**STANDARD ASSESSMENT FORM- B**

(DEPARTMENTAL INFORMATION)

**OPHTHALMOLOGY**

|  |
| --- |
| *1. Kindly read the instructions mentioned in the* ***Form ‘A’****.*  *2. Write* ***N/A*** *where it is* ***Not Applicable****. Write* ***‘Not Available’****, if the facility is* ***Not Available****.* |

**A. GENERAL**:

1. Date of LOP when PG course was first Permitted: \_\_\_\_\_\_\_\_\_\_
2. Number of years since start of PG course: \_\_\_\_\_\_\_\_\_
3. Name of the Head of Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Number of PG Admissions (Seats): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Number of Increase of Admissions (Seats) applied for: \_\_\_\_\_\_\_\_\_
6. Total number of Units: \_\_\_\_\_\_\_\_\_\_
7. Number of beds in the Department: \_\_\_\_\_\_\_\_\_\_\_\_
8. Total number of ICU beds/ High Dependency Unit (HDU) beds in the department:\_\_\_\_\_\_\_\_
9. Number of Units with beds in each unit: (Specialty applicable):

|  |  |  |  |
| --- | --- | --- | --- |
| Unit | Number of Beds | Unit | Number of beds |
| Unit-I |  | Unit-V |  |
| Unit-II |  | Unit-VI |  |
| Unit-III |  | Unit-VII |  |
| Unit-IV |  | Unit-VIII |  |

j. Details of PG inspections of the department in last five years:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of  Inspection | Purpose of  Inspection  *(Lop for starting a course/permission for increase of seats/ Recognition of course/ Recognition of increased seats /Renewal of Recognition/Surprise /Random Inspection/ Compliance Verification inspection/other)* | Type of Inspection (Physical/ Virtual) | Outcome  *(LOP received/denied. Permission for increase of seats received/denied. Recognition of course done/denied. Recognition of increased seats done/denied /Renewal of Recognition done/denied /other)* | No of seats Increased | No of seats  Decreased | Order issued on the basis of inspection  *(Attach copy of all the order issued by NMC/MCI) as* ***Annexure*** |
|  |  |  |  |  |  |  |

k. Any other Course/observer ship (PDCC, PDF, DNB, M.Sc., PhD, FNB, etc.) permitted/ not permitted by MCI/NMC is being run by the department. If so, the details thereof:

|  |  |  |
| --- | --- | --- |
| Name of Qualification (course) | Permitted/not Permitted by MCI/NMC | Number of Seats |
|  | Yes/No |  |
|  | Yes/No |  |

**B. INFRASTRUCTURE OF THE DEPARTMENT:**

**a. OPD**

No of rooms: \_\_\_\_\_\_\_\_\_\_

**Area of each OPD room (add rows)**

|  |  |
| --- | --- |
|  | **Area in M2** |
| **Room 1** |  |
| **Room 2** |  |
|  |  |

Waiting area: \_\_\_\_\_\_ M2

Space and arrangements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adequate/ not adequate. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not adequate, give reasons/details/comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**b. Wards**

No of wards: \_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Parameters** | **Details** |
| Distance between two cots (in meter) |  |
| Ventilation | Adequate/Not Adequate |
| Infrastructure and facilities |  |
| Dressing /Procedure Room |  |

**c. Operation Theatres:**

i. Do you full fill Operation Theatre infrastructure guidelines given in Part -A of the form:   
 Yes/ No

If no, what measure are you taking to rectify the deficiencies?

ii. Total number of operation theatre (tables) per week for each unit:

**d. Department office details:**

|  |  |
| --- | --- |
| **Department Office** | |
| Department office | Available/not available |
| Staff (Steno /Clerk) | Available/not available |
| Computer and related office equipment | Available/not available |
| Storage space for files | Available/not available |

|  |  |
| --- | --- |
| **Office Space for Teaching Faculty/residents** | |
| Faculty | Available/not available |
| Head of the Department | Available/not available |
| Professors | Available/not available |
| Associate Professors | Available/not available |
| Assistant Professor | Available/not available |
| Senior residents rest room | Available/not available |
| PG rest room | Available/not available |

**e. Seminar room**

Space and facility: Adequate/ Not Adequate

Internet facility: Available/Not Available

Audiovisual equipment details:

**f. Library facility pertaining to the Department/Speciality (Combined Departmental and Central Library data):**

|  |  |
| --- | --- |
| **Particulars** | **Details** |
| **Number of Books** |  |
| Total books purchased in the last three years( attach list as Annexure |  |
| Total Indian Journals available |  |
| Total Foreign Journals available |  |

Internet Facility: Yes/No

Central Library Timing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Central Reading Room Timing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Journal details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Journal** | | **Indian/foreign** | **Online/offline** | **Available up to** |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |

**g. Departmental Research Lab:**

|  |  |
| --- | --- |
| Space |  |
| Equipment |  |
| Research Projects Done in past 3 years |  |
| list Research projects in progress in research lab |  |

**h. Departmental Museum:**

|  |  |
| --- | --- |
| Space |  |
| Total number of Specimens |  |
| Total number of Chart/ Diagrams |  |

**i. Equipment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Equipment** | **Must/ Desirable** | **Available/ Not available** | **Functional Status** | **Comments** |
| **Cataract** | | | | |
| Operating Microscope |  |  |  |  |
| Ultrasound A Scan |  |  |  |  |
| Ultrasound B Scan |  |  |  |  |
| Keratometer |  |  |  |  |
| Specular microscope |  |  |  |  |
| Laser Interferometer |  |  |  |  |
| IOL Master |  |  |  |  |
| Phaco emulsification machine |  |  |  |  |
| **Cornea and Refractive surgery** | | | | |
| Pachymeter |  |  |  |  |
| Contrast sensitivity |  |  |  |  |
| Contrast sensitivity chart |  |  |  |  |
| Orbscan or Pentacam |  |  |  |  |
| Videokeratography |  |  |  |  |
| Facility for amniotic membrane  harvesting and storage (Deep  freezer at -80◦C) |  |  |  |  |
| LASIK Laser |  |  |  |  |
| Lenses for laser |  |  |  |  |
| C3R |  |  |  |  |
| **Vitreo-retina& Uvea** | | | | |
| Operating Microscope with Biome and re inverter |  |  |  |  |
| Indirect Ophthalmoscopes 6 |  |  |  |  |
| Fundus Camera 2 |  |  |  |  |
| Fundus fluorescein angiography (FFA) /ICG atleast 1 |  |  |  |  |
| Optical Coherence Tomography (OCT) 1 |  |  |  |  |
| Electroretinogram (ERG)-FF+MF 1 |  |  |  |  |
| Multifocal ERG (MfERG) 1 |  |  |  |  |
| Micro-perimetry 1 |  |  |  |  |
| Vitrectomy machines 2 |  |  |  |  |
| Endo laser 2 |  |  |  |  |
| Nd YAG laser for capsulotomy 1 |  |  |  |  |
| Red laser 1 |  |  |  |  |
| Lenses for laser |  |  |  |  |
| Laser Indirect Ophthalmoscopy 1 |  |  |  |  |
| Cryophotocoagulation 1 |  |  |  |  |
| Surgical sets required for Retinal Surgery |  |  |  |  |
| **Glaucoma** | | | | |
| Gonioscope (Goldmann1 or 2 mirror) |  |  |  |  |
| Non-contact tonometer |  |  |  |  |
| Applanation tonometer in all slit lamps |  |  |  |  |
| Pachymetry |  |  |  |  |
| Perkins tonometer/Tonopen |  |  |  |  |
| Standard Automated perimeter with normative database and progression analysis software |  |  |  |  |
| Fundus camera |  |  |  |  |
| **Pediatric Ophthalmology and Neuro-ophthalmology** | | | | |
| Indirect Ophthalmoscope |  |  |  |  |
| Synaptophore |  |  |  |  |
| Pediatric Refraction Set |  |  |  |  |
| Red green goggles |  |  |  |  |
| Hess or Lees chart |  |  |  |  |
| Teller’s / Cardiff Visual Acuity Cards |  |  |  |  |
| Prism Bar |  |  |  |  |
| Randot/ TNO test |  |  |  |  |
| Maddox wing/ Maddox rod |  |  |  |  |
| Electroretinogram (ERG) |  |  |  |  |
| VER |  |  |  |  |
| **Low Vision** | | | | |
| Indirect Ophthalmoscope |  |  |  |  |
| Low vision assessment kit |  |  |  |  |
| Low vision aids  • Filter lenses that  control glare  • Telescopes  /magnifiers/  Adaptive devices  • Electronic Aids  including CCTV |  |  |  |  |
| **Community Ophthalmology** | | | | |
| 1. Provision of transport facilities for the patients to base hospital for surgeries. |  |  |  |  |
| 2. Equipment and other logistics for conducting outreach comprehensive eye screening camp in the remote and underserved areas. |  |  |  |  |
| 3. Facilities for conducting Community based research, surveys. |  |  |  |  |
| 4. Tele-ophthalmology setup |  |  |  |  |

**j. List of Department specific laboratories/investigation room with important Equipment:**

|  |  |  |
| --- | --- | --- |
| **Name of Laboratory** | **List of important equipment available with functional status** | **Adequate/ Inadequate** |
| Visual field analyser |  |  |
| OCT |  |  |
| TMS |  |  |
| FFA |  |  |
| ERG |  |  |
| B scan |  |  |
| Optical biometer |  |  |
| Keratometer |  |  |
| Photography |  |  |
| Optical dispensary |  |  |

**C. SERVICES:**

**i. Specialty clinics run by the department of Ophthalmology with number of patients in each:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Clinic** | **Weekday/s** | **Timings** | **Number of cases (average)** | **Name of Clinic In-charge** |
| Glaucoma Clinic |  |  |  |  |
| Retina and Vitreoretinal Surgery Clinic |  |  |  |  |
| Refraction Clinic |  |  |  |  |
| Eye Bank |  |  |  |  |
| Squint Clinic |  |  |  |  |
| Paediatric Ophthalmology |  |  |  |  |
| Uvea and Medical Retina |  |  |  |  |
| Orbit and Oculoplasty |  |  |  |  |
| Low vision aids |  |  |  |  |
| Neuroophthalmology |  |  |  |  |
| Cornea and Ocular Surface |  |  |  |  |
| Contact Lens |  |  |  |  |
|  |  |  |  |  |

**ii. Outreach services:**

* Number of outreach camps conducted in a year
* Community eye care programmes run by the department (school eye checkups, diabetic retinopathy screening programmes etc.); number of patients seen per visit/ camp

**iii. Facilities available:**

1. Phaco Surgery: Yes / No
2. Ophthalmic laser: Yes / No
3. Retinal Surgery: Yes / No
4. Eye Bank: Yes / No

**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF OPHTHALMOLOGY:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Numbers** | | | | |
| **Parameter** | **On the day of assessment** | **Previous Day Data** | **Year 1** | **Year 2** | **Year 3**  **(last year)** |
| 1 | 2 | - | 3 | 4 | 5 |
| Total numbers of Out-Patients |  |  |  |  |  |
| Out-Patients attendance (write **Average daily Out-Patients attendance** in column 3,4,5)\* |  |  |  |  |  |
| Total numbers of new Out-Patients |  |  |  |  |  |
| New Out Patients attendance  (write average in column 3,4,5) \* for Average daily New Out-Patients attendance |  |  |  |  |  |
| Total Admissions for Year |  |  |  |  |  |
| Bed occupancy |  |  | X | X | X |
| Bed occupancy for the whole year above 75% (Prepare a Data Table) | X | X | Yes/No | Yes/No | Yes/No |
| Total Major surgeries in the department |  |  |  |  |  |
| Major Surgeries  (write average in column 3,4,5) |  |  |  |  |  |
| Total Minor surgeries in the department |  |  |  |  |  |
| OCT scans |  |  |  |  |  |
| HFA |  |  |  |  |  |
| Biometry |  |  |  |  |  |
| CT Scan per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| MRI per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| Histopathology Workload per day (average of all working days) |  |  |  |  |  |
| Cytopathology Workload per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| OPD Cytopathology Workload per day (average of all working days) |  |  |  |  |  |
| Haematology workload per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| OPD Haematology workload per day (average of all working days) |  |  |  |  |  |
| Biochemistry Workload per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| OPD Biochemistry Workload per day (average of all working days) |  |  |  |  |  |
| Microbiology Workload per day (OPD + IPD) (average of all working days) |  |  |  |  |  |
| OPD Microbiology Workload per day (average of all working days) |  |  |  |  |  |

**\* Average daily Out-Patients attendance** is calculated as below.

Total OPD patients of the department in the year divided by total OPD days of the department in a year

**E. MAJOR SURGERIES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Surgery** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3 (last Year)** |
| **LID & LACRIMAL** | | | | |
| 1. TARSORAPHY |  |  |  |  |
| 2. LID REPAIR |  |  |  |  |
| 3. ECTROPION &  ENTROPION |  |  |  |  |
| 4. PTOSIS  CORRECTION |  |  |  |  |
| 5. DCT |  |  |  |  |
| 6. DCR |  |  |  |  |
| 7. PROBING |  |  |  |  |
| 8. TUMOUR EXCISION  WITH LID  RECONSTRCTION |  |  |  |  |
| STRABISMUS |  |  |  |  |
| ORBITAL PROCEDURES |  |  |  |  |
| CYCLOCRYO / CYLOPHOTOCOAGULATION |  |  |  |  |
| OCULAR SURFACE – PTERYGIUM EXCISION WITH GRAFT |  |  |  |  |
| **CATARACT** | | | | |
| 1. ECCE |  |  |  |  |
| 2. SICS |  |  |  |  |
| 3. PHACOEMULSIFICATION |  |  |  |  |
| 4. SECONDARY IOL IMPLANTATION |  |  |  |  |
| **RETINA** | | | | |
| 1. INTRAVITREAL INJECTIONS |  |  |  |  |
| 2. ANTERIOR VITRECTOMY |  |  |  |  |
| 3. PPV |  |  |  |  |
| 4. SCLERAL BUCKLING |  |  |  |  |
| **GLAUCOMA** | | | | |
| 1. TRABECULECTOMY |  |  |  |  |
| 2. GLAUCOMA VALVE IMPLANT SURGERY |  |  |  |  |
| **CORNEA** | | | | |
| 1. KERATOPLASTY |  |  |  |  |
| 2. CORNEAL / CORNEO SCLERAL TEAR REPAIR |  |  |  |  |
| 3. C3R |  |  |  |  |
| **MINOR SURGICAL PROCEDURES** | | | | |
| 1. FB REMOVAL – CONJUNCTIVAL / CORNEAL |  |  |  |  |
| 2. CHALAZION – INCISION & CURETTAGE |  |  |  |  |
| 3. EPILATION |  |  |  |  |
| 4. SYRINGING |  |  |  |  |
| 5. SUBCONJUNCTIVAL INJECTION |  |  |  |  |
| 6. SUTURE REMOVAL |  |  |  |  |
| 7. CONJUNCTIVAL TEAR SUTURING |  |  |  |  |
| 8. PST |  |  |  |  |
| **LASER** | | | | |
| 1. YAG PI |  |  |  |  |
| 2. YAG CAP |  |  |  |  |
| 3. FOCAL & PAN RETINAL PHOTOCOAGUATION |  |  |  |  |
| **KERATOREFRACTIVE PROCEDURE** |  |  |  |  |

**F. STAFF**:

**i. Unit-wise faculty and Senior Resident details:**

Unit no: \_\_\_\_\_\_\_\_

| **Sr. No.** | **Designation** | **Name** | **Joining date** | **Relieved/**  **Retired/working** | **Relieving Date/ Retirement Date** | **Attendance in days for the year/part of the year \* with percentage of total working days\*\***  **[days ( %)]** | **Phone No.** | **E-mail** | **Signature** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |
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\* - Year will be previous Calendar Year (from 1st January to 31st December)

\*\* - Those who have joined mid-way should count the percentage of the working days accordingly.

**ii. Total eligible faculties and Senior Residents (fulfilling the TEQ requirement, attendance requirement and other requirements prescribed by NMC from time-to-time) available in the department:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Designation** | **Number** | **Name** | **Total number of Admission (Seats)** | **Adequate / Not Adequate for number of Admission** |
| Professor |  |  |  |  |
| Associate Professor |  |  |
| Assistant  Professor |  |  |
| Senior Resident |  |  |

**iii. P.G students presently studying in the Department:**

| **Name** | **Joining date** | **Phone No** | **E-mail** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

**iv. PG students who completed their course in the last year:**

| **Name** | **Joining date** | **Relieving Date** | **Phone no** | **E-mail** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

**G. ACADEMIC ACTIVITIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.**  **No.** | **Details** | **Number in the last**  **Year** | **Remarks**  **Adequate/ Inadequate** |
| 1. | Clinico- Pathological conference |  |  |
| 2. | Clinical Seminars |  |  |
| 3. | Journal Clubs |  |  |
| 4. | Case presentations |  |  |
| 5. | Group discussions |  |  |
| 6. | Guest lectures |  |  |
| 7. | Death Audit Meetings |  |  |

*Note:* *For Seminars, Journal Clubs, Case presentations, Guest Lectures the details of dates, subjects, name & designations of teachers and attendance sheets to be maintained by the institution and to be produced on request by the Assessors/PGMEB.*

**Publications from the department during the past 3 years:**

|  |
| --- |
|  |

**H. EXAMINATION:**

**i. Periodic Evaluation methods (FORMATIVE ASSESSMENT):**

(Details in the space below)

**ii. Detail of the Last Summative Examination:**

1. **List of External Examiners:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation** | **College/ Institute** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **List of Internal Examiners:**

|  |  |
| --- | --- |
| **Name** | **Designation** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. **List of Students:**

|  |  |
| --- | --- |
| **Name** | **Result**  **(Pass/ Fail)** |
|  |  |
|  |  |
|  |  |

**d. Details of the Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Insert video clip (5 minutes) and photographs (ten).

**I. MISCELLANEOUS:**

**i. Details of data being submitted to government authorities, if any:**

**ii. Participation National Program for Prevention and control of Blindness**

(If yes, provide details)

**iii. Any Other Information**

1. **Please enumerate the deficiencies and write measures are being taken to rectify those deficiencies:**

**Date: Signature of Dean with Seal Signature of HoD with Seal**

**K. REMARKS OF THE ASSESSOR**

|  |
| --- |
| *1. Please* ***DO NOT*** *repeat information already provided elsewhere in this form.*  *2. Please* ***DO NOT*** *make any recommendation regarding grant of permission/recognition.*  *3. Please* ***PROVIDE DETAILS*** *of deficiencies and irregularities like fake/ dummy faculty, fake/dummy patients, fabrication/falsification of data of clinical material, etc. if any that you have noticed/came across, during the assessment. Please attach the table of list of the patients (IP no., diagnosis and comments) available on the day of the assessment/inspection.*  *4. Please comment on the infrastructure, variety of clinical material for the all-round training of the students.* |