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 1	2	Borderline 3	Acceptable 4	5	Above expectations 6	Not observed
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.