Preparatory workshop
Practice assessment

PMP report

PMP

- What Candidate needs to prepare
- Tips on good practice
- What Examiner will assess
- Consensus in Marking

Prepare for
Practice Management Package (PMP)
Practice Assessment
Exit Exam

7 March 2025

PMP Rating Form

Please use the latest version of PMP Rating Form (Feb 2025)

- Practice setting (Part A)
- Clinic management (Part B)
- Pharmacy (Part C)
- Dangerous drug management (Part CII)

The Hong Kong College of Family Physicians

香港家庭醫學學院

Practice Management Package (PMP)

Candidate	
Practice name & address	(working in the practice since_____/_____)
Assessor	
Date of assessment	

Attachment 1 to 11

Hong Kong College of Family Physicians
Exit Examination

List of Attachments
to be submitted by candidates for Practice Assessment

Attachment		
Attachment 1	Information on	Type of practice(group/solo/public/private)
		Average no. of patients seen per week
		Average consultation time and average waiting time
	Name card (if available)	
Attachment 2	General clinic design illustrated with diagram	
Attachment 3	Prolong waiting protocol	
Attachment 4	Protocol for staff: Request for medical assistance in waiting area / vicinity of clinic	
Attachment 5	List of education leaflets / e-pamphlet commonly used by the candidate	
Attachment 6	Other diagnostic equipment and treatment facilities (not listed in the PMP)	
Attachment 7	Emergency equipment and drugs	
Attachment 8	Disinfection and sterilization protocol	
Attachment 9	Routine and urgent appointment protocol	
Attachment 10	Data access protocol	
Attachment 11	Needle stick injury protocol	
Attachment 12	Cases log for Part D (Medical Records)	
Attachment 13	Case summaries for Part E (Investigation)	

Feb 2025

PMP Appendixes

References in your PMP report preparation

The latest version of PMP Appendixes
(**April 2025**)

**Practice Management Package
Appendixes**

Appendix A   **Details of Permitted Sizes and Measurement of Signboards**

Appendix B   **Infection control measures (patient triage, PPE)**

Appendix C   **Routine Environmental Cleaning**

Appendix D   **"Spills" Protocol**

Appendix E   **Disinfection**

Appendix F   **Sterilization**

Appendix G   **Private Healthcare Facilities Ordinance**

Appendix H   **Telemedicine**

Appendix I   **Waste Management**

Appendix J   **Needle Stick Injury and Blood / Body Substance
Occupational Exposure Management Protocol**

Appendix K   **Handling and Disposal of Sharps**

Appendix L   **Procedures of Proper Dispensing**

Appendix M   **Vaccine Storage**

Appendix N   **Expired Medication Disposal**

Appendix O   **Dangerous Drugs Ordinance**

PMP Appendixes

References in your PMP report preparation

The latest version of PMP Appendixes
(**April 2025**)

Appendix N (Expired Medication disposal)
The list of 'Further reading' is updated

1. COLLECTION

Trip Ticket

Waste Producer retains 1 copy

Waste Producer to produce copies on request

2. TRANSPORT

Trip Ticket

Waste Collector keeps trip-ticket during transportation.

Waste Collector retains 1 copy

3. DISPOSAL

Trip Ticket

Disposal Point Manager retains original

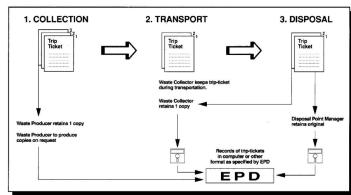Records of trip-tickets in computer or other format as specified by EPD

E P D

Figure 3 - The Trip-Ticket System for Tracking the Consignment of Chemical Waste

Further reading:

A Guide to the Chemical Waste Control Scheme, Environmental Protection Department, Hong Kong, October 2016

https://www.epd.gov.hk/epd/sites/default/files/epd/gn_pdf/GN2014P217-e.pdf

A Guide to the Registration of Chemical Waste Producers, Environmental Protection Department, Hong Kong, August 2024
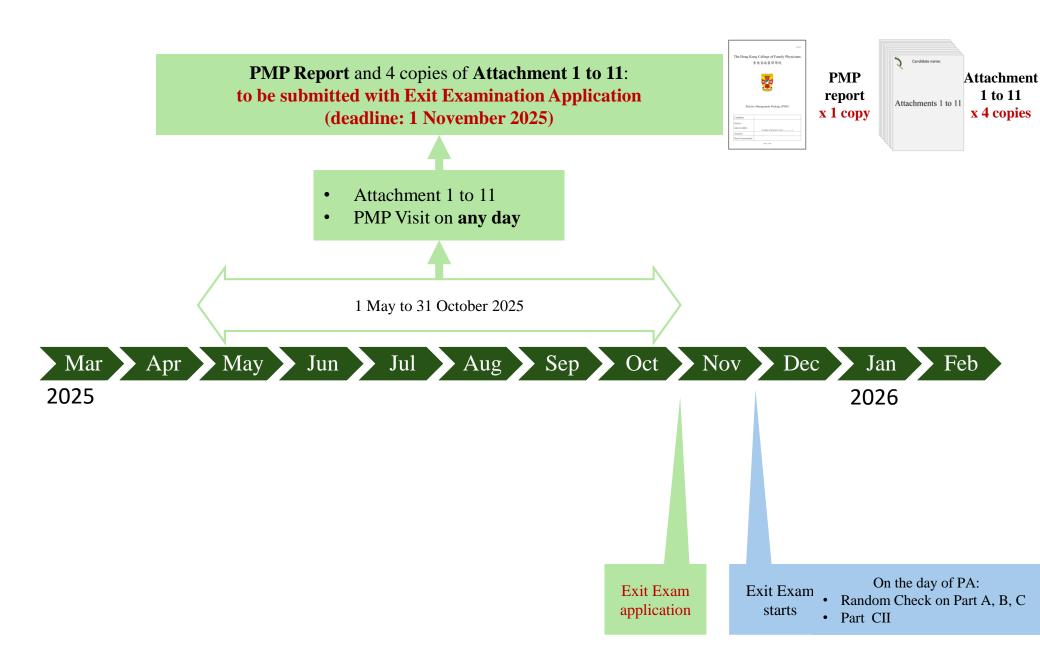
https://www.epd.gov.hk/epd/sites/default/files/epd/gn_pdf/GN2014P218-e.pdf

Code of Practice on the Packaging, Labelling and Storage of Chemical Wastes, Environmental Protection Department, Hong Kong

https://www.epd.gov.hk/epd/sites/default/files/epd/gn_pdf/GN2014P215-e.pdf

PMP Report preparation

PMP Report and 4 copies of **Attachment 1 to 11**:
**to be submitted with Exit Examination Application
(deadline: 1 November 2025)**

PMP report x 1 copy

Attachment 1 to 11 x 4 copies

- Attachment 1 to 11
- PMP Visit on **any day**

1 May to 31 October 2025

| Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |

2025

2026

Exit Exam application

Exit Exam starts

On the day of PA:
- Random Check on Part A, B, C
- Part CII

Part D

Prepare for Part D

- What Candidate needs to prepare
- Tips on good practice
- What Examiner will assess
- Consensus in Marking

Prepare for
Part D (Medical Records)
Practice Assessment
Exit Exam

7 March 2025

1

Prepare for Part D

Updates:

Satisfactory (or above) performance in PERMIx 3A and 3B in BVTS Higher Training
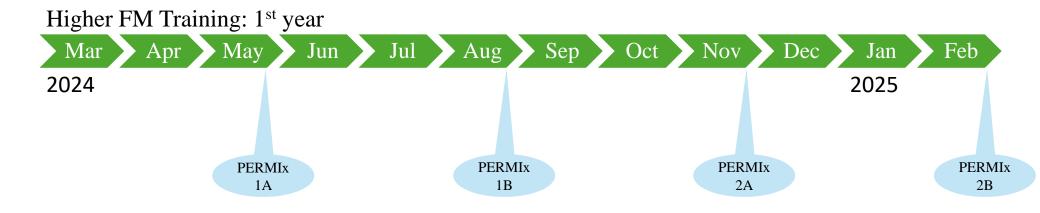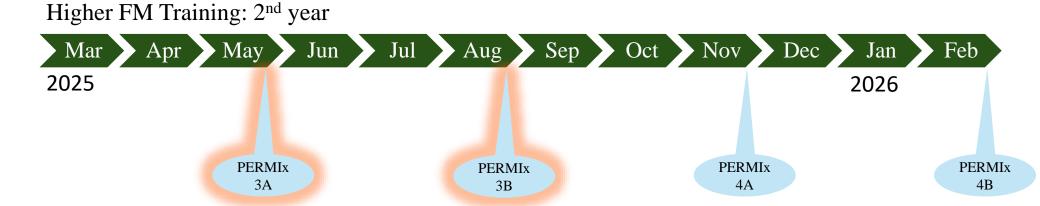
Cases collection / Attachment 12 preparation:

- Collect 50 Cases in a one-week-period period

- The one-week can be between 20 September to 20 November 2025 (tentative)

- Paper / print-out based

- The 50 Case-log = Attachment 12 ,

  to be submitted on or before 21 November 2025 (tentative)

Assessment format in Part D (Medical Records) of PA

- The same assessment format as in the previous year (i.e. 2025 Exit Exam)

- D2 (Basic Information) and D3 (Consultation notes)

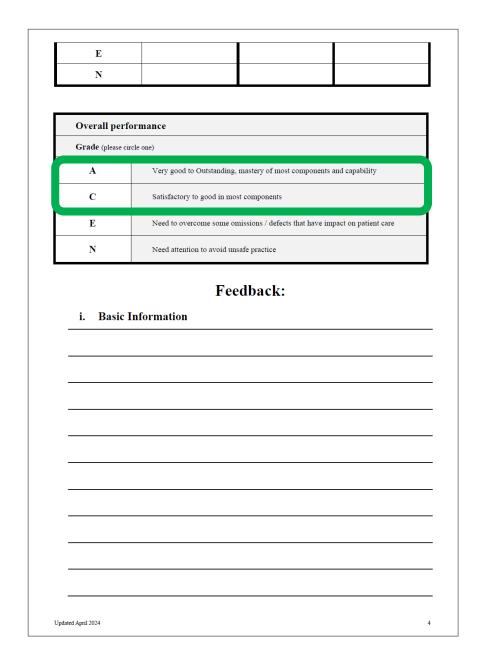# Satisfactory (or above) performance in PERMIx 3A and 3B in BVTS Higher Training

Higher FM Training: 1st year

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb

2024   2025

PERMIx 1A   PERMIx 1B   PERMIx 2A   PERMIx 2B

Higher FM Training: 2nd year

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb

2025   2026

PERMIx 3A   PERMIx 3B   PERMIx 4A   PERMIx 4B

Satisfactory (or above) performance in PERMIx 3A and 3B in BVTS Higher Training

Left document (page 1)

The Hong Kong College of Family Physicians

香港家庭醫學學院

Practice visit:

Medical Record Review including

Investigation (PERMIx)

Trainee	
Practice name & address	(Working in the practice since____/____)
Supervisor/ Assessor	
Period Assessed	1st assessment: week from	2nd Assessment: week from
Date of assessment	
Signature	

Updated April 2024

Left document (PERMIx Assessment Form)

PERMIx Assessment Form

Record type Assessed: ☐ Electronic ☐ Hard copy ☐ Both

Overall Format Appropriate to FM Practice ☐ Yes ☐ No, DO NOT PROCEED if No

Enter the Date and pt identifier like pt so (U1/24 AM N0005)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
0. Legibility															
i. Allergy / Adverse drug reactions															
ii. Basic Information (As appropriate)															

Can include Current medication list, Problem list (Current / Past health), Family history of significant illness, Genogram, Social history, occupation, basic parameters like Blood pressure/BMI, Growth chart, immunization status, tobacco and alcohol use as appropriate

Grade (please circle one)

A				
C				
E				
N				

iii. Consultation notes

History
Physical Examination
Diagnosis/Working diagnosis/Problem List
Management
Investigation Justification (if av)
Anticipatory care advice as appropriate (if av)

Grade (please circle one)

| A | | | | |
| C | | | | |

Updated April 2024

Right document (page 4)

E			
N			

Overall performance
Grade (please circle one)

A	Very good to Outstanding, mastery of most components and capability
C	Satisfactory to good in most components
E	Need to overcome some omissions / defects that have impact on patient care
N	Need attention to avoid unsafe practice

Feedback:

i. **Basic Information**

_____

_____

_____

_____

_____

_____

_____

_____

Cases collection / Attachment 12 preparation

Timeline

Attachment 12
to be submitted on OR before 21 November 2025 (tentative)

Any 'One week':
- The **medical records of 50 Patients** consulted the Candidate
- **Attachment 12** (the Case-1og)

20 Sep to 20 Nov 2025 (tentative)

| Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |

2025

2026

Exit Exam application

Exit Exam starts

On the day of PA: Examiners select 8 cases for Part D assessment

Cases collection / Attachment 12 preparation

Required format

Same as 2025 Exit Exam

Attachment 12

A list of the

the 50 patients consulted you

during the cases collection period

The patients can source from more than one clinic that you are working

Attachment 12: format

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 SEP 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 SEP 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21SEP 2022	18 SEP 1999
4	6677	CHL	F	12	ALLERGIC RHINITIS	21 SEP 2022	12 MAY 2011
5	4454	CHC	M	67	HT	21 SEP 2022	12 JAN 2011
...	...	....	...	...	...	....	....
50	2323	LKH	M	38	URTI	24 OCT 2022	24 OCT 2011
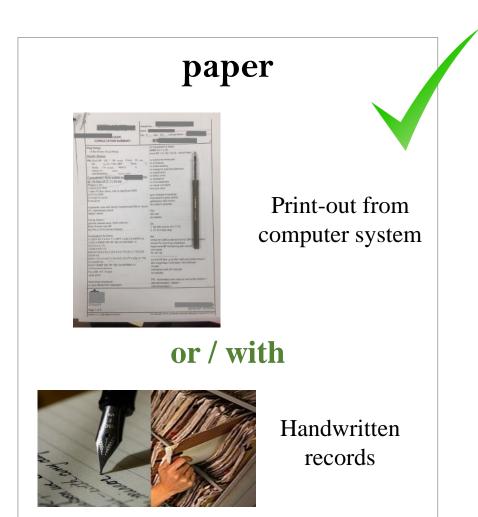
Confidentiality: Do not include patient's name, HKID

Sample layout of Attachment 12

The medical records in Part D (i)

The format

paper

Print-out from computer system

or / with

Handwritten records

on the computer screen
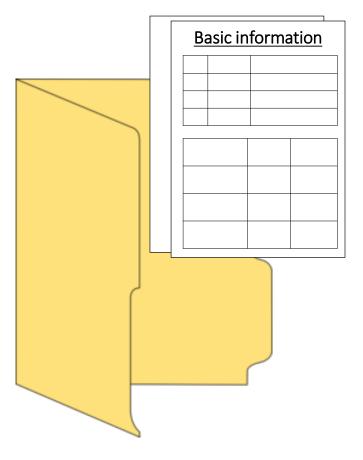
The medical records in Part D (ii)

The content of each medical record for assessment should **at least include**:

Basic information

Consultation notes

The medical records in Part D (iii)

Basic information

On following areas

as appropriate and as applicable

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Basic information

Please note:
It is not mandatory to have full documentation on all the areas in every record
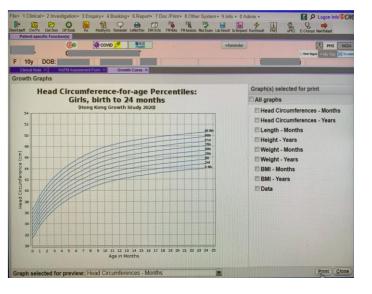
Basic information in PERMIx and Part D of PA

- There are differences in the format of assessment in PERMIx and Part D of PA

- Conventionally, the Part D (Medical Records) assessment is paper / print-out based

- For clinics that using computer based medical record system, suggest:
  - Make use of the existing system to fulfil the documentation of basic information as much as possible
  - Create template / tables to supplement the documentation of basic information if necessary
  - Not suggest to create a brand-new template to enter all the "Basic Information" for PA
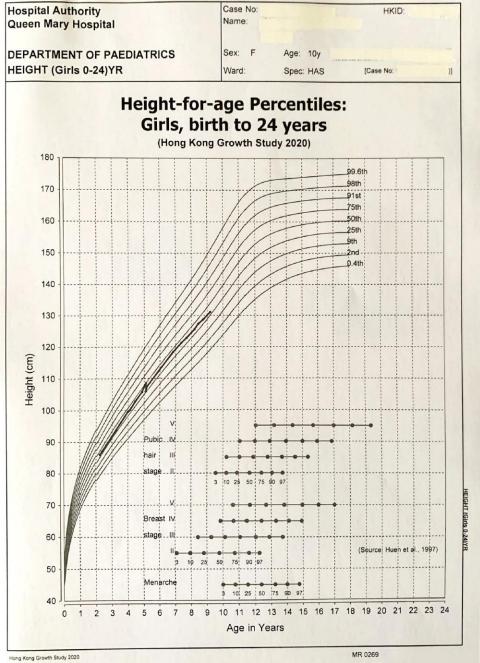
Make use of the existing system
to fulfil the documentation of basic information as much as possible

HOSPITAL AUTHORITY
[redacted] **Cluster**

FAMILY MEDICINE
HAFM ASSESSMENT FORM

Personal Information

Occupation:	house wife	Work Place:	
Education:	secondary	Staff / Family:	
Religion:	nil	Marital Status:	Married

Staff Information

Relation:		Staff Name:	
Office:		Rank:	
Phone:	Ext.		

Medical History

Procedure: lumpectomy & sentinel lymph node biopsy 2016

Hypertension	☐	DM	☐		
Heart Disease	☑ chronic rheumatic heart dis	CVA	☐		
Lipid	☐	Thyroid	☐		nil
CA	☑ breast cancer	Tuberculosis	☐		
Epilepsy	☐	Psychiatric Illness	☐		
Back Injury	☐				
Others:	allergic rhinitis				
Cholesterol:	Not Tested				

Habits

Smoking: Non-smoker
Alcohol: Non-drinker
Remarks:

no substance abuse

Immunization

08-Jan-2020   Seasonal Influenza 2019/2020

Gynaecological Information

Menarche:	13 y/o	Menstrual Cycle:	/ days (duration / cycle length)
Obstetric History:	G 2 P 2	NSD	
Contraception:			
Menopause:	46 y/o		
	HRT ☐		
Remarks:	nil		

Family History

	FA	MO	SB	OT	(FA-Father, MO-Mother, SB-Sibling, OT-Others)
Hypertension:	☐	☐	☐	☐	
Diabetes Mellitus:	☐	☐	☐	☐	
Heart Disease:	☐	☐	☐	☐	
CVA:	☐	☐	☐	☐	
Lipid:	☐	☐	☐	☐	
Thyroid:	☐	☐	☐	☐	
CA:	☑	☐	☑	☐	father leukemia , elder sister cervical cancer
Tuberculosis:	☐	☐	☐	☐	
Epilepsy:	☐	☐	☐	☐	
Psychiatric Illness:	☐	☐	☐	☐	
Others:	☐	☑	☐	☐	OA knees

Date 26-Sep-2020   Dr./RN: [redacted]

Family Tree

Draw genogram here

Prefers type-in the information as much as possible, instead of all hand-written

Print-out

HOSPITAL AUTHORITY

HA IMMUNIZATION SUMMARY

Name:

Sex: M   Age: 23y   Chinese Name:
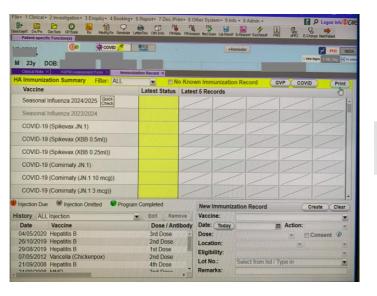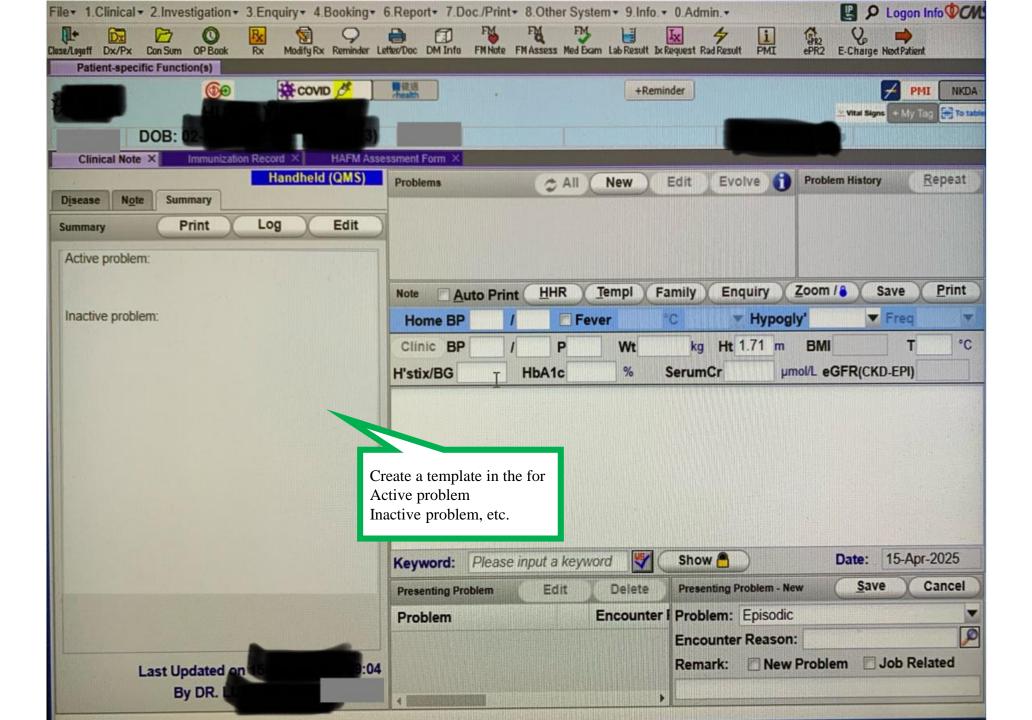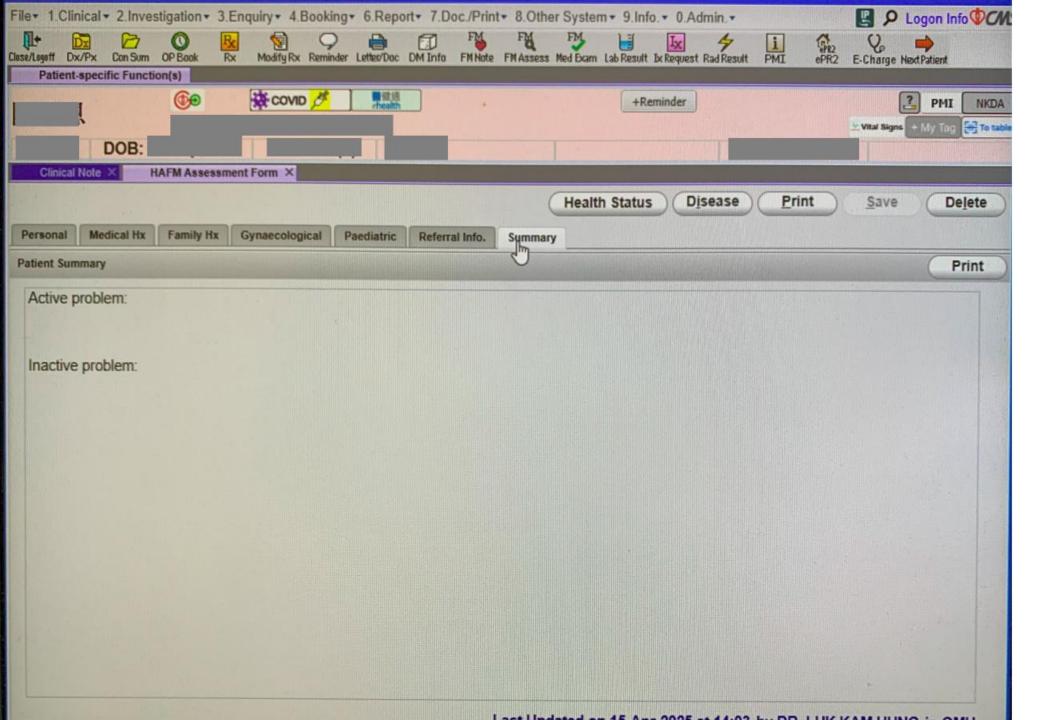
Allergy: (1)No Known Drug Allergy

Vaccine	Latest Status	Latest 5 Records				
Seasonal Influenza 2024/2025						
Seasonal Influenza 2023/2024						
COVID-19 (Spikevax JN.1)						
COVID-19 (Spikevax (XBB 0.5ml))						
COVID-19 (Spikevax (XBB 0.25ml))						
COVID-19 (Comirnaty JN.1)						
COVID-19 (Comirnaty (JN.1 10 mcg))						
COVID-19 (Comirnaty (JN.1 3 mcg))						
COVID-19 (Comirnaty (XBB))						
COVID-19 (Comirnaty (Bivalent))						
COVID-19 (Comirnaty (10 mcg))						
COVID-19 (Comirnaty (3 mcg))						
Pneumococcal (PCV15)						
Pneumococcal (23vPPV)						
Pneumococcal (PCV13)						
Mpox (Monkeypox)						
MMR	COMPLETED	2nd Dose 21/09/2008	1st Dose 10/06/2003			
BCG						
Hepatitis B	COMPLETED	3rd Dose 04/05/2020	2nd Dose 26/10/2019	1st Dose 29/08/2019	4th Dose 21/09/2008	3rd Dose 05/09/2002
Hepatitis B Immunoglobulins						
DTaP + IPV						
Anti-Tetanus Toxoid (ATT)						
Varicella (Chickenpox)	COMPLETED	2nd Dose 07/05/2012	1st Dose 10/06/2006			
COVID-19 (CoronaVac)						
COVID-19 (Comirnaty (BNT162b2))						
COVID-19 (Comirnaty (XBB 10 mcg))						

醫院管理局
HOSPITAL AUTHORITY
Page 1 of 2

Printed by DR.
from Queen Mary Hospital
(15-Apr-2025 09:04)

Logon Info ♥CMS

Close/Logoff | Dx/Px | Con Sum | OP Book | Rx | Modify Rx | Reminder | Letter/Doc | DM Info | FM Note | FM Assess | Med Exam | Lab Result | Ix Request | Rad Result | PMI | ePR2 | E-Charge | Next Patient

Patient-specific Function(s)

COVID | 健通 health | +Reminder | PMI | NKDA

Vital Signs | + My Tag | To table

DOB: 02-

Clinical Note × | Immunization Record × | HAFM Assessment Form ×

Handheld (QMS)

Disease | Note | Summary

Summary | Print | Log | Edit

Active problem:

Inactive problem:

Problems | ⟳ All | New | Edit | Evolve | ⓘ | Problem History | Repeat

Note | ☐ Auto Print | HHR | Templ | Family | Enquiry | Zoom /🔒 | Save | Print

Home BP [ ] / [ ] | ☐ Fever | [ ] °C | ▾ Hypogly' [ ] | ▾ Freq [ ] ▾

Clinic BP [ ] / [ ] | P [ ] | Wt [ ] kg | Ht 1.71 m | BMI [ ] | T [ ] °C

H'stix/BG [ ] | HbA1c [ ] % | SerumCr [ ] µmol/L | eGFR(CKD-EPI) [ ]

Create a template in the for
Active problem
Inactive problem, etc.

Keyword: *Please input a keyword* | Show 🔒 | Date: 15-Apr-2025

Presenting Problem | Edit | Delete | **Presenting Problem - New** | Save | Cancel

Problem | Encounter | Problem: Episodic ▾

Encounter Reason: [ ] 🔍

Remark: ☐ New Problem ☐ Job Related

Last Updated on 15...........9:04
By DR. LU

Close/Logoff Dx/Px Con Sum OP Book Rx Modify Rx Reminder Letter/Doc DM Info FM Note FM Assess Med Exam Lab Result Ix Request Rad Result PMI ePR2 E-Charge Next Patient

Patient-specific Function(s)

COVID   健通 rhealth   +Reminder   ? PMI   NKDA

DOB: Vital Signs + My Tag To table

Clinical Note ✕   HAFM Assessment Form ✕

Health Status   Disease   Print   Save   Delete

Personal | Medical Hx | Family Hx | Gynaecological | Paediatric | Referral Info. | Summary

Patient Summary   Print

Active problem:

Inactive problem:

Last Updated on 15 Apr 2025 at 14:03 by DR. LUK KAM HUNG in OMU

Drug Allergy: (1)No Known Drug Allergy

Last Update on 15-Apr-2025 at 02:03 pm by DR. _____ **in QMH**

Active problem:

Inactive problem:

醫院管理局
HOSPITAL
AUTHORITY

Printed by DR.

from

Page 1 of 1

(pm)

Create template / tables to supplement the documentation of basic information, if necessary, e.g.
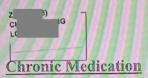
Chronic Problem List

	Active Problems	Since
1	chronic rheumatic heart disease	1997
2	Ca breast	2016
3	allergic rhinitis	2009
4		
5		
6		
7		
8		

	Inactive problems	Since
1		
2		
3		
4		
5		
6		
7		
8		

Last updated on: __17/9/2020__

Allergy: N/Y
G6PD: N/Y
Alert: N/Y

Chronic Medication

No.	Drug Name	Dosage and frequency	Started	Stopped
1	atenolol	100mg daily	19/6/2011	12/7/2011
2	Norvasc	5mg daily	13/7/2011	6/9/2011
3	" "	7.5mg daily	7/9/2011	9/8/2012
4	" "	2.5mg daily	17/6/2015	4/10/2015
5	" "	5mg daily	7/10/2015	26/10/2017
6	diltiazem CR	30mg tds	27/10/2017	12/4/2018
7	" "	30 mg bd	13/4/2018	continue
8	hytrin	5mg daily	20/8/2012	continue
9	Natrilix SR	1.5mg daily	8/2/2019	continue
10				

Last updated on: __18/9/2020__

Not necessary to list the dates of dosage adjustment

The medical records in Part D (iv)

Consultation notes

On following areas
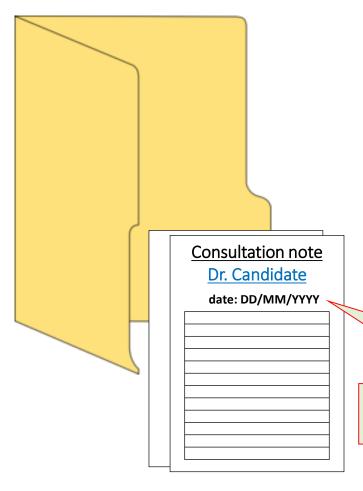
as appropriate and as applicable

- Main reason(s) of consultation
- Clinical findings
- Diagnosis / working diagnosis
- Management
- Anticipatory care advice

Consultation note
Dr. Candidate
date: DD/MM/YYYY
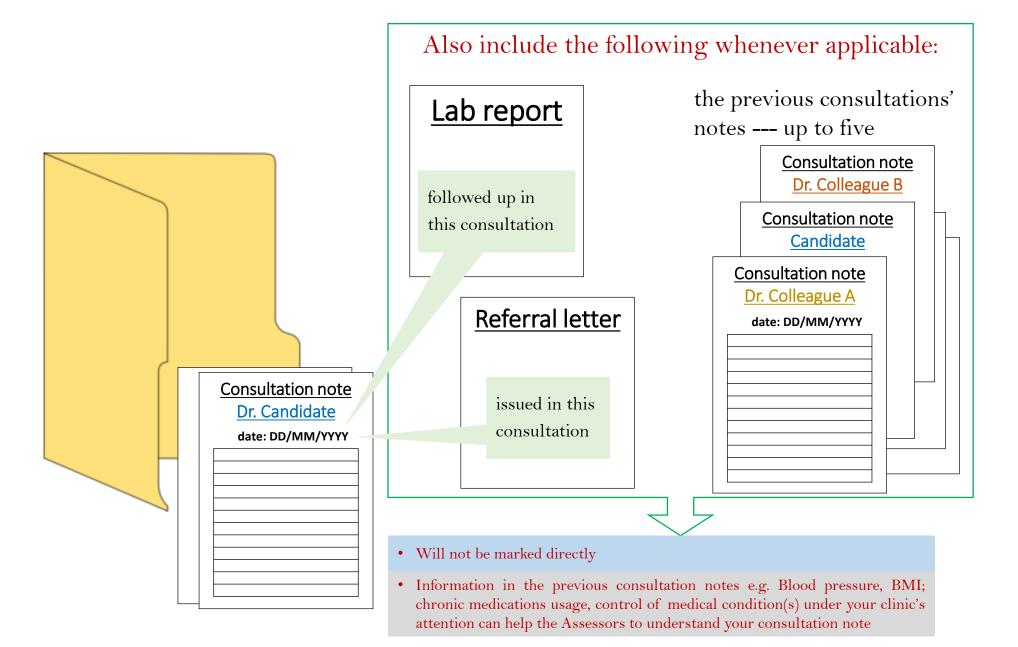
Please note:
- **As appropriate and as applicable**
- **Not mandatory in every consultation**

Date of the consultation: to be stated in the **Attachment 12**

The medical records in Part D (v)

Also include the following whenever applicable:

Lab report

followed up in this consultation

the previous consultations' notes --- up to five

Consultation note
Dr. Colleague B

Consultation note
Candidate

Consultation note
Dr. Colleague A

date: DD/MM/YYYY

Referral letter

issued in this consultation

Consultation note
Dr. Candidate

date: DD/MM/YYYY

- Will not be marked directly

- Information in the previous consultation notes e.g. Blood pressure, BMI; chronic medications usage, control of medical condition(s) under your clinic's attention can help the Assessors to understand your consultation note

The medical records in Part D (vi)

Suggest paper-flag the pages for Examiners

The medical records in Part D (vii)

- **Keep in your clinic**
- **To be assessed by PA examiner on the Examination Day**

The medical records in Part D (viii)

Readily retrievable and available upon the Examiners' request

May be required to verify the genuineness e.g. through the clinic computer record system/ relevant persons

Assessment format in Part D (Medical Records) of PA

Same as 2025 Exit Exam

Part D (Medical Records) Rating Form

Part D (Medical Records)

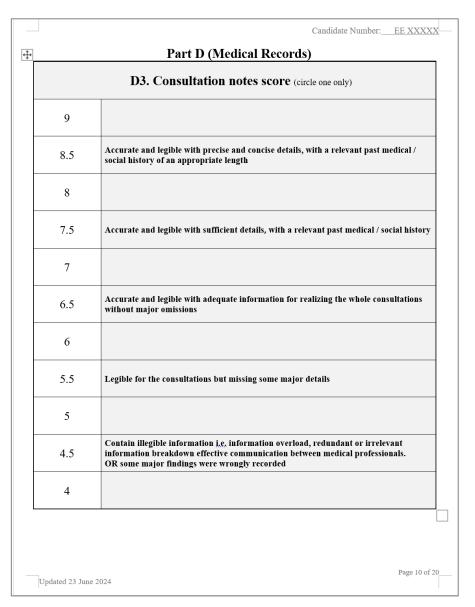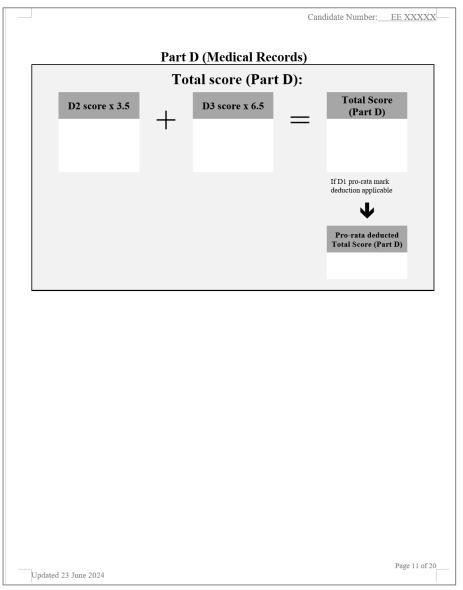| *Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log* →	1	2	3	4	5	6	7	8
D1. Legibility (Tick if okay)								
D2. Basic Information								
• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate) • Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity								
D3. Consultation notes								
Main reason(s) of consultation								
Clinical findings								
Diagnosis/ Working diagnosis								
Management								
Anticipatory care advice (as applicable)								

Part D (Medical Records)

D2. Basic Information score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details**
8	
7.5	**Accurate and legible with sufficient details**
7	
6.5	**Accurate and legible with adequate information for realizing the basic information without major omissions**
6	
5.5	**Legible but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded**
4	

Part D (Medical Records) Rating Form

Part D (Medical Records)

D3. Consultation notes score (circle one only)	
9	
8.5	Accurate and legible with precise and concise details, with a relevant past medical / social history of an appropriate length
8	
7.5	Accurate and legible with sufficient details, with a relevant past medical / social history
7	
6.5	Accurate and legible with adequate information for realizing the whole consultations without major omissions
6	
5.5	Legible for the consultations but missing some major details
5	
4.5	Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded
4	

Part D (Medical Records)

Total score (Part D):

D2 score x 3.5 **+** D3 score x 6.5 **=** Total Score (Part D)

If D1 pro-rata mark deduction applicable

↓

Pro-rata deducted Total Score (Part D)

Part D (Medical Records) Rating Form

Feedback on Part D (Medical records)

Written comment:
- *please quote the Case serial number (i.e. case 1 --- 100)*
- *mandatory if you rate 'fail' (below 65%) in Part D*

_____

_____

_____

_____

_____

_____

_____

Feedback on Part D (Medical records)

- *please tick the area(s) need attention / improvement according to the overall performance*
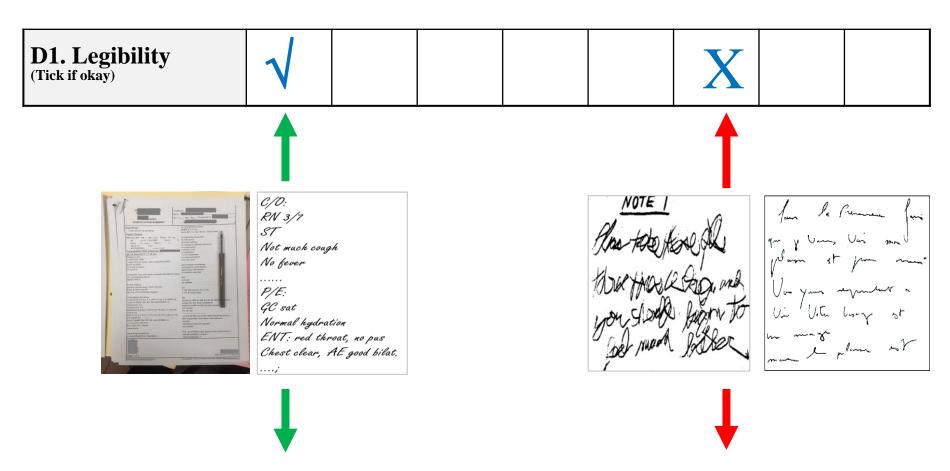- *mandatory if you rate fail (below 65%) in Part D*

Overall performance on D2 (Basic information): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on D3 (Consultation notes): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

D1 (Legibility): marking

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8
	8	12	23	25	35	39	41	48

Please enter the Serial no. of the records i.e. 1 to 50 of the Attachment 12

D1 (Legibility): marking

D1. Legibility (Tick if okay)	√					X		

Examiners proceed to assess
the medical record

the whole case will not be marked
pro-rata mark deduction in Part D
total score

D2 (Basic Information): marking

D2. Basic Information								
• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate) • Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity								

Examiner would jot down the impression of each of the eight selected cases

Marking Scale for D2 (Basic information)

Examiner marks all the eligible medical records
Then give a global mark in Part D2 (basic information)

D2. Basic Information score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details**
8	
7.5	**Accurate and legible with sufficient details**
7	
6.5	**Accurate and legible with adequate information for realizing the basic information without major omissions**
6	
5.5	**Legible but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals.** **OR some major findings were wrongly recorded**
4	

Criterion performance

D3 (Consultation notes)
Date of the consultation

Attachment 12

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 May 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 May 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21 May 2022	18 SEP 1999
4	9932	STKM	F	1	URTI	21 May 2022	6 AUG 2011
5				12	ALLERGIC RHINITIS		
6			M	67	HT		
...	...	....	...	...	...	....	....
100	2323	LKH	M	38	URTI	29 June 2022	24 OCT 2011

If the assessor choose to assess this record

This consultation notes would be selected for assessment

D3 (Consultation notes): marking

D3. Consultation notes							
Main reason(s) of consultation							
Clinical findings							
Diagnosis/ Working diagnosis							
Management							
Anticipatory care advice (as applicable)							

Examiner would jot down the impression of each of the eight selected cases

D3 (Consultation notes): marking

D3. Consultation notes								
Main reason(s) of consultation								
Clinical findings								
Diagnosis/ Working diagnosis								
Management								
Anticipatory care advice (as applicable)								

NOT "Idea / Concern / Expectation of the patient"!

Marking Scale for D3 (Consultation notes)

Examiner marks all the eligible medical records
Then give a global mark in Part D3 (Consultation notes)

|	D3. Consultation notes score (circle one only)
9	
8.5	**Accurate and legible with precise and concise details, with a relevant past medical / social history of an appropriate length**
8	
7.5	**Accurate and legible with sufficient details, with a relevant past medical / social history**
7	
6.5	**Accurate and legible with adequate information for realizing the whole consultations without major omissions**
6	
5.5	**Legible for the consultations but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded**
4	

Criterion performance
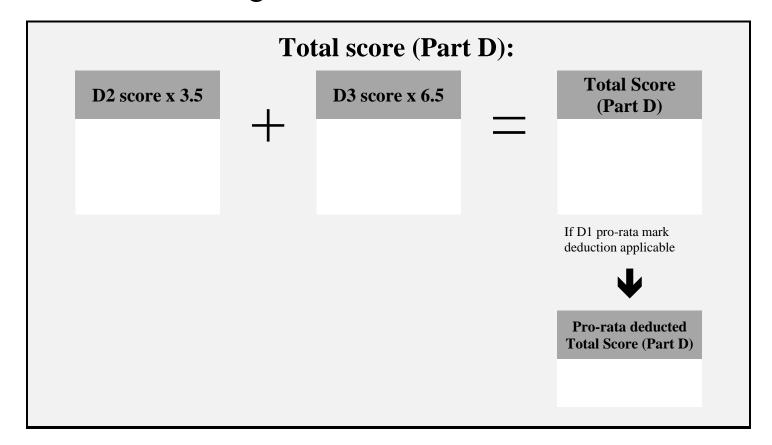
Part D (Medical Records): total score

Mark distribution:

D2 (Basic information): 35%

D3 (Consultation notes): 65%

Passing mark: Total score $\geq$ 65%

Total score (Part D):

D2 score x 3.5		D3 score x 6.5		Total Score (Part D)
	+		**=**	

If D1 pro-rata mark deduction applicable

⬇

Pro-rata deducted Total Score (Part D)

Feedback on Part D (Medical records)

- *please tick the area(s) need attention / improvement according to the overall performance*
- *mandatory if you rate fail (below 65%) in Part D*

Overall performance on D2 (Basic information): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on D3 (Consultation notes): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Part E

Prepare for Part E

- What Candidate needs to prepare
- Tips on good practice
- What Examiner will assess
- Consensus in Marking

Prepare for
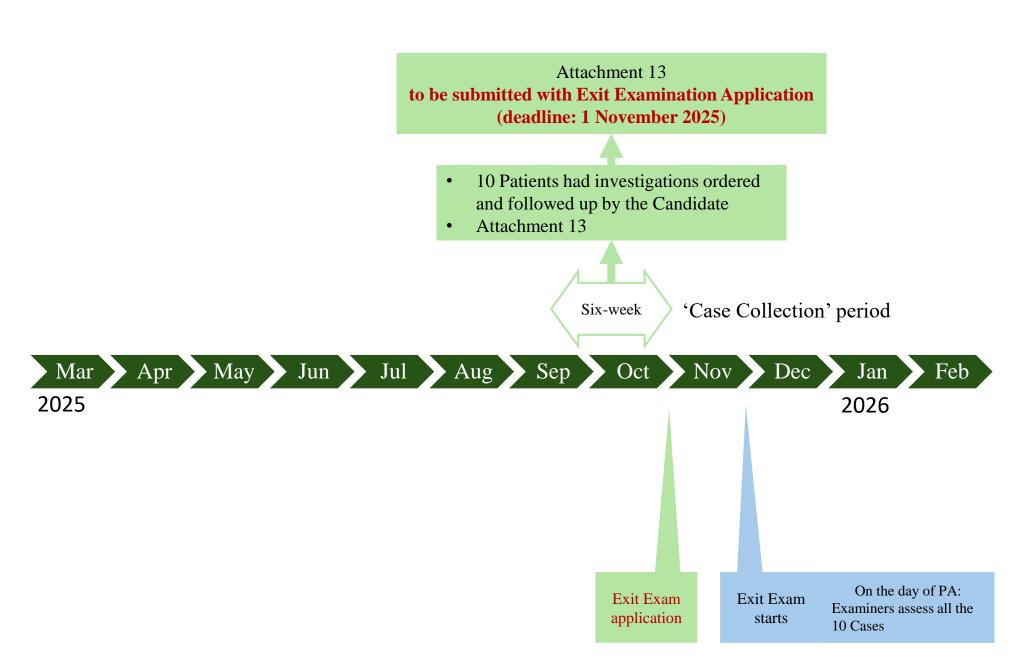Part E (investigation)
Practice Assessment
Exit Exam

7 March 2025

1

Prepare for Part E

1. Everyday practice:

    a. rational use of investigations (justification)

    b. appropriate follow up on the investigation results & patients

2. Familiarize with ICPC-2 coding
3. Practice write up short cases summaries
4. **Look for Cases that have the potential to submit for PA (Part E)**

    a. Have investigations initiated, ordered by the candidate

    b. Follow up of the investigation results expected to occur within the 'Case Collection' period

Part E (Investigation) preparation

Attachment 13
to be submitted with Exit Examination Application
(deadline: 1 November 2025)

- 10 Patients had investigations ordered and followed up by the Candidate
- Attachment 13

Six-week 'Case Collection' period

| Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |

2025

2026

Exit Exam application

Exit Exam starts

On the day of PA: Examiners assess all the 10 Cases

	E2. Justification Performance
	The investigations were targeted to the clinical findings, performed at appropriate time, the medical record was precise; provided effective patient care
	The investigations were targeted to the clinical findings, performed at appropriate time
	The investigations were in line with the clinical findings, likely solving the presenting problem
	The investigations were not in line with the clinical findings, not likely solving the presenting problem
	The investigations did not consider significant clinical findings appropriately
	The investigations OR the management of clinical condition(s) did not consider red flags appropriately
	The medical record was disorganized, impairing the communication with other health care workers

		E4. Follow up Performance
		The follow up was targeted to the clinical findings and the investigation results, performed at appropriate time, the medical record was precise; provided effective patient care
		The follow up was targeted to the clinical findings and the investigation results, performed at appropriate time
		The follow up was in-line with the clinical findings and the investigation results
		The follow up was not in line with the clinical findings OR the investigation results
		The follow up did not consider significant investigation results appropriately
		The follow up of investigation results OR the management of clinical condition(s) did not consider red flags appropriately
		The medical record was disorganized, impairing the communication with other health care workers

Thanks