King Abdulaziz University

Faculty of Medicine

Department of Family and Community Medicine

FAMILY MEDICINE

STUDENT LOGBOOK 2017-2018

Student's Name	
Supervising Faculty	
Site Coordinator (Preceptor)	
PHC center	

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Introduction:

Dear Doctor Of Tomorrow

Welcome to the fifth year clerkship in Family Medicine. We wish you a pleasant, educational rotation.

This Logbook together with the Student's Manual are helpful tools for you to know what to do, and authentize what has been done and for us to comprehend what you have achieved and best evaluate you.

It will be the main base for your continuous assessment and will also be reviewed and used during the end of rotation assessment.

Pay a careful attention to your supervisor(s) and primary health care center trainer(s). Your regular on time attendance, active interactions and proactions are essential for a successful rotation.

Please don't hesitate to nicely ask and seek the help of anybody at the center and enjoy a hopefully useful rotation.

Best Wishes,

Notes about filling the log-book

1) Try to fill and write whatever you can write while you are in the center and to take directly the signature of the supervisor attended the case or the activity.

2) Later you can add at home some additional information's and learning points by reviewing the textbooks or other sources.

3) No limits for the number of cases, try your best to see and do as much activities as you can. You can add extra papers for each section if the papers in your logbook were not enough or you can use the back of the logbook papers. **NB:** For the common problems at least 10 cases should be seen and written.

4) Make sure to read about the cases you have seen and critically appraise each case management using updated references

5) It is suspected that you will see and register many varieties of cases but try as much as possible to see cases related to the topics and the family medicine course curriculum (See the study guide)

6) The most important thing in the log book is the evidence that you are trying to learn and get learning points from what you have seen.

   Examples of the evidences for these important points are:

   a- Writing scientific Information's and learning points about the cases seen and its treatment.
   b- Writing the steps of doing a skill.
   c- Adding information's from reading about the cases, skills and activities.
   d- Proper suitable critical scientific judgments about the management of the cases seen.
   e- Adding to the log book papers, charts, tables etc which will aid your benefit. For examples papers showing the normal values of a laboratory test or drug pamphlet showing drug information.

NB: Not to overdo putting big number of patient health education leaflets (but of course selective number is advisable).

7) Occasionally you may not see cases belonging to certain part of the log book. This is suspected and accepted but do your best to see the needed cases, and usually we compare between the logbooks of the students in the same group to check the availability or absence of these cases in the specific center.

8) Cases discussed with the faculty members or preceptors even if not seen can be added to the suitable sections of the logbook. <u>But make it clear for that cases that it was not seen</u> but discussed.

9) It is advisable to write the cases in the "SOAP" format.

10) If the space provided for writing notes about one case or one experience was not enough you can extend you writing on the whole page.

11) At the end of the log book in the free papers for log of experiences you can add any extra learning experience you encounter it during the practical time of the rotations.

12) Write in a professional:
    a- Eligible hand writing (can be readable).
    b- No need for typing
    c- No need for arts (flowers and stickers)

13) Of course good appearance, arrangement and shape of the log-book is appreciated; but remember that the most important thing is the content and its quality particularly the learning points.

SOAP NOTES GUIDELINES

Subjective

Subjective data includes what the patient tells you during the interview. It should be documented in a brief but logical and complete fashion. It should include the patient identifiers such as age, race and gender. This should be followed by the current symptoms, interval history, relevant past medical and surgical history, relevant family and social history and pertinent review of systems. All documentation should be grammatically correct and in the form of complete sentences.

Objective

Objective data includes the vital signs, physical examination relevant to the complaints, laboratory findings and radiology and pathology reports.

Assessment

Assessment is the diagnosis and should be as complete as possible given the current data. If the most specific diagnosis is 'cough' then that should be the first diagnosis but this should be followed by a differential diagnosis that should include the most likely etiologies for the cough. If the patient has other related or contributory illnesses like COPD or HTN then these should be listed as well.

Plan

Plan is the final portion of the SOAP note and should include any educational materials given or discussed, further testing or evaluations planned, the therapeutic interventions, and the plan for a return visit.

Any future evaluations, lab tests, radiology tests or immunizations should be listed. Do not write 'continue current medication' or 'refilled current medications' as this is inadequate for continuity of care. Specify each medication, the dose, the number given and the number of refills allowed. Lastly, document any referrals made and the reason for each referral

Encounter /cases seen	Discussion points raised	what was discussed/what learning need was identified	What reading was done /what did they learn	Now if you see the patient again what will be your approach

LOG OF EXPERIENCES

Experience: Common Problems

(e.g. diabetes, hypertension, bronchial asthma, back pain, infections, trauma, skin disorders, etc.)

Model case

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
1.		Date: Place: Attended with Name: Signature
2.	.	Date: Place: Attended with Name: Signature

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
3.		Date: Place: Attended with Name: Signature
4.		Date: Place: Attended with Name: Signature
5.		Date: Place: Attended with Name: Signature

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
6.		Date: Place: Attended with Name: Signature
7.		Date: Place: Attended with Name: Signature
8.		Date: Place: Attended with Name: Signature

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
9.		Date: Place: Attended with Name: Signature
10.		Date: Place: Attended with Name: Signature
11.		Date: Place: Attended with Name: Signature

LOG OF EXPERIENCES

<u>Experience</u>: Psychiatric, behavioral and Emotional problems

(e.g. Stress reactions, grief reactions, anxiety, depression, addiction, family conflicts, abuse (children, mothers, elderly, etc.))

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
1.		Date: Place: Attended with Name: Signature
2.		Date: Place: Attended with Name: Signature

LOG OF EXPERIENCES

Experience: **Acute and Emergent Problems**

(e.g. chest pain, acute abdomen, shock, trauma, etc.)

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
1.		Date: Place: Attended with Name: Signature
2.		Date: Place: Attended with Name: Signature

LOG OF EXPERIENCES

<u>Experience</u>: Preventive Health Care (Promotive and Preventive Care)

(e.g. Antenatal / Postnatal care, child screening, immunization, Premarital counseling, pre-placement counseling, Periodic health counseling, etc.)

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
1.		Date: Place: Attended with Name: Signature
2.		Date: Place: Attended with Name: Signature

No.	Description of the case in SOAP format. The plan should include education, investigations and treatment (therapy, referral, follow up, and returning visit plan (+ Learning notes).	Authentication
3.		Date: Place: Attended with Name: Signature
4.		Date: Place: Attended with Name: Signature
5.		Date: Place: Attended with Name: Signature

LOG OF EXPERIENCES

Experience: **Health education (counseling)**

(e.g. use of inhalers, smoking cessation, dieting advice, exorcise, family spacing, etc.)

No.	Describe the encounter and patient's details, what was done to him and how and who else was involved. (+Learning notes)	Authentication
1.		Date: Place: Attended with Name: Signature
2.		Date: Place: Attended with Name: Signature

LOG OF EXPERIENCES

Experience: **The mini attachments: Laboratory**

The attachement	**A brief description of the things learned, cases or procedures observed.**
1) The first laboratory attachment: Place: Date: Attended with: Name: Signature:	
2) The second laboratory attachment: Place: Date: Attended with: Name: Signature:	

<u>LOG OF EXPERIENCES</u>

<u>Experience:</u> The mini attachments: The Pharmacy

The attachement	A brief description of the things learned, cases or procedures observed. (+Learning notes)
1) The first pharmacy attachment: Place: Date: Attended with: Name: Signature:	
2) The second pharmacy attachment: Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

Experience: **The mini attachments: Dressing Room (Treatment room).**

The attachement	**A brief description of the things learned, cases or procedures observed. (+Learning notes)**
1) The first dressing room attachment: Place: Date: Attended with: Name: Signature:	
2) The second dressing room attachment: Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

Experience: The mini attachments: Emergency Room.

The attachement	A brief description of the things learned, cases or procedures observed. (+Learning notes)
1) The first emergency room attachment: Place: Date: Attended with: Name: Signature:	
2) The second emergency room attachment: Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

The Practical Skills and Competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				1.
Name: Sig.				2.
Name: Sig.				3.
Name: Sig.				4.
Name: Sig.				5.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				6.
Name: Sig.				7.
Name: Sig.				8.
Name: Sig.				9.
Name: Sig.				10.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				11.
Name: Sig.				12.
Name: Sig.				13.
Name: Sig.				14.
Name: Sig.				15.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				16.
Name: Sig.				17.
Name: Sig.				18.
Name: Sig.				19.
Name: Sig.				20.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				21.
Name: Sig.				22.
Name: Sig.				23.
Name: Sig.				24.
Name: Sig.				25.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				26.
Name: Sig.				27.
Name: Sig.				28.
Name: Sig.				29.
Name: Sig.				30.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				31.
Name: Sig.				32.
Name: Sig.				33.
Name: Sig.				34.
Name: Sig.				35.

LOG OF EXPERIENCES

The Practical Skills and competencies:

(A list of the disease-based competencies and skills done or seen: See **Appendix. A** minimum of 50% of the listed skills and competencies has to be done during the 5 weeks rotation).

Authentication	Place	Date	The skill or competency	No.
Name: Sig.				36.
Name: Sig.				37.
Name: Sig.				38.
Name: Sig.				39.
Name: Sig.				40.

LOG OF EXPERIENCES

Experience: **Complementary medicine session**

The attachement	A brief description of the things learned, cases or procedures observed. (+Learning notes)
Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

Experience: **The home care visit**

The attachement	A brief description of the things learned, cases or procedures observed. (+Learning notes)
Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

Experience: **Nursing home visit**

The attachement	A brief description of the things learned, cases or procedures observed. (+Learning notes)
Place: Date: Attended with: Name: Signature:	

LOG OF EXPERIENCES

Experience: **Community health resources**

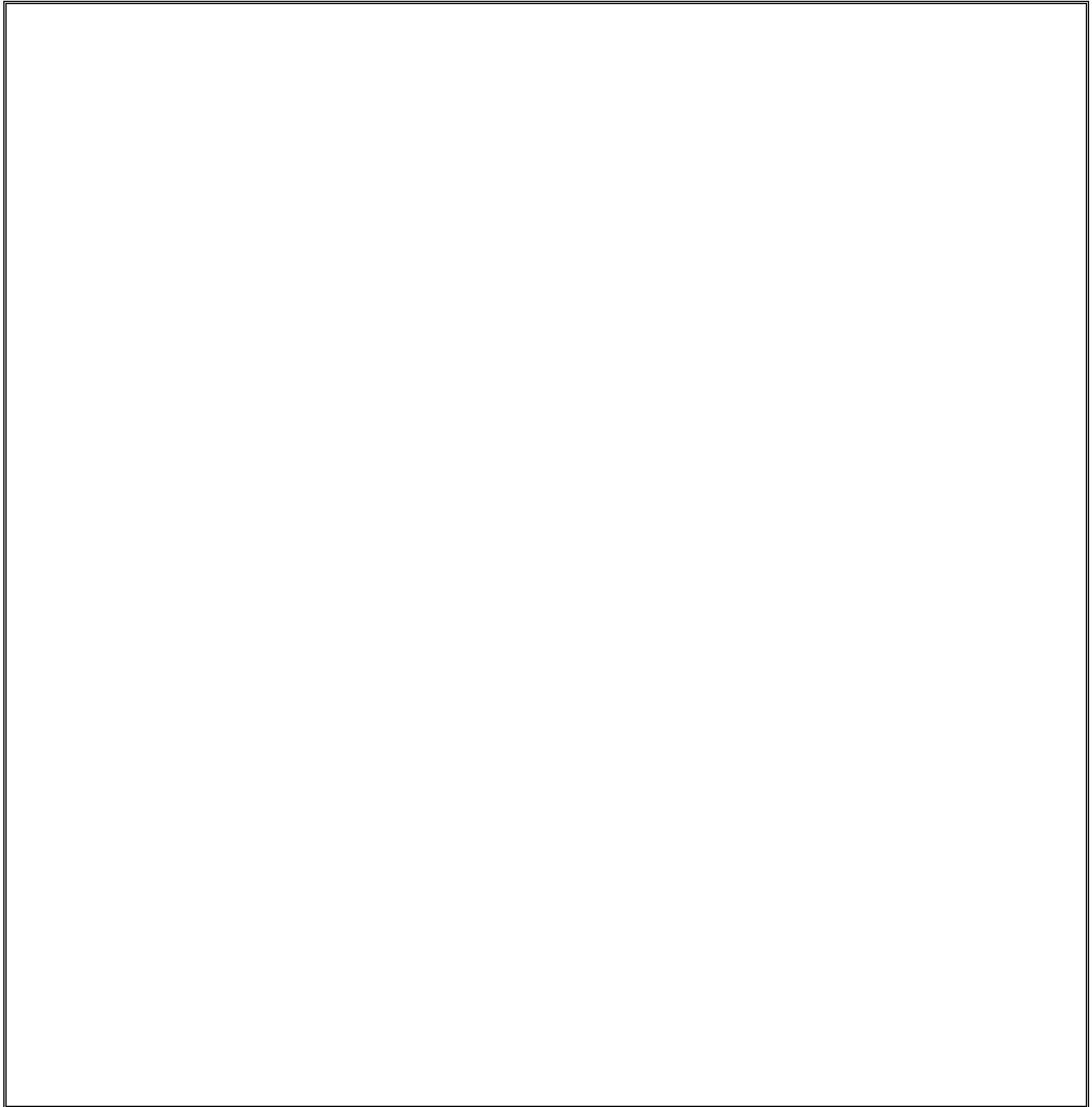
(Write down the health resources in the community, which are helpful for the center

role in health care " + Learning notes ")

LOG OF EXPERIENCES

Other activities And experiences:

(On the next pages document the case scenarios, presentations, lectures, other out center extra-reach activities, or any other beneficial experiences you come across during the attachment).



LOG OF EXPERIENCES

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Appendix A

List Of Comprehended And Practiced Competencies:

1. How to breaking bad news or dealing with a demanding or angry patient.
2. How to write a proper referral letter.
3. Using the Problem Oriented Medical Record "POMR" in documentation of medical data for patients.
4. Plotting charts for anthropometric measurements (weight, height, head circumference, etc.)
5. Listing developmental milestones systematically including normal psychosocial developments of a child.
6. Giving advice for a balanced diet for a child or a pregnant women or an adult.
7. Examining and managing a child with diarrhea, URTI, UTI or any other acute problem.
8. Giving antenatal and post-natal care consultation.
9. Exercise education for a pregnant woman or obese patient, or a diabetic or a hypertensive patient.
10. Prescribing for a pregnant lady or a child, or an elderly.
11. Psychosocial preparation of a pregnant lady for delivery.
12. Giving birth spacing advise.
13. Fundosopic examination.
14. Otoscopic examination.
15. Measuring blood pressure using sphygmomanometer

16. Interviewing and managing a case of URTI.

16. Interviewing and counseling a diabetic patient.

17. Interviewing and counseling a hypertensive patient.

18. Interviewing and counseling an acute asthma patient, including drug instruction demonstrating the usage of inhalers, spacers, desk haler….etc. and measuring lung functioning using the peak flow meter and educating patient on in usage of PFM.

19. Giving psychotherapy, consulting and prescribing for a depressed or an anxious patient.

20. Giving counseling for smoking cessation.

21. Interviewing and counseling a patient with headache.

22. Interviewing and counseling a case of irritable bowel syndrome.

23. Interviewing and counseling a patient with back pain including examination and exercise education.

24. Dealing with a red eye.

25. How you perform ABC's of First Aids and effective CPR?

27. Giving I/M injection.

28. Giving I.V injection.

29. How you dress a wound?

30. How to interpret urinalysis results?

31. How to interpret CBC?

32. How to interpret a lipid profile?

33. How to interpret a renal profile?

34. How to interpret a liver profile?

35. How to use a glucometer?

36. How to use and interpret a dipstick for a diabetic?

37. How you interpret CXR, KUB, plain x-ray abdomen and x-ray?

38. Health educating a group of patients & relatives.

39. Reading an article critically and designing for project, survey and paper publishing.

40. Family medicine based outreach activity.