently detailed □ Accurately reports the Mental State Examination □ Accurately reports the risk assessment (suicidal, homicidal, and self-harm ideation) □ Considers relevant comorbidities	

Synthesizing skills	Synthesizes all the clinical information into a diagnosis, differential diagnosis, and case formulation	□ Presentation includes information to support the preferred diagnosis and differential □ Provides a probable working diagnosis including co-morbidities supported by evidence from the interview □ Provides a differential diagnosis supported by evidence from interview	
Synthesizing skills	Presents a formulation covering the rudimentary bio-psycho-social factors influencing the patient and their disorder	□ Identifies some contributing biological factors □ Identifies some contributing psychological factors □ Identifies some contributing social and cultural factors □ Starts to consider the interplay between these components	

5. Treatment Plan

Item	Expectation	Criterion	Comments
Presents a coherent, safe and appropriate treatment plan	Identifies information required to consolidate the diagnosis	□ Identifies bio-psycho-social investigations required to confirm the diagnosis or provide optimal care to the patient	

	Communicates a safe multimodal treatment plan	□ Presents an immediate and short-term treatment plan □ Suggests specific biological therapies for the patient □ Suggests specific non-pharmacological interventions for the patient, including psychotherapeutic approaches and social and culturally safe interventions	

Resident Name: _____ PGY_____

Date: _____

☐ **Practice** ☐ **Foundations/General STACER**

Evaluation Scoring Sheet

Your performance on today's evaluation, based on your level of training:	☐ Does Not Meet Expectations ☐ Meets Expectations

COMMENTS:

STRENGTHS:

1.

2.

3.

AREAS FOR IMPROVEMENT: 1. 2. 3.
RECOMMENDATIONS: To increase your effectiveness, you may wish to consider beginning or doing more of the following: 1. 2. 3.

Resident Signature:	
Evaluator Name & Signature:	
Evaluator Name & Signature	