Reference for SITM

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| --- | --- |
| **Trainee Name:** | |
| **SITM applied for:** | |
| **Referee Name (must be substantive consultant) & Position:** | |
| **Do you support this trainee’s choice of SITM** | Yes / No  If No please explain why: |
| **Please comment on the surgical skills of the trainee if the SITM is one of the following:**  **Gynaecological surgical sare**  **Oncology**  **Management of complex non-malignant disease**  **Urogynaecology and vaginal surgery**  **Management of subfertility**  **Robotic assisted gynaecological surgery** |  |
| **Please comment on the scanning skills of this trainee if the trainee is applying for the following SITM:**  **Prenatal diagnosis**  **Management of subfertility**  **Complex early pregnancy and non-elective gynaecology** |  |
| **Do you think the trainee will be able to complete the SITM with the necessary training?** |  |
| **Any other comments regarding the trainee** |  |

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

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