**STANDARD ASSESSMENT FORM- B**

 (DEPARTMENTAL INFORMATION)

**RADIATION ONCOLOGY**

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| --- |
| *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 ofInspection | Purpose ofInspection*(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 -XIIII*** |
|  |  |  |  |  |  |  |

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. 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 |

 **d. Seminar room**

Space and facility: Adequate/ Not Adequate

 Internet facility: Available/Not Available

 Audiovisual equipment details:

**e. List of Department specific laboratories with important Equipment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Laboratory** | **Size in square meter** | **List of important equipment available with total numbers** | **Adequate/ Inadequate** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**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: List of important equipment available and their functional status.**

1. **Equipment for Teletherapy**
* Give details of the Radiotherapy Unit Stating Type of Unit Linear Accelerator (Electrons/Photons). Cobalt Unit/Cesium units/Deep E-ray/superficial X-ray etc.
* Equipment for Radio-surgery, IMRT, IGRT, SBRT, Robotic Mounted Linear Accelerator etc. with details
* Facilities for intra operative radiotherapy / Hyperthermia
1. **Equipment for Brachytherapy**

Specify whether rate (LDR/MDR/HDR), Manual/Remote, Pre-Loaded/After-Loading/Sources used.

* For Intracavitory
* For Interstitial
* For surface moulds
* For Ophthalmic applications
* For facilities for pre-operative Radiotherapy
1. **Equipment for Treatment Planning: Manual (or) Computerized Treatment Planning System?**

Furnish details of equipment:

* + - 1. **Facility for patient immobilization (furnish details):**
			2. **Facility for casting individualized shielding blocks (furnish details):**
			3. **Facility for tissue compensation (furnish details):**
			4. **Equipment for department of medical physics.**
* Facilities for Dosimetery Equipment (furnish details):
* Facilities for Radiation Monitoring (furnish details):
* Facilities for Radiation Protection (furnish details):

Facilities for mould room equipment (furnish details):

**C. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF RADIATION ONCOLOGY:**

|  |  |
| --- | --- |
| **Parameter** | **Numbers** |
| **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 |  |  |  |  |  |
| Bed occupancy  |  |  | X | X | X |
| Bed occupancy for the whole year above 75%. | X | X | Yes/No | Yes/No | Yes/No |
| ECG per day. (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| X-rays per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| Ultrasonography per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| CT scan per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| MRI per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| Cytopathology Workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Cytopathology Workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Haematology workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Haematology workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Biochemistry Workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Biochemistry Workload per day. (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| Microbiology Workload per day (OPD + IPD)... (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Microbiology Workload per day. (write average of all working days in column 3, 4 and 5)  |  |  |  |  |  |
| Palliative cancer care OPD load |  |  |  |  |  |
| Palliative cancer care IPD load |  |  |  |  |  |
| Total number of patients given Radiotherapy |  |  |  |  |  |
| Total number of patients given Teletherapy |  |  |  |  |  |
| Total number of patients given Brachytherapy |  |  |  |  |  |
| Total number of patients given TPS Plan |  |  |  |  |  |
| Total number of patients given Mould Room procedure |  |  |  |  |  |
| Total number of patients given Chemotherapy |  |  |  |  |  |
| Total Deaths. \*\* |  |  |  |  |  |
| Total Blood Units Consumed including Components. |  |  |  |  |  |

\* **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

 *\*\** The details of deaths sent by hospital to the Registrar of Births/Deaths

**D. SERVICES:**

**i. Any intensive care service provided:**

(List in the space provided below)

**ii. Any Specialized service provided by the department of Radiation Oncology:**

(Give details in space provided below)

**iii. Services provided by the department of Radiation Oncology:**

**E. 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 |  |  |
| AssistantProfessor |  |  |
| 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**  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

**F. 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 |  |  |
| 8. | Physician conference/ Continuing Medical Education (CME) organized. |  |  |
| 9. | Symposium  |  |  |

*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:**

|  |
| --- |
|  |

**G. 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** |
|  |  |  |
|  |  |  |
|  |  |  |
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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).

**H. MISCELLANEOUS:**

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

**ii. Participation in National Programs.**

**(If yes, provide details)**

**iii. Any Other Information**

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

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

**J. 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.* |