Reference for ATSM

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| **Trainee Name:** |
| **ATSM applied for:** |
| **Referee Name (must be substantive consultant) & Position:**  |
| **Do you support this trainee’s choice of ATSM** | Yes / NoIf No please explain why: |
| **Please comment on the surgical skills of the trainee if the ATSM is one of the following:** **Benign Abdominal Surgery: open & laparoscopic****Gynaecological Oncology****Subfertility and reproductive health****Urogynaecology and vaginal surgery****Emergency Gynaecology and Early pregnancy** |  |
| **Please comment on the scanning skills of this trainee if the trainee is applying for the Fetal Medicine ATSM****Subfertility and reproductive health****Emergency Gynaecology and Early pregnancy** |  |
| **Do you think the trainee will be able to complete the ATSM with the necessary training?** |  |
| **Any other comments regarding the trainee** |  |

Signature of Referee……………………………………………………………………………………………………………………………

Date ………………………………………………………………………………………………………………………………………………….