

Colleague feedback questionnaire

for Dr _____

Licensed doctors are expected to seek feedback from colleagues and review and act upon that feedback where appropriate.

The purpose of this exercise is to provide doctors with information about their work through the eyes of those they work with, and is intended to help inform their further development.

Please do not write your name on this questionnaire. No one will be identified when this information is given back to the doctor.

Please answer all the questions. If you feel you cannot answer any question, please tick 'Don't know'.

Please mark the box like this with a ball point pen. If you change your mind just cross out your response and make your new choice.

Please write today's date here: / /

Please rate your colleague in each of the following areas by ticking one box in each line.

		Poor	Less than satisfactory	Satisfactory	Good	Very good	Don't know
1	Clinical knowledge	<input type="checkbox"/>					
2	Diagnosis	<input type="checkbox"/>					
3	Clinical decision making	<input type="checkbox"/>					
4	Treatment (including practical procedures)	<input type="checkbox"/>					
5	Prescribing	<input type="checkbox"/>					
6	Medical record keeping	<input type="checkbox"/>					
7	Recognising and working within limitations	<input type="checkbox"/>					
8	Keeping knowledge and skills up to date	<input type="checkbox"/>					
9	Reviewing and reflecting on own performance	<input type="checkbox"/>					
10	Teaching (students, trainees, others)	<input type="checkbox"/>					
11	Supervising colleagues	<input type="checkbox"/>					
12	Commitment to care and wellbeing of patients	<input type="checkbox"/>					
13	Communication with patients and relatives	<input type="checkbox"/>					
14	Working effectively with colleagues	<input type="checkbox"/>					
15	Effective time management	<input type="checkbox"/>					

Please decide how far you agree with the following statements by ticking one box in each line.

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Don't know
16	This doctor respects patient confidentiality	<input type="checkbox"/>					
17	This doctor is honest and trustworthy	<input type="checkbox"/>					
18	This doctor's performance is not impaired by ill health	<input type="checkbox"/>					

19	This doctor is fit to practise medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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20 Please add any other comments you want to make about this doctor.

The next questions will give us some information about who took part in the survey.

21 What is your role? (tick one)	<input type="checkbox"/> Doctor	If you are a doctor, are in in a training grade?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Health Visitor/Midwife	<input type="checkbox"/> Pharmacist		
	<input type="checkbox"/> Health Care Assistant	<input type="checkbox"/> Administrator/Receptionist/Secretary			
	<input type="checkbox"/> Allied Healthcare Professional	<input type="checkbox"/> Non-clinical Manager			
	<input type="checkbox"/> Other (please specify):				
	<input type="text"/>				
29 How recently have you been familiar with this doctor's practice?	<input type="checkbox"/> Current colleague	<input type="checkbox"/> Within the last 2 years	<input type="checkbox"/> 2 - 5 years ago		
	<input type="checkbox"/> 6 - 10 years ago	<input type="checkbox"/> 10+ years ago			
23 How often do you have contact with the doctor?	<input type="checkbox"/> Most days	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less often	