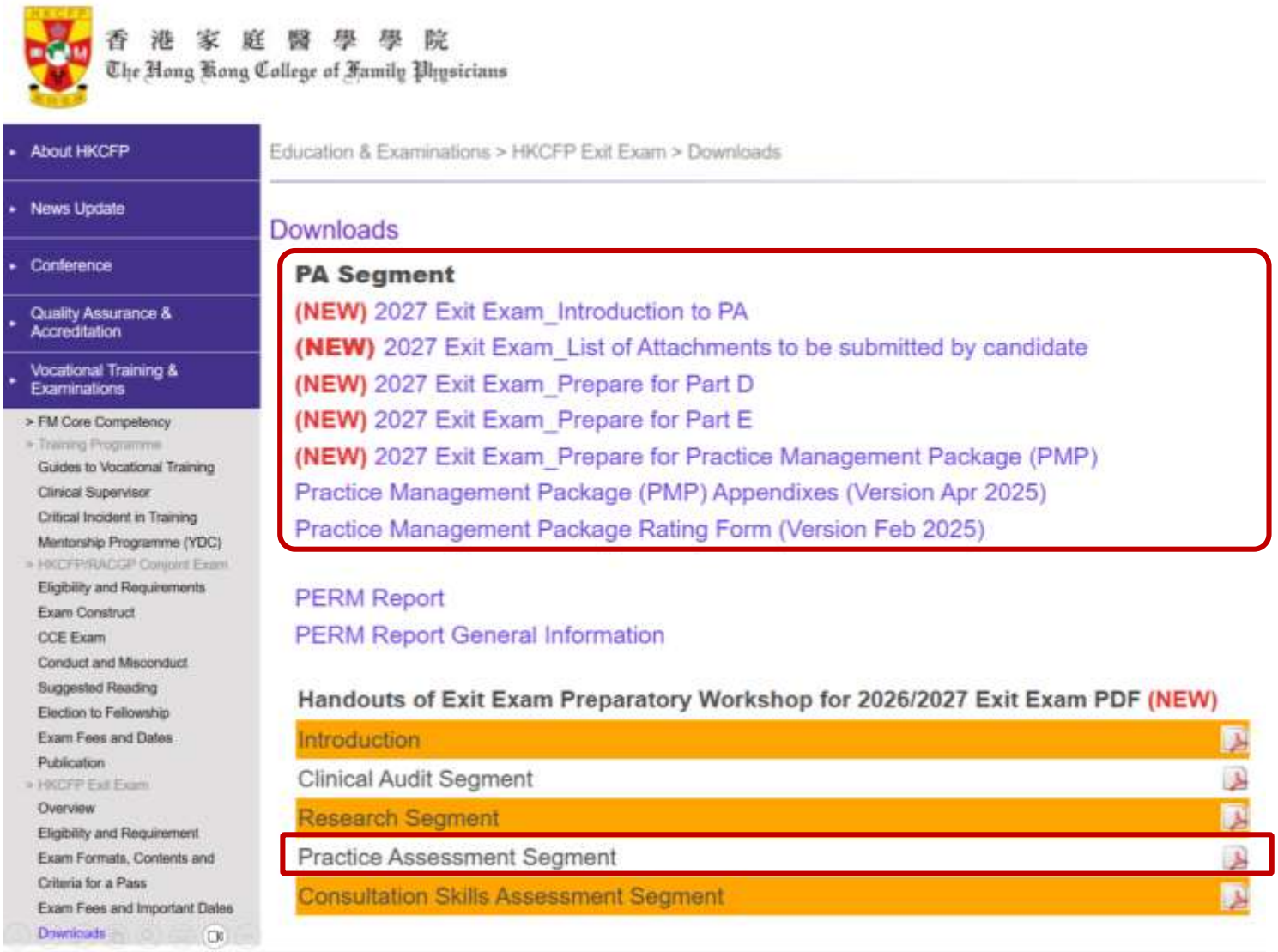
2027 Exit Examination
Pre-Exit Examination Workshop for Candidates

Practice Assessment

28 August 2026

Please also refers to the information in the Introductory and Preparatory Workshops



Information provided

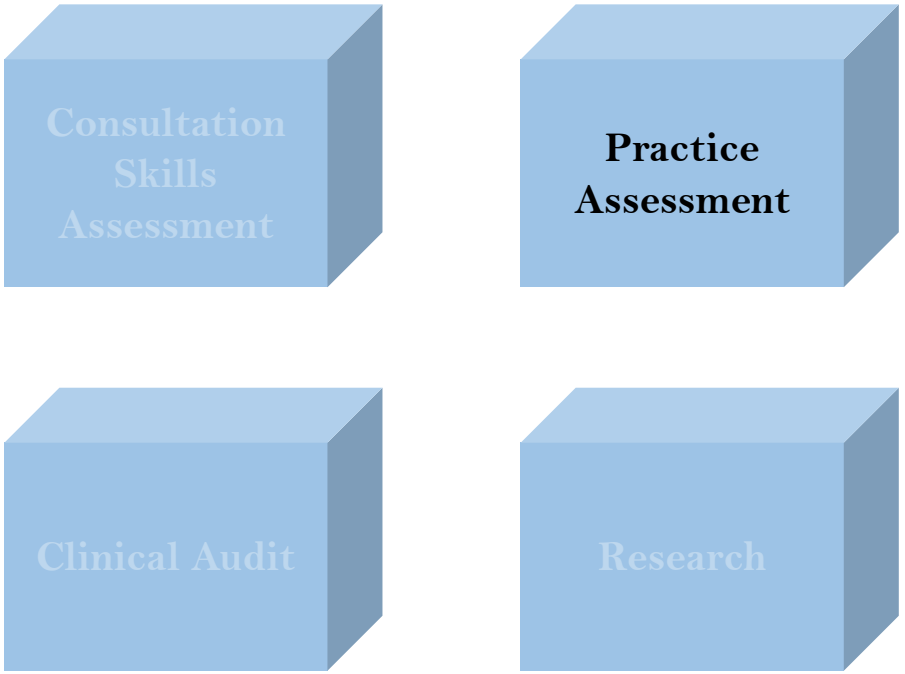
Candidate needs to prepare

Tips on good practice for Candidate

Examiner will assess

Consensus / recommendation in marking

HKCFP Exit Examination

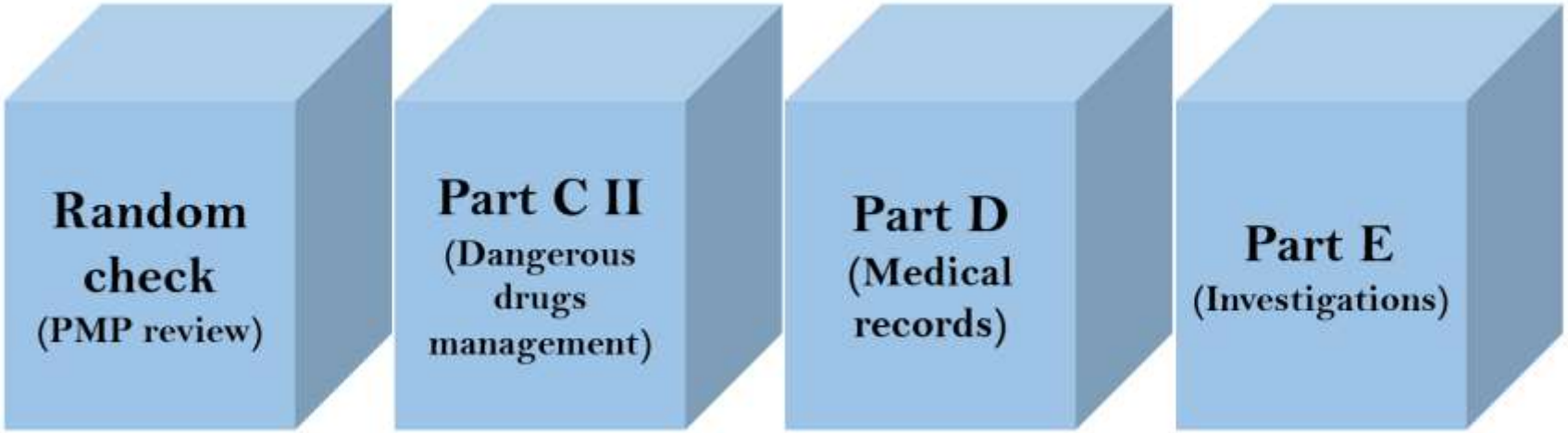


Candidate can choose to take either Clinical Audit or Research

Practice Assessment is an assessment of

- the candidate’s knowledge and understanding of the medical practice
- the standard of the candidate’s practice
- the candidate’s practice management skills

Practice Assessment consists of four Parts



PA Documents

PA Documents submission deadlines

Submit
on OR before
3rd November 2026
(with the Exit Examination application)

1 copy

PMP report

4 copies

Attachment
1 to 11

for Random check (PMP review)

4 copies

Attachment
13

for Part E (Investigations)

Submit
on OR before 21st November 2026

4 copies

Attachment
12

for Part D (Medical Records)

List of Attachments 1 - 13
to be submitted by candidates for Practice Assessment

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

Suggestion on printing & binding your PA Documents

A4 size

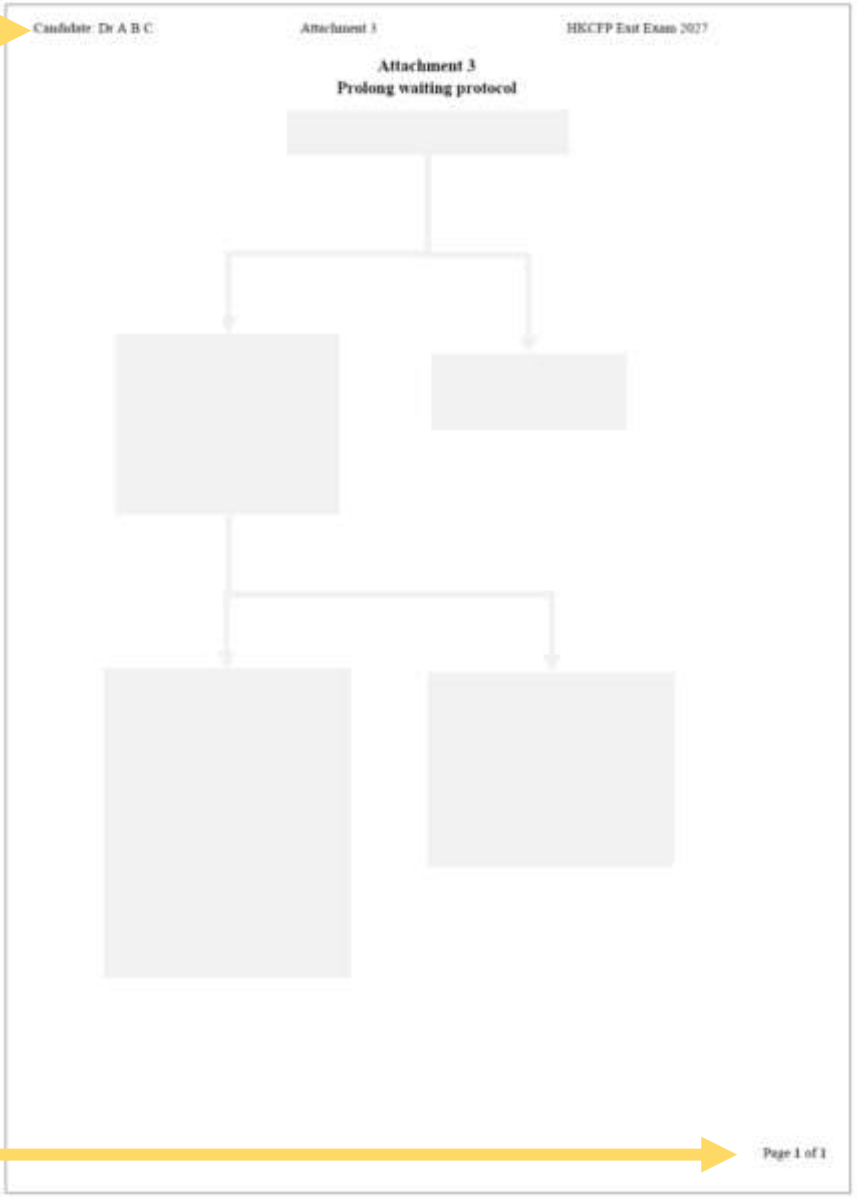
Insert header/ footer; indicating:
- Candidate name / number
- Attachment no.
- Page number

Double-side printing preferred

If an Attachment has multiple pages → staple

For each of the four sets of the documents use detachable binding e.g. treasury tags or binder clips

∵ only some (NOT all) of the Attachments will be selected and distributed to PA Examiners



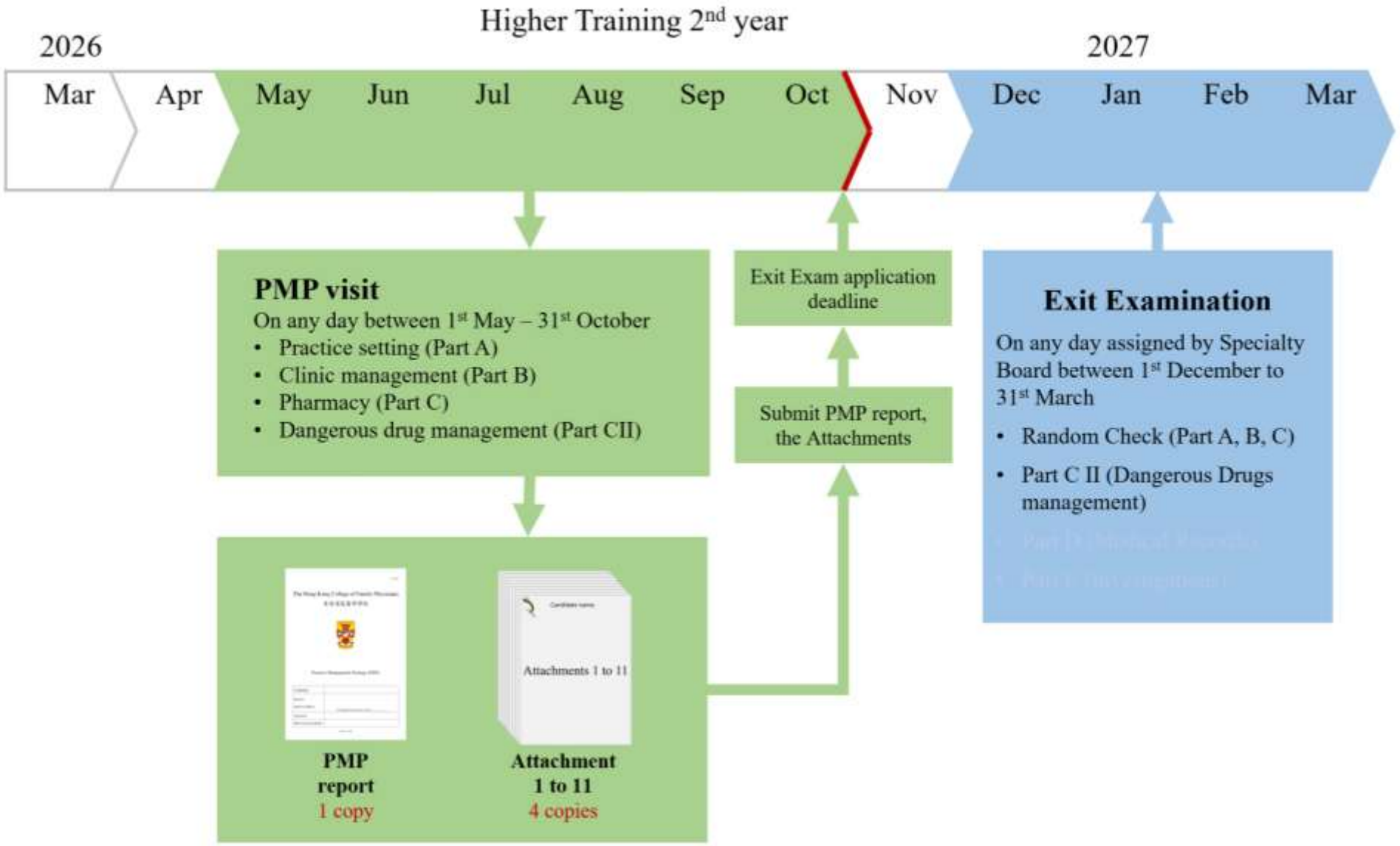
Random Check (PMP review)

Part CII of PA

PMP report

Attachment 1 to 11

Prepare for PMP review (Random Check, Part C II)



Part D (Medical Records)

Satisfactory performance in PERMIx, Higher Training

50 patients' medical records

Attachment 12

Satisfactory performance in PERMIx, Higher Training

The Hong Kong College of Family Physicians

香港家庭醫學學院

Practice visit:

Medical Record Review including

Investigation (PERMIx Report ____)

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		

A	
C	
E	
N	

Overall performance: Clear, update, precise, consistent and concise	
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 may have impact on patient care
N	Illegible or Major Wrong information which significantly affect patient management or medical communication

Feedback:

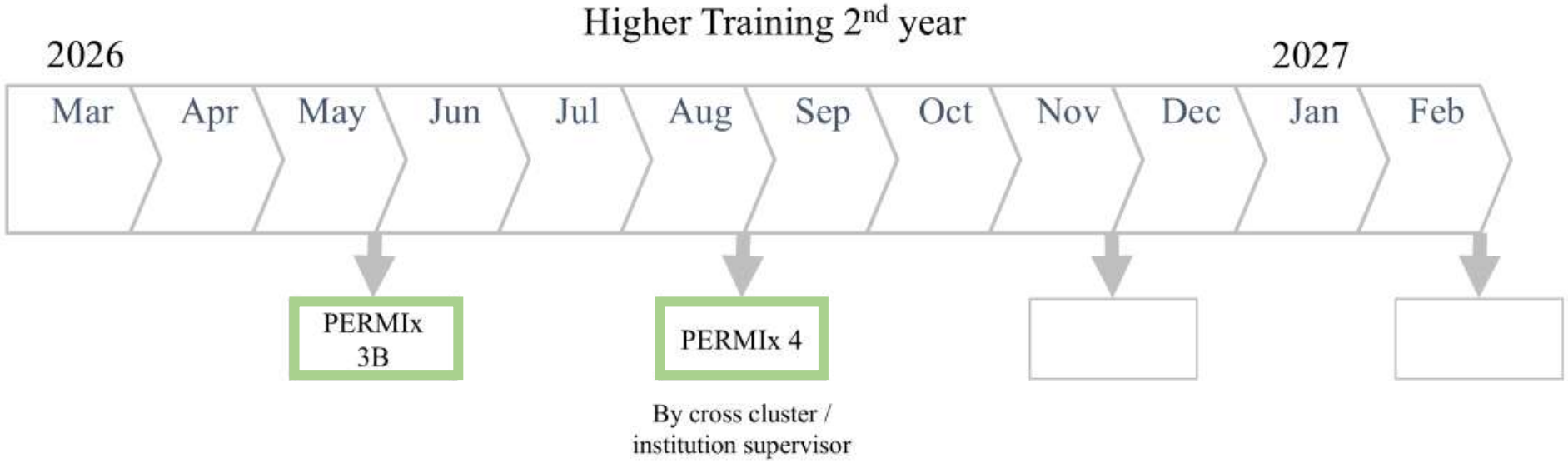
i. Basic Information

Assessment 1:

Assessment 2:

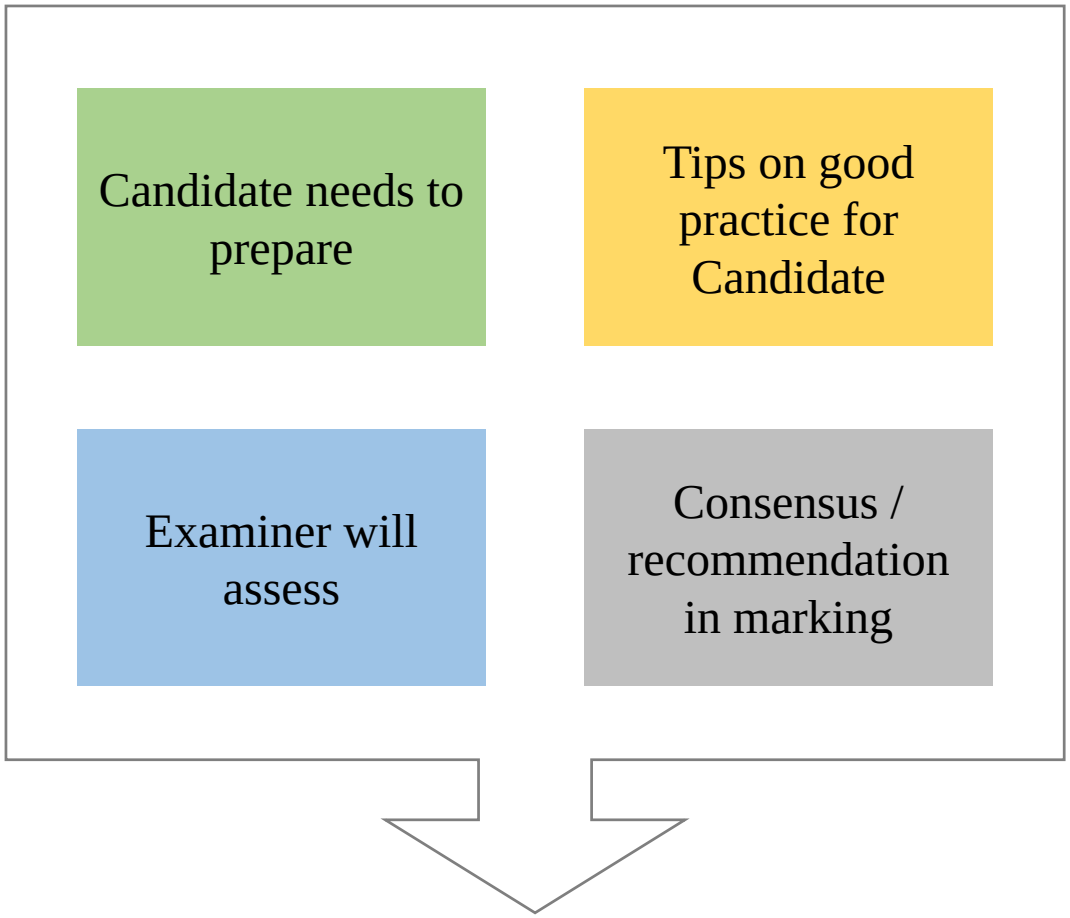
ii. Consultation notes including Investigation, Anticipatory Care

Satisfactory performance in PERMIx, Higher Training



Submit your PERMIx 3B and 4 reports to BVTS

50 patients' medical records for Part D



Presentation materials of the Introductory & Preparatory Workshops available in the College website

50 patients' medical records for Part D

- The 50 patients were seen by you within **a one-week period**
- The one-week period must be within:

  15 September 2026 to 20 November 2026
- To be submitted on or before 21 November 2026

Part D
Case collection period

50 patients' medical records for Part D

- The 50 patients

Head counts
Not the repeated attendances of individual patients

- The patients could be seen by you in different clinics
- Health Screening / Medical Assessment excluded

Attachment 12

- A table of the 50 cases collected
- Standard format
  - Serial no. (i.e. 1 – 50)
  - Patient record number
  - Patient initials
  - Sex
  - Age
  - Diagnosis
  - Date of the consultation (by the candidate)
  - Estimated duration of the consultation (by the candidate)
  - Date first attended the clinic (by the candidate OR another doctor)
- Confidentiality: **do not** include patient's name, HKID

New requirement from 2027 Exit Exam

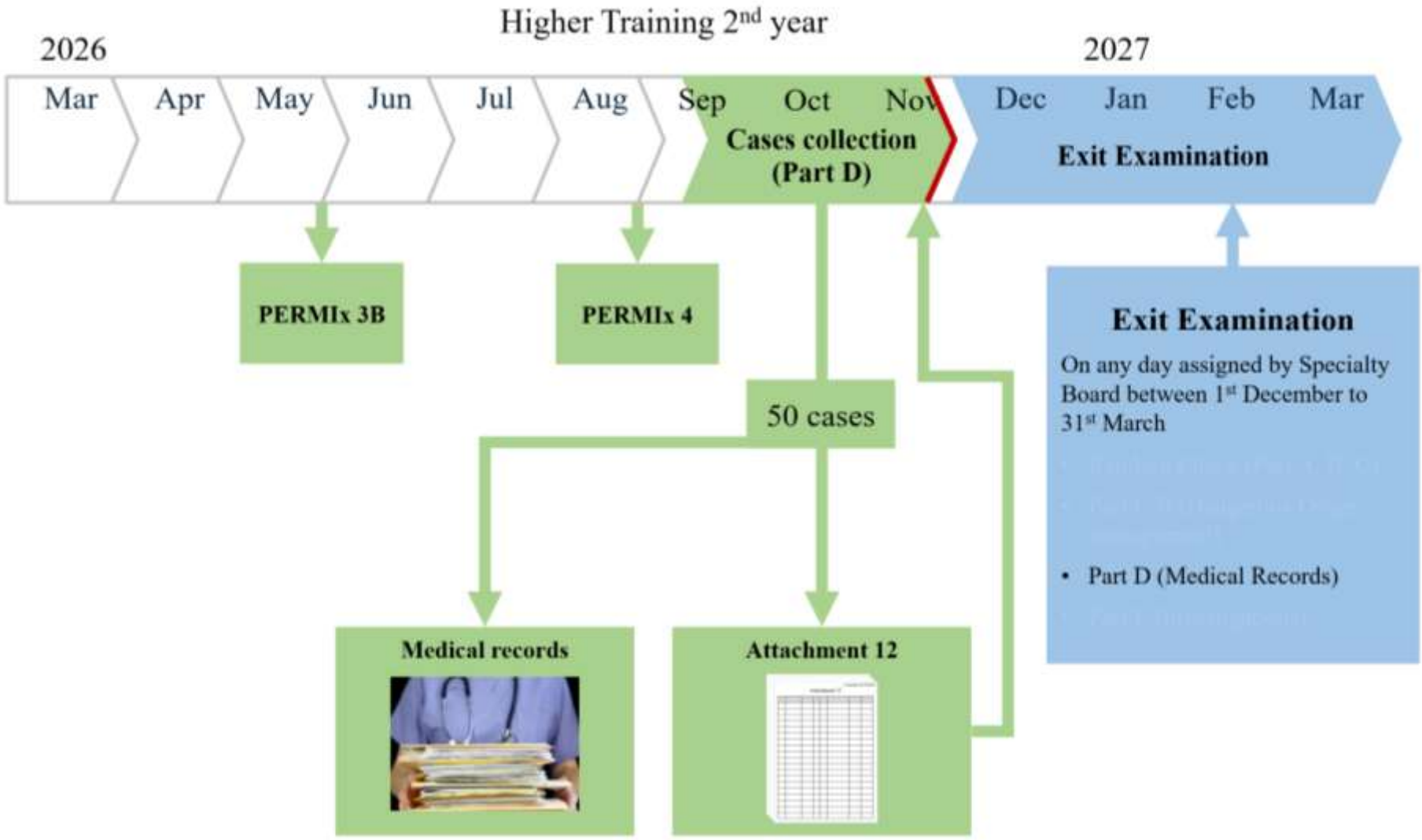
Attachment 12

New requirement from 2027 Exit Exam

Sample

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Estimated duration of the consultation	Date first attended the clinic
1	3216	NFK	F	25	URTI	20 SEP 2022	8 min	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 SEP 2022	25 min	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21SEP 2022	18 min	18 SEP 1999
4	6677	CHL	F	12	ALLERGIC RHINITIS	21 SEP 2022	10 min	12 MAY 2011
5	4454	CHC	M	67	HT	21 SEP 2022	8 min	12 JAN 2011
…	…	….	…	…	…	….	….	….
50	2323	LKH	M	38	URTI	24 OCT 2022	6 min	24 OCT 2011

Prepare for Part D (Medical Records)

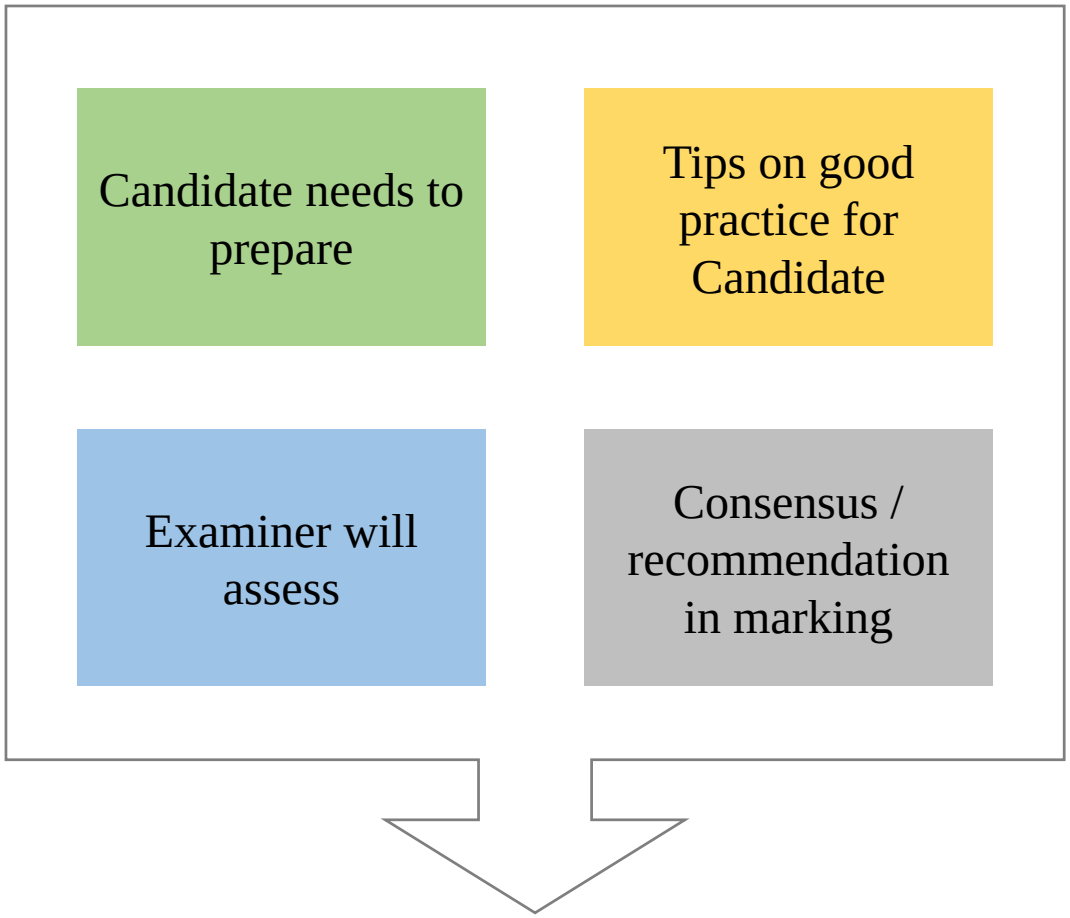


Part E (Investigations)

10 patients' medical records

Attachment 13

10 patients' medical records in Part E, Attachment 13



Presentation materials of the Introductory & Preparatory Workshops available in the College website

10 patients' medical records in Part E

The ten patients

- were seen and had investigations ordered by you
- had the investigation results followed up by you

  between 15 September 2026 and 31 October 2026

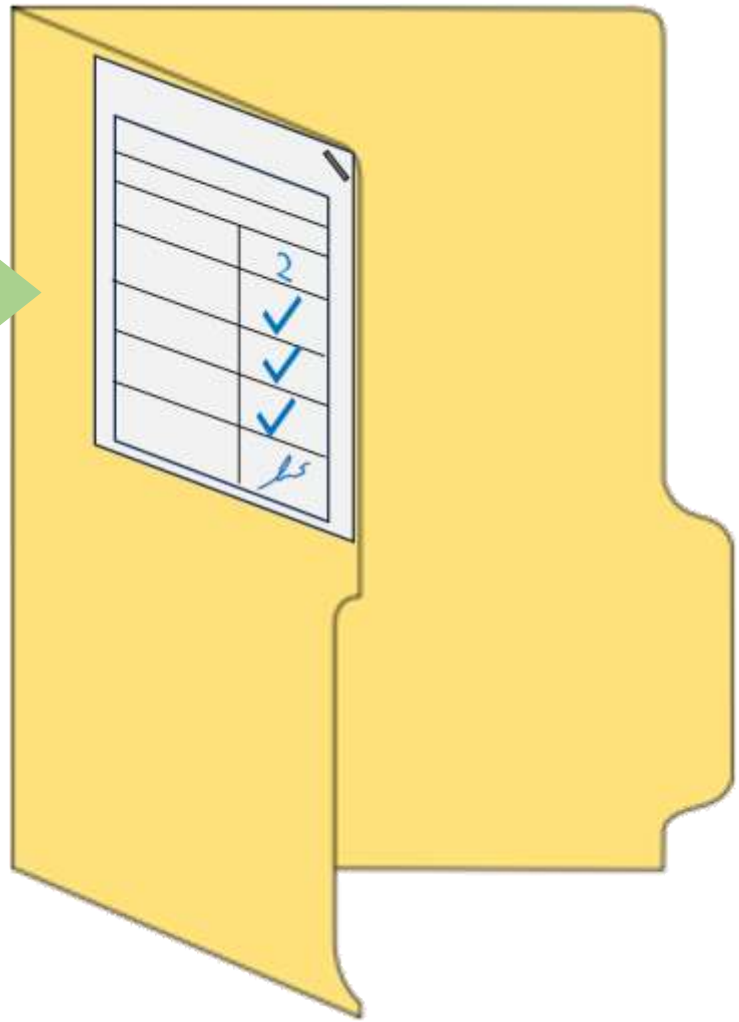
Part E
Case collection period

- can be seen by you in different clinics
- cannot be those you submitted for Attachment 12 (Part D)

10 patients' medical records in Part E

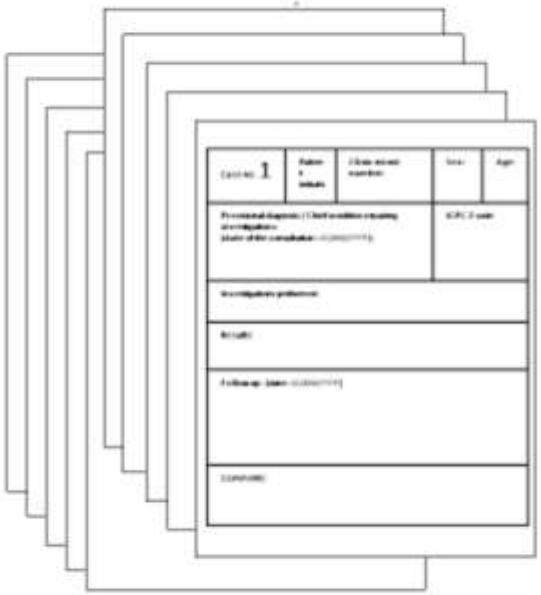
New requirement from 2027 Exit Exam

Check list for Medical Records	
Part E (Investigations)	
Case no (e.g. Case 1 – 10)	
Consultation notes (investigation ordered)	
Copy of the investigation reports	
Consultation notes (follow up)	
Candidate (signature):	



Attachment 13

Case summary



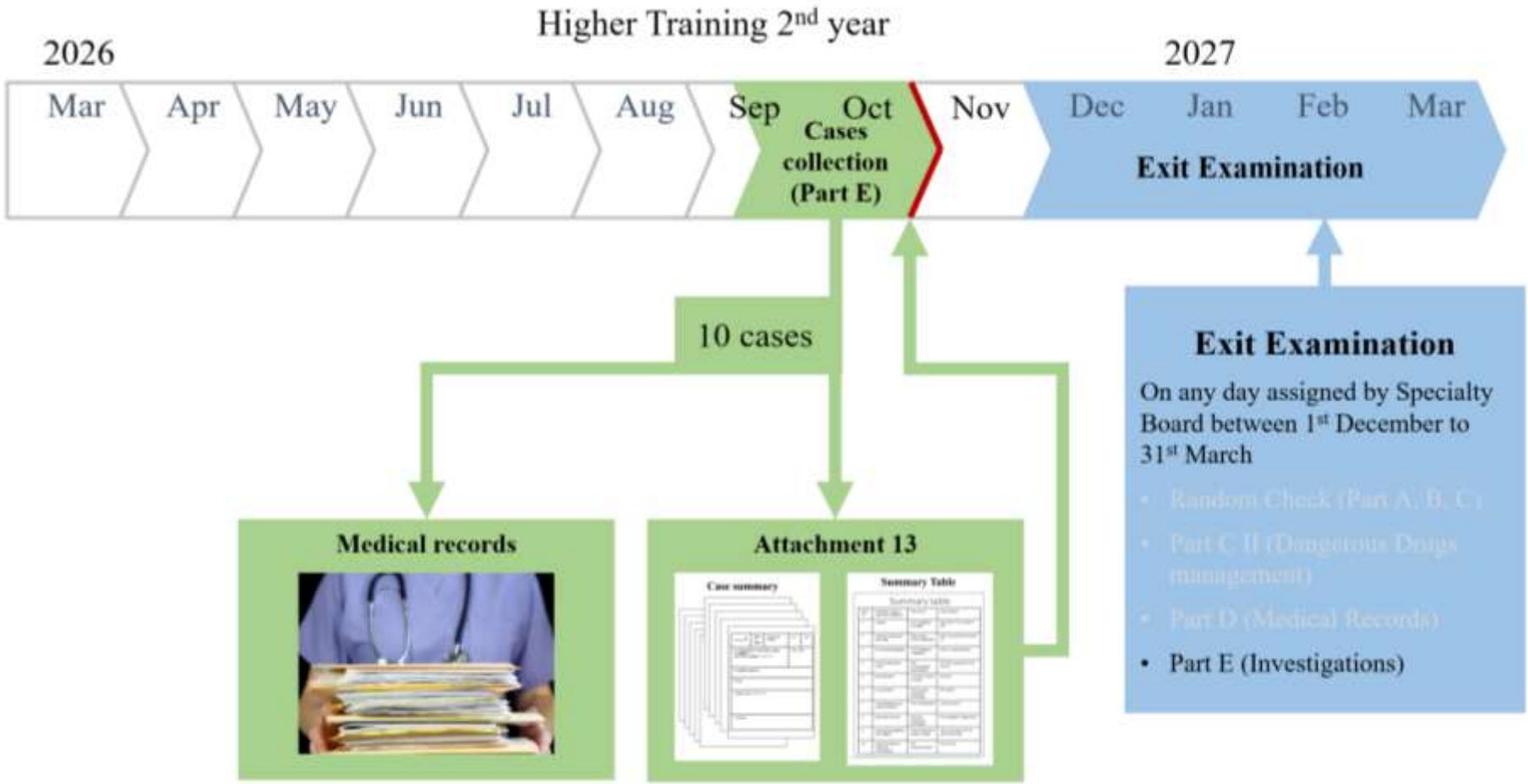
Summary Table

Summary table

Case no.	Diagnosis/ condition requiring investigation	ICPC-2 Code	Tests ordered
1	malaise	A04 (weakness/ tiredness)	CBC, LFT, TFT, Urine C/ST, CXR
2	Anaemia ? Large bowel pathology	B82 (anaemia other/ unspecified)	CBC, Fe- profile, CEA, Stool OB x 3
3	Poor gnarstal dyspepsia	D07 (dyspepsia/ indigestion)	OGD, US upper abdomen
4	Annual hypertension check	K86 (uncomplicated hypertension)	RFT, FBS, lipid profile, Urine Protein
5	Sprained ankle	L77 (sprain/ strain of ankle)	XR ankle
6	Low back pain	L03 (low back symptoms/ complaints)	XR LS spine
7	Hypercholesterolemia, newly started on statins	T93 (Lipid disorder)	Lipid profile, ALT
8	Dystrophic toenails	S22 (nail symptoms/ complaints)	Nail clipping for fungal culture
9	Amenorrhea, pregnancy test negative	W05 (menstruation absent/ scanty)	FSH, LH, Prolactin, TFT, US pelvis, PAP smear
10	Hyperthyroidism on treatment (carbimazole)	T85 (Hyperthyroidism)	Free T4, TSH

- Should contain:
  - Case summaries of the 10 patients
  - A table of the 10 cases collected
- Standard format (please refer to the Introductory Workshop)
- Confidentiality: **do not** include patient's name, HKID

Prepare for Part E (Investigations)



Exam day

- Exam Date arrangement
- When Examiners arrive
- Clinic inspection with the candidate
  - Random check
  - Part C II
- Assess Medical Records
  - Part D
  - Part E
- When the Exam ends

Exam Date arrangement

Will be within either:

Period A **OR** Period B

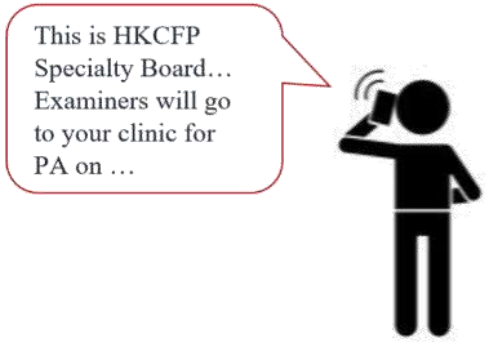
Dec	Jan	Feb	Mar

Exact dates of each period: please refer to the updated Exam Announcement

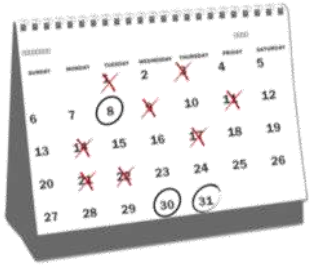
No exam on public holidays

Candidates will be notified of the Examination period:

Candidate will be informed **2 working days before** the exam day

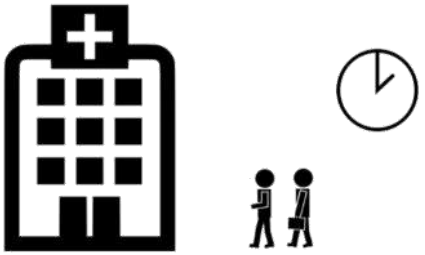


Exam date once confirmed cannot be changed



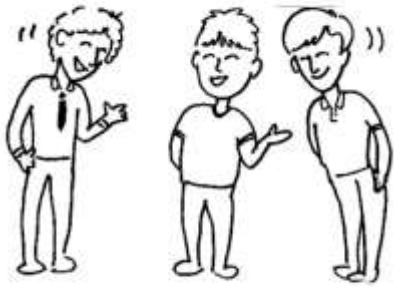
Your cooperation appreciated!

Examiners will usually visit on **Mondays - Fridays (daytime) or Saturdays (morning)** with reference to the Candidate's clinic hours



When Examiners arrive

Introduction



In addition to the **three PA Examiners**, other delegates may be present, such as:

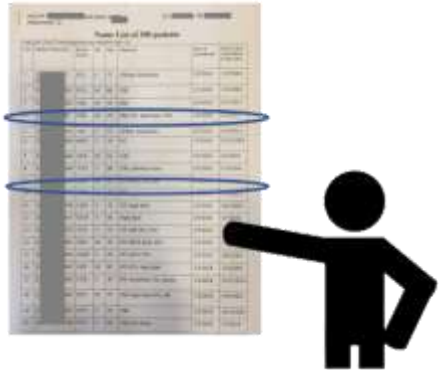
- **Trainee examiner**
- **Observing examiner**
- **Exam observer**
- **QA examiner**

Identification and assurance of confidentiality

Candidate

Examiners choose eight records from the Attachment 12

Candidate (clinic staff can help) fetches the records



Clinic inspection with the candidate (Random check and Part C II)

Examiners mark according to the

PA Rating Form

Can have notes on hand

Same as PMP visit

candidate answers and demonstrates

Examiners give marks independently

Examiners may cross check candidate's answers with the clinic staff if needed

Random check
(PMP Review)

Random Check (PMP review): the marking sheets

- Selected items from your PMP report , and
- the relevant Attachment(s) you submitted

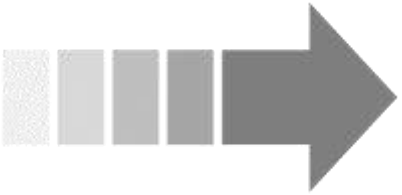
Making sheet in the PA rating form

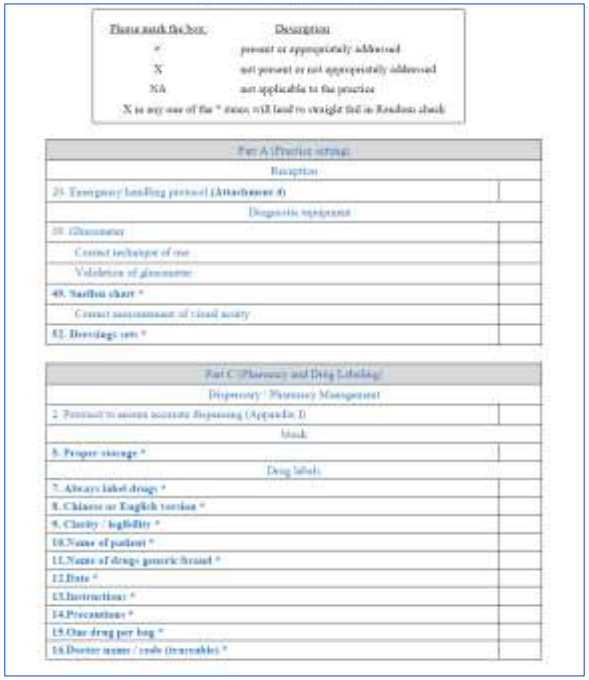
The Hong Kong College of Family Physicians
香港家庭醫學學院

Practice Management Package (PMP)

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

Updated April 2018 1





Please mark the box	Description
√	present or appropriately addressed
X	not present or not appropriately addressed
NA	not applicable to the practice

X in any one of the * items will lead to straight fail in Random check

Part A (Practice setting)	
Reception	
29. Emergency handling protocol (Attachment 4)	
Diagnostic equipment	
30. Glucometer	
Correct technique of use	
Validation of glucometer	
49. Snellen chart *	
Correct measurement of visual acuity	
82. Dressings sets *	

Part C (Pharmacy and Drug Labelling)	
Dispensary / Pharmacy Management	
2. Protocol to ensure accurate dispensing (Appendix I)	
Stock	
5. Proper storage *	
Drug labels	
7. Always label drugs *	
8. Chinese or English version *	
9. Clarity / legibility *	
10.Name of patient *	
11.Name of drugs generic/brand *	
12.Date *	
13.Instructions *	
14.Precautions *	
15.One drug per bag *	
16.Doctor name / code (traceable) *	

Items and relevant Attachment(s) selected from:

1. *Parts A or/ and B; AND*
2. *Part C*

Marking principle:
same as in PMP visit

Random Check (PMP review): result grading

Candidate Number: EE XXXXX

Random Check (PMP review)

Grade *(please tick one)*			Description
Pass	**A**		*Mastery of most components and capability*
	C		*Satisfactory standard in most components*
Fail	**E**		*Demonstrates several major omissions and/or defects (or deficiency in area with *)*
	N		*Unsafe practice*

Marking principle:
same as in PMP visit

Part C II
(Dangerous drugs management)

Part C II (Dangerous Drugs management): the marking sheets

Part C II checklist
in the PMP report

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	

Updated April 2018

Making sheet in the PA rating form

Part C II (Dangerous Drugs management)

Checklist

Please tick the boxes as appropriate

Authorized person

(Knowledge)

Who could be the DD authorized person(s) in a medical clinic?

(Practice)

DD authorized person(s) in this clinic:

☐ Contingency plan in case the usual DD authorized person not available in the clinic

DD receptacle

(Knowledge)

What is the basic legal requirement to store DD?

(Practice)

☐ Locked, can only be opened by the authorized person(s) / appropriate delegates

DD storage, check for expiry

(Practice)

☐ DD stored in the receptacle

☐ Stock checked for expiry

Expired DD

(Knowledge)

What is the procedure to dispose expired DD in your clinic?

(Practice: if no expired DD kept in the clinic, mark N/A)

Expired DD kept in the clinic? If yes, check:

☐ stored in the receptacle

☐ recorded

☐ disposed

Continue on the next page➔

Marking principle:
same as in PMP visit

Part C II (Dangerous drugs management): result grading

Candidate Number: EE XXXXX

Please mark and comment according to the "Checklist on Dangerous Drugs (DD) Management"

Part C II (Dangerous Drugs management)

		Knowledge	Practice
1.	**Authorized person***		
2.	**DD receptacle***		
3.	**DD: storage, check for expiry***	N/A	
4.	**Expired DD: storage, record, disposal*** (if DD in the clinic not expired → ask 'Knowledge'; 'Practice' mark N/A)		
5.	**DD register***		

Overall result
(must pass in both knowledge and practice to have overall pass here)

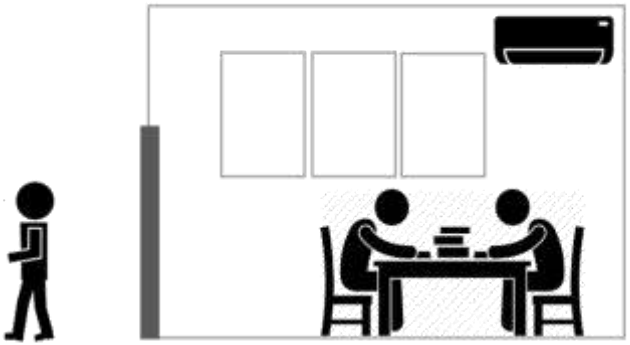
Pass		**Fail**	

Marking principle:
same as in PMP visit

Assess Medical Records
(Part D and Part E)

Prepare a room of adequate audio-visual privacy, for Examiners to assess your records

candidate can show the basic layout of the medical records before start marking

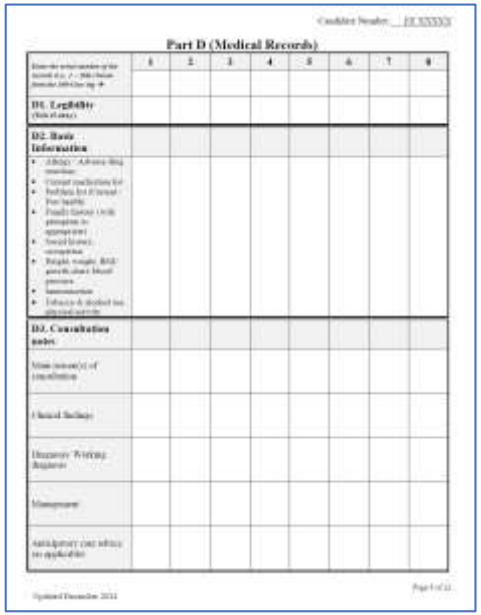


Examiners assess the records
No viva

Examiners mark independently

Part D
(Medical records)

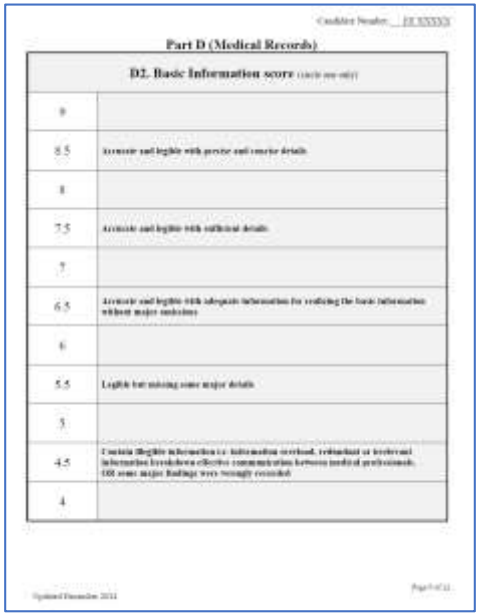
Part D (Medical Records) Rating Form


Candidate Number: __ (E.g. XXXXX)

Part D (Medical Records)

Enter the serial number of the record (i.e. 1 — 30) (Same number as Q1a) →	1	2	3	4	5	6	7	8
D1. Legibility (Tick if okay)								
D2. Basic Information • Allergy / Adverse drug reaction • Current medications list • Problem list (Current / Past / active) • Family history (with principles in 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)								

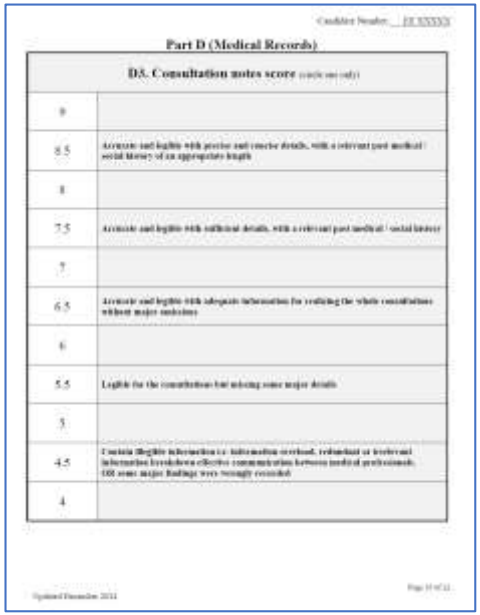
Updated December 2021


Candidate Number: __ (E.g. XXXXX)

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 realising 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	

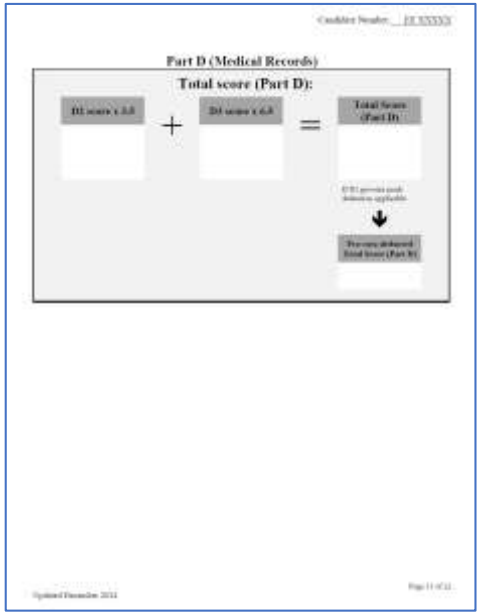
Updated December 2021


Candidate Number: __ (E.g. XXXXX)

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 realising 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	

Updated December 2021


Candidate Number: __ (E.g. XXXXX)

Part D (Medical Records)

Total score (Part D):

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

If D1 provide mark deduction as applicable

↓

Process deducted Total Score (Part D)

Updated December 2021

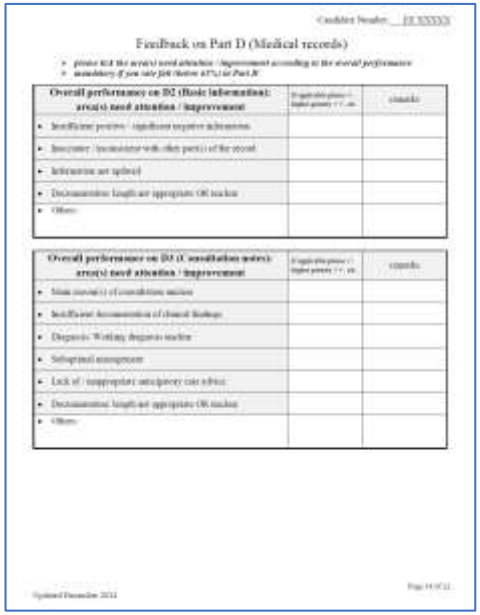

Candidate Number: __ (E.g. XXXXX)

Feedback on Part D (Medical records)

Written comment:

- *please quote the Case serial number (i.e. case 1 — 30)*
- *mandatory if you rate 'fail' (below 65%) in Part D*

Updated December 2021


Candidate Number: __ (E.g. XXXXX)

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 B*

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/ Inconsistent/ Inaccurate of clinical findings		
• Diagnosis / Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Updated December 2021

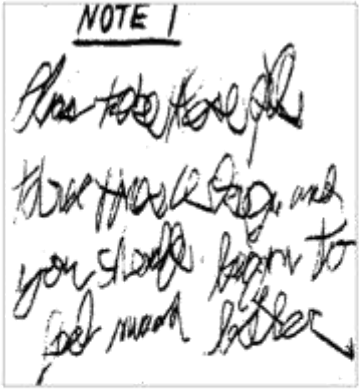
Eight cases will be selected from the Attachment 12

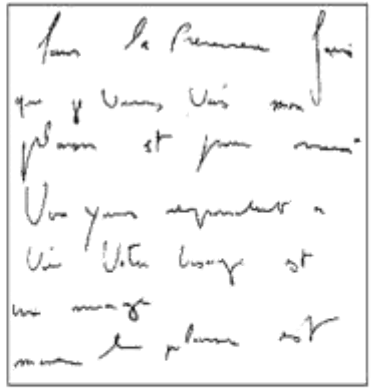
Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8
	8	12	23	25	35	46	48	50

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

D1 (Legibility): marking

C/O:
RN 3/7
ST
Not much cough
No fever
.....
P/E:
GC sat
Normal hydration
ENT: red throat, no pus
Chest clear, AE good bilat.
....;





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								

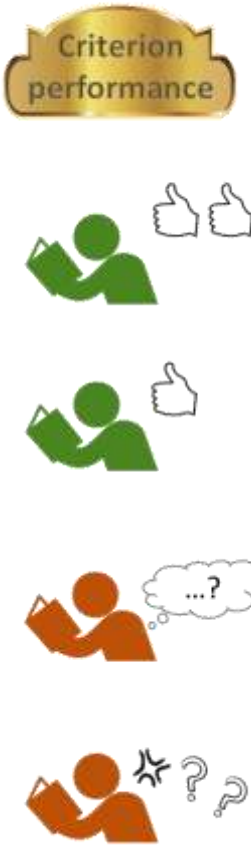
Examiners jot down the impression of each Case

After assessing all the Cases

A global mark on D2 (Basic information)

Marking Scale for 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	



D3 (Consultation notes): marking

Sample

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Estimated duration of the consultation	Date first attended the clinic
1	3216	NFK	F	25	URTI	20 SEP 2022	8 min	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 SEP 2022	25 min	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21SEP 2022	18 min	18 SEP 1999
4	6677	CHL	F	12	ALLERGIC RHINITIS	21 SEP 2022	10 min	12 MAY 2011
5	4454	CHC	M	67	HT	21 SEP 2022	8 min	12 JAN 2011
…	…	….	…	…	…	….	….	….
50	2323	LKH	M	38	URTI	24 OCT 2022	6 min	24 OCT 2011

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"!

Examiners jot down the impression of each Case

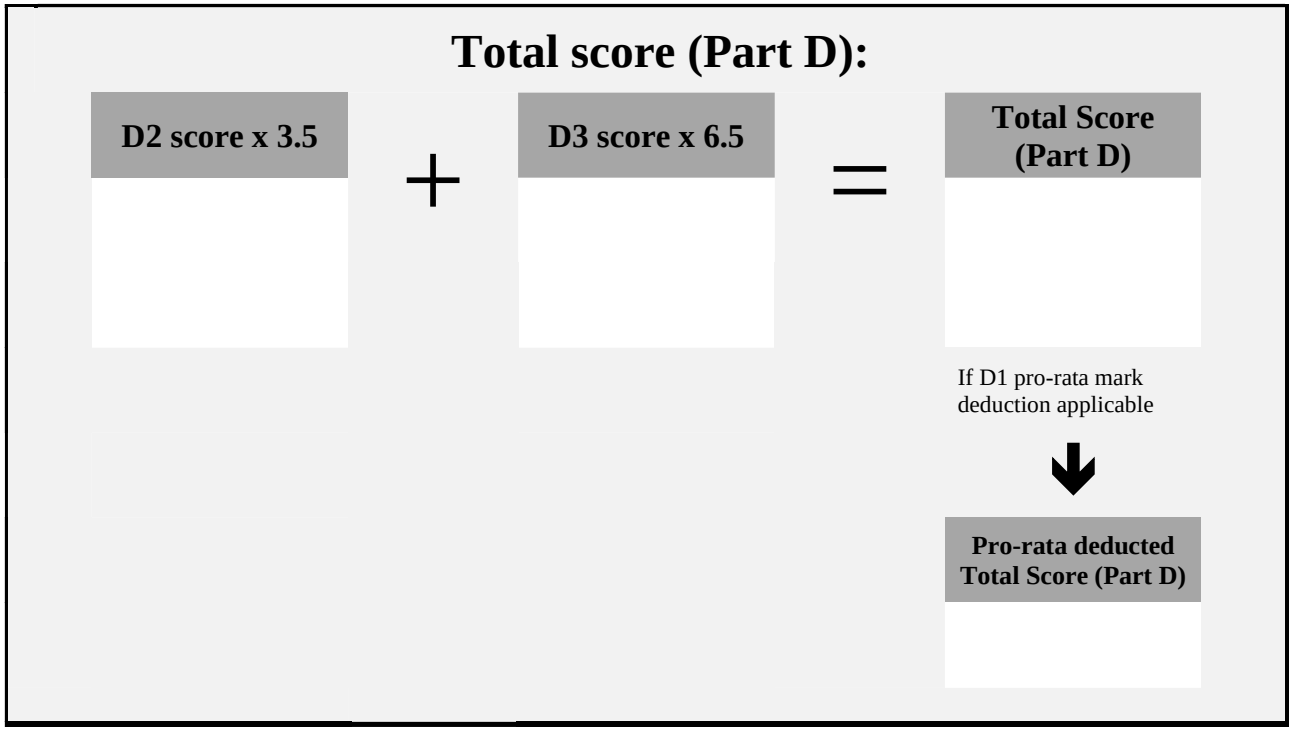
After assessing all the Cases

A global mark on D2 (Basic information)

Marking Scale for 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	

Part D (Medical Records): total score



Mark distribution:

D2 (Basic information): 35%

D3 (Consultation notes): 65%

Passing mark: Total score ≥ 65%

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
(Investigations)

Part E (Investigations) Rating Form (i)

Candidate Number: EE XXXXX

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1. Investigation indication documentation										
E2. Justification										
E3. Results documentation										
E4. Follow up										

Please note

- E1 (Investigation indication documentation): IF NOT shown in the record → cross the box; no need to mark the concerned case, apply pro-rata deduction to 'total score in Part E'
- E3 (Results documentation): IF report copy NOT available OR result NOT recorded in the 'follow up' medical notes → cross the box; no need to mark E4 of the concerned case; apply pro-rata deduction to 'E4 score'
- Assessment should be based on the medical records, but can consider score adjustment if the candidate offers appropriate additional information in the 'Comment' section. Attachment 13.

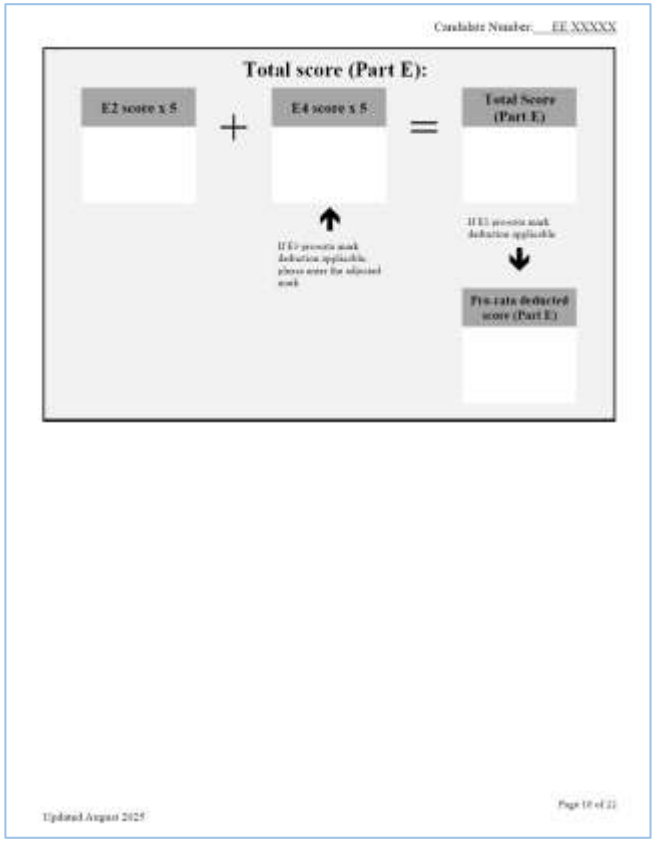
Candidate Number: EE XXXXX

E2. Justification score	
circle one mark ONLY ↓	References
9	
8.5	The investigations were targeted to the clinical findings, performed at appropriate time, the medical record was precise; provided effective patient care
8	
7.5	The investigations were targeted to the clinical findings, performed at appropriate time
7	
6.5	The investigations were in line with the clinical findings, likely solving the presenting problem
6	The investigations were not in line with the clinical findings, not likely solving the presenting problem
5.5	The investigations did not consider significant clinical findings appropriately
5	
4.5	The investigations OR the management of clinical condition(s) did not consider red flags appropriately
4	The medical record was disorganized, impairing the communication with other health care workers

Candidate Number: EE XXXXX

E4. Follow up score	
circle one mark ONLY ↓	References
9	
8.5	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
8	
7.5	The follow up was targeted to the clinical findings and the investigation results, performed at appropriate time
7	
6.5	The follow up was in line with the clinical findings and the investigation results
6	The follow up was not in line with the clinical findings OR the investigation results
5.5	The follow up did not consider significant investigation results appropriately
5	
4.5	The follow up of investigation results OR the management of clinical condition(s) did not consider red flags appropriately
4	The medical record was disorganized, impairing the communication with other health care workers

Part E (Investigations) Rating Form (ii)



Candidate Number: EE XXXXX

Total score (Part E):

E2 score x 5	+	E4 score x 5	=	Total Score (Part E)

If E2 / pre-rata mark deduction applicable, please enter the adjusted mark

If E2 pre-rata mark deduction applicable

Pro-rata deducted score (Part E)

Updated August 2025

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Candidate Number: EE XXXXX

Feedback on Part E (Investigations)

- *please quote the Case number (i.e. case 1 — 16)*
- *mandatory if you rate 'fail' (below 65%) in Part E*

Updated August 2025

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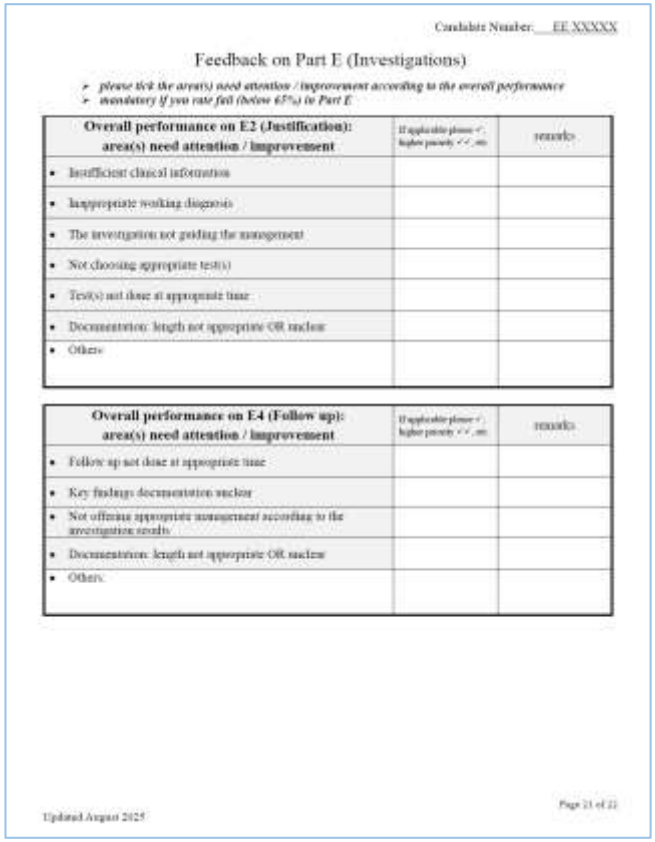

Candidate Number: EE XXXXX

Feedback on Part E (Investigations)

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

Overall performance on E2 (Justification): area(s) need attention / improvement	If applicable please √, higher priority √√, etc	remarks
• Insufficient clinical information		
• Inappropriate working diagnosis		
• The investigation not guiding the management		
• Not choosing appropriate test(s)		
• Test(s) not done at appropriate time		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on E4 (Follow up): area(s) need attention / improvement	If applicable please √, higher priority √√, etc	remarks
• Follow up not done at appropriate time		
• Key findings documentation unclear		
• Not offering appropriate management according to the investigation results		
• Documentation: length not appropriate OR unclear		
• Others:		

Updated August 2025

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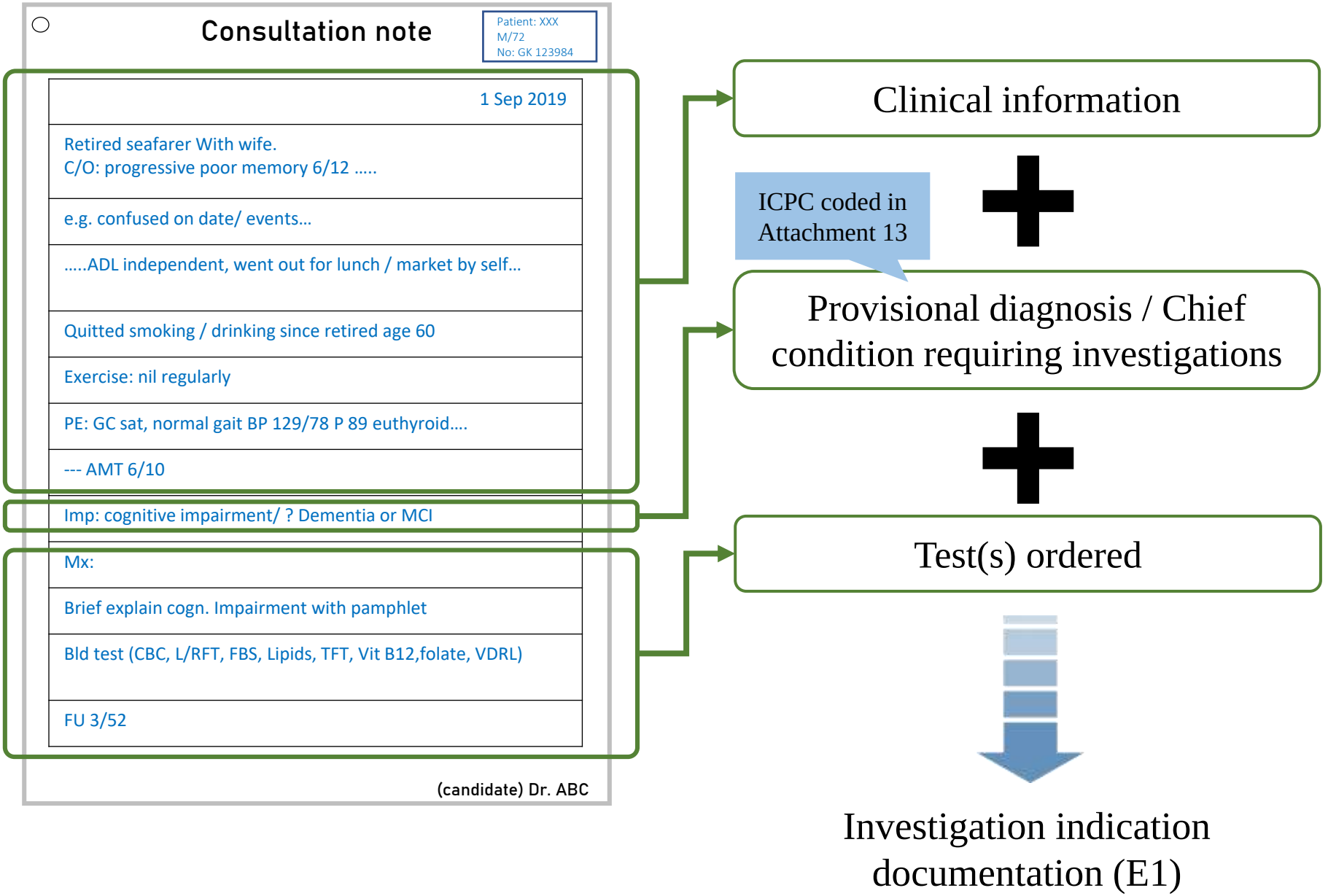
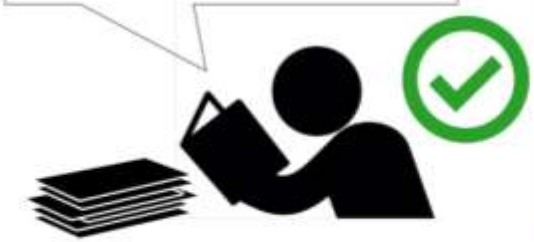
E1 (Investigation indication documentation)



Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

E1 (Investigation indication documentation): marking

Indication(s) of the investigation documented in record



Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	✓									
E2 Justification										
E3. Results documentation										
E4. Follow up										

→ Examiners proceed to assess the record

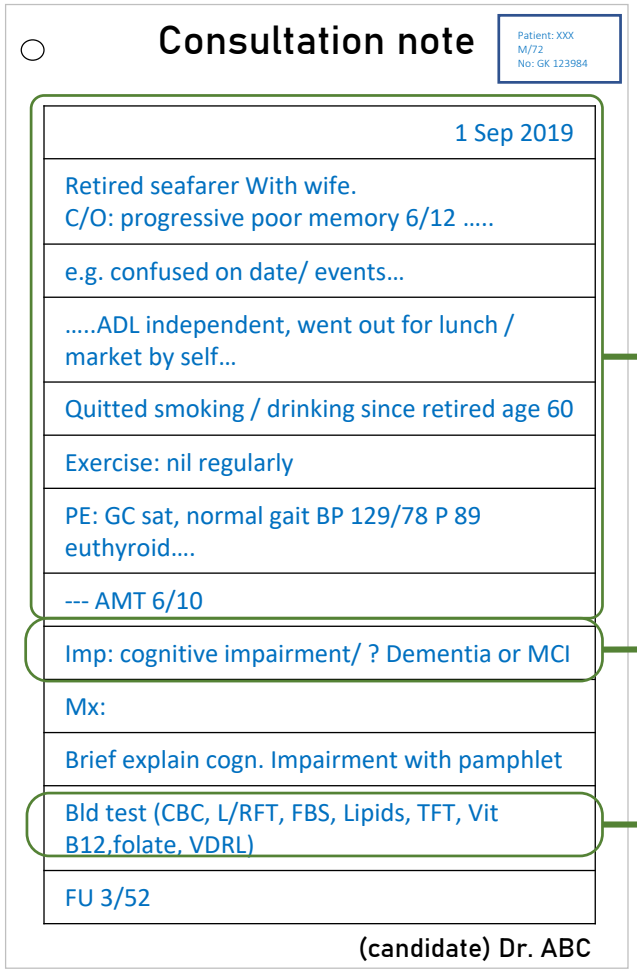
Indication(s) of the investigation **cannot be found** in the record

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	X									
E2 Justification	X									
E3. Results documentation	X									
E4. Follow up	X									

→ the whole case will not be assessed
→ pro-rata mark deduction in Part E total score

E2 (Justification)



Consultation note

Patient: XXX
M/72
No: GK 123984

1 Sep 2019
Retired seafarer With wife. C/O: progressive poor memory 6/12 …..
e.g. confused on date/ events…
…..ADL independent, went out for lunch / market by self…
Quitted smoking / drinking since retired age 60
Exercise: nil regularly
PE: GC sat, normal gait BP 129/78 P 89 euthyroid….
--- AMT 6/10
Imp: cognitive impairment/ ? Dementia or MCI
Mx:
Brief explain cogn. Impairment with pamphlet
Bld test (CBC, L/RFT, FBS, Lipids, TFT, Vit B12,folate, VDRL)
FU 3/52

(candidate) Dr. ABC

Marking of E2 (Justification)
is the **Examiner's judgement** on the records :

- Clinical information
- Provisional diagnosis / Chief condition requiring investigations
- Test(s) ordered

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E2 (Justification)

Examiner marks all the eligible medical records
Then give a global mark

E2. Justification score	
circle one mark ONLY ↓	References:
9	
8.5	**The investigations were targeted to the clinical findings, performed at appropriate time, the medical record was precise; provided effective patient care**
8	
7.5	**The investigations were targeted to the clinical findings, performed at appropriate time**
7	
6.5	**The investigations were in line with the clinical findings, likely solving the presenting problem**
6	**The investigations were not in line with the clinical findings, not likely solving the presenting problem**
5.5	**The investigations did not consider significant clinical findings appropriately**
5	
4.5	**The investigations OR the management of clinical condition(s) did not consider red flags appropriately**
4	**The medical record was disorganized, impairing the communication with other health care workers**

E3 (Results documentation)

Consultation note

Patient: XXX
M/72
No: GK 123984

21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

(candidate) Dr. ABC

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Investigation results/ findings

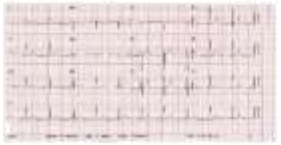
+

Copy of the investigation reports, e.g.

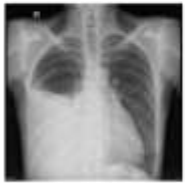
X-ray report

CT scan

Ultrasound scan



For chest X-Ray: : if report not available



film

OR

Results documentation (E3)

E3 (Results documentation): marking

- The investigation results documented in the medical record
  AND
- The investigation/ laboratory report (copy) available

E3. Results documentation	✓									
E4. Follow up	↓									

→ Examiners proceed to assess the record, E4 (follow up)

- The investigation results **NOT** documented in the medical record
  OR
- The investigation/ laboratory report (copy) **NOT** available

E3. Results documentation	X									
E4. Follow up	X									

→ "Follow up" of the case will not be assessed
→ pro-rata mark deduction in E4 (follow up) score

E4 (follow up)

Consultation note

Patient: XXX
M/72
No: GK 123984

21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

(candidate) Dr. ABC

Marking of E4 (follow up)
is the **Examiner's judgement** on the records:

Investigation results/ findings:

Documented in the Medical record &

Diagnosis

Management

Other clinical information elicited (if any)

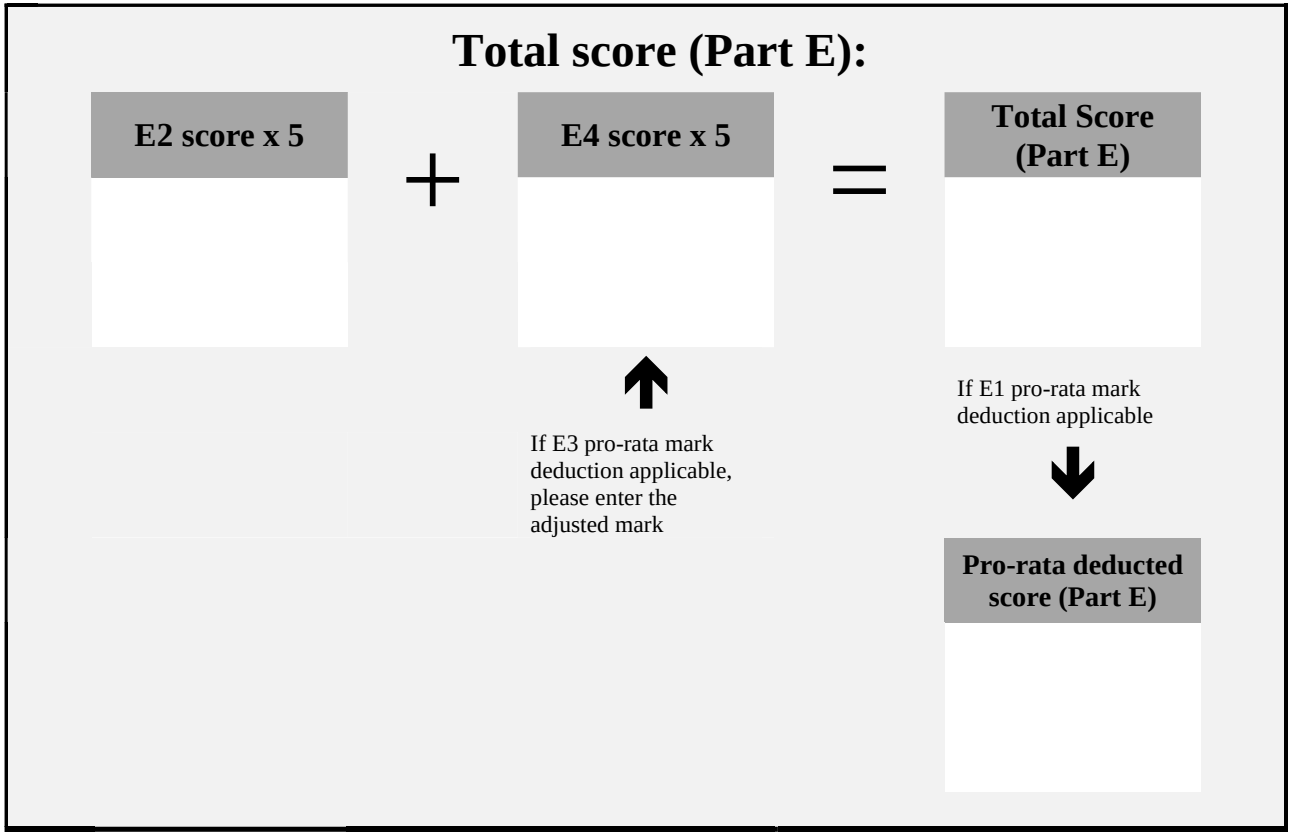
Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E4 (follow up)

Examiner marks all the eligible medical records
Then give a global mark

E4. Follow up score	
circle one mark ONLY ↓	References:
9	
8.5	**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**
8	
7.5	**The follow up was targeted to the clinical findings and the investigation results, performed at appropriate time**
7	
6.5	**The follow up was in-line with the clinical findings and the investigation results**
6	**The follow up was not in line with the clinical findings OR the investigation results**
5.5	**The follow up did not consider significant investigation results appropriately**
5	
4.5	**The follow up of investigation results OR the management of clinical condition(s) did not consider red flags appropriately**
4	**The medical record was disorganized, impairing the communication with other health care workers**

Part E (Investigation): total score



Mark distribution:

E2 (Justification): 50%

E4 (Follow up): 50%

Passing mark Total score ≥ 65%

Feedback on Part E (Investigations)

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

Overall performance on E2 (Justification): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient clinical information		
• Inappropriate working diagnosis		
• The investigation not guiding the management		
• Not choosing appropriate test(s)		
• Test(s) not done at appropriate time		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on E4 (Follow up): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Follow up not done at appropriate time		
• Key findings documentation unclear		
• Not offering appropriate management according to the investigation results		
• Documentation: length not appropriate OR unclear		
• Others:		

When the Exam ends

- The Examiners will call you back
- Please check with the Examiners that all the medical records had returned to you
- Confirm by signing on the note provided

This is to confirm that all the medical records used in Practice Assessment today had returned to me.
Date
Candidate:
Signature:

Pass / Fail

When Pass-fail discrepancy among Examiners' marking occur in

Random check, Part C II:

'Pass' = two or all the Examiners give passing grade

When Pass-fail discrepancy among Examiners' marking occur in

Part D, Part E:

Average of the three Examiners' Total Score will be considered:

Examiner 1	Examiner 2	Examiner 3	Average of the Total Score	Pass / Fail
Pass	Pass	Pass	*Not applicable*	**Pass**
Pass	Fail	Pass	Pass	**Pass**
Pass	Fail	Fail	Pass	by 4th Examiner
Pass	Pass	Fail	Fail	by 4th Examiner
Pass	Fail	Fail	Fail	**Fail**
Fail	Fail	Fail	*Not applicable*	**Fail**

4th Examiner

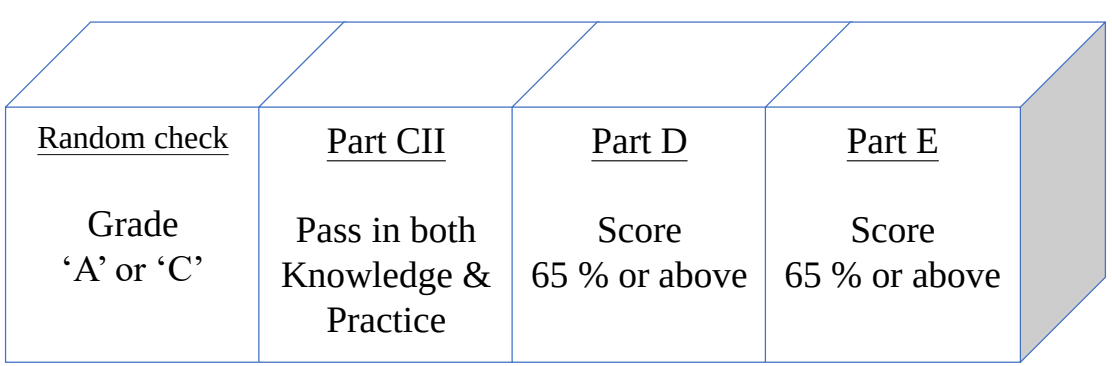
- The 4th Examiner may go to your clinic **in either Period A or Period B**
- 2-working-day notice in advance
- assesses the same set of materials seen by the previous three PA Examiners

- must keep all the examination materials seen by the previous PA Examiners; at least until the end of Period B

QA Examiner

- The QA Examiner may go to your clinic
  - **With the other PA Examiners**
  - **OR in a separate date (either in Period A or Period B)**
- 2 or more working days notice in advance
- assesses the same set of materials seen by the PA Examiners
- Quality Assurance purpose
- Randomly selected, not based on the performance or the Exam results of the Candidates
- Not affect the Candidates' Exam results

From PA to passing the Exit Examination



=

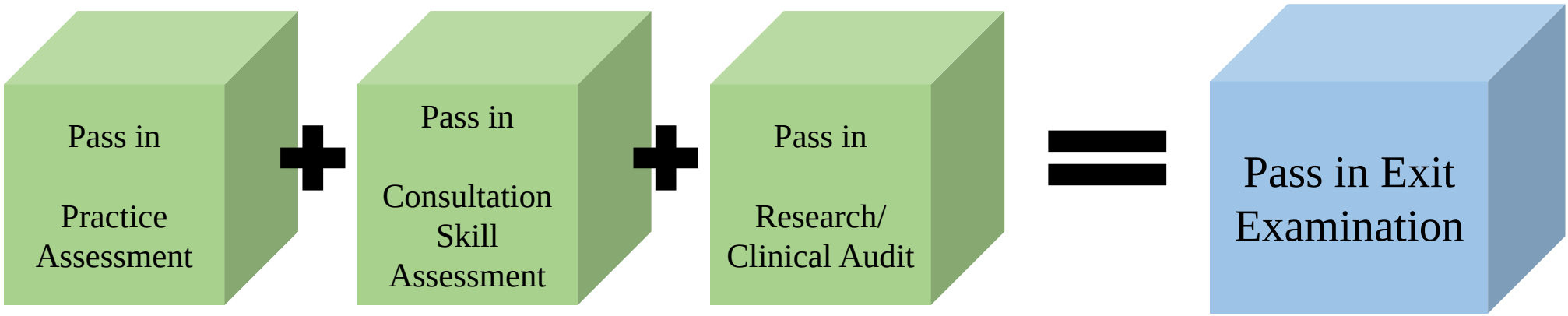
Pass in

Practice
Assessment

Valid for five years;
same as other Segments of Exit Examination

Fail in PA:
All the failed Part(s) need to be re-attempted as a whole set

From PA to passing the Exit Examination



Enquiry

Specialty Board secretary:

alkyyu@hkcfp.org.hk

Tel: 2528 6618 (Alky or John)