**STANDARD ASSESSMENT FORM- B**

(DEPARTMENTAL INFORMATION)

**RADIO DIAGNOSIS**

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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: \_\_\_\_\_\_\_\_\_\_

g. 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 -XIIII*** |
|  |  |  |  |  |  |  |

h. 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:**

**i. 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 |

**ii. Seminar room**

Space and facility: Adequate/ Not Adequate

Internet facility: Available/Not Available

Audiovisual equipment details:

**iii. 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** |
|  |  | |  |  |
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**iv. Departmental Research:**

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

**v. Equipment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Equipment** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** | **Adequate**  **Yes/No** |
| X-Ray Machines- Static  i.  ii.  iii. |  |  |  |  |
| X-Ray Machines- Portable  i.  ii.  iii. |  |  |  |  |
| X-Ray Machines- TV/Imaging facility |  |  |  |  |
| CT Scan (Mention slices, year of manufacturing with other specifications)  i.  ii. |  |  |  |  |
| MRI (Mention Tesla, year of manufacture with other specifications) |  |  |  |  |
| USG – Grey Scale (mention probes available with each machine)  i.  ii.  iii. |  |  |  |  |
| USG – Colour Doppler (mention probes available with each machine)  i.  ii.  iii. |  |  |  |  |
| Mammography |  |  |  |  |
| DSA |  |  |  |  |
| Digital X-Ray storage system (PACS system) |  |  |  |  |
| Any other equipment (add rows) |  |  |  |  |

**C. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF RADIO DIAGNOSIS:**

| **Parameter** | **On the day of assessment** | **Previous day data** | **Year 1** | **Year 2** | **Year 3**  **(Last Year)** |
| --- | --- | --- | --- | --- | --- |
| **(1)** | **(2)** | **-** | **(3)** | **(4)** | **(5)** |
| **Total Plain X-rays (write average of all working days in a year in column 3, 4, 5)** |  |  |  |  |  |
| IVP |  |  |  |  |  |
| Barium Swallow |  |  |  |  |  |
| Barium Upper GI studies |  |  |  |  |  |
| Barium Meal Follow through |  |  |  |  |  |
| *Barium Enema* |  |  |  |  |  |
| *HSG* |  |  |  |  |  |
| *Silography* |  |  |  |  |  |
| Urethrogram |  |  |  |  |  |
| MCUG |  |  |  |  |  |
| Fistulography/ Sinography |  |  |  |  |  |
| Total Number of Ultrasonography |  |  |  |  |  |
| Number of Ultrasonography  *(write average of all working days in a year in column 3, 4, 5)* |  |  |  |  |  |
| Doppler studies for abdominal vessels and scrotal conditions |  |  |  |  |  |
| Doppler study for peripheral vessels. Prepare data table. |  |  |  |  |  |
| Doppler study for carotid vessels |  |  |  |  |  |
| Other Doppler studies |  |  |  |  |  |
| USG Guided procedures-FNAC/ Biopsy |  |  |  |  |  |
| USG Guided procedures –aspiration/intervention |  |  |  |  |  |
| Total CT scan |  |  |  |  |  |
| **Total CT scan per day**  *(write average of all working days in a year in column 3, 4, 5)* |  |  |  |  |  |
| Number of  plain CT Scans *(without contrast)* |  |  |  |  |  |
| Number of plain CT Scans Brain. Prepare data table |  |  |  |  |  |
| Number of plain CT Scans Abdomen. Prepare data table |  |  |  |  |  |
| Number of  plain CT Scans Head and Neck |  |  |  |  |  |
| Number of CT contrast Enterography |  |  |  |  |  |
| Number of CT contrast Urography. Prepare data table |  |  |  |  |  |
| Number of CT contrast Enema |  |  |  |  |  |
| CT guided procedures like FNAC/BIOPSY |  |  |  |  |  |
| Total MRI |  |  |  |  |  |
| **Total MRI per day**  (write average of all working days in a year in column 3, 4, 5) |  |  |  |  |  |
| Number of plain MRI (without contrast) |  |  |  |  |  |
| Number of plain MRI Brain. Prepare data table |  |  |  |  |  |
| Number of plain MRI for spine. Prepare data table |  |  |  |  |  |
| Number of MRI with contrast |  |  |  |  |  |
| Number of MR Urography |  |  |  |  |  |
| Number of MR Cholangiopancreatography. Prepare data table |  |  |  |  |  |
| Mammography. Prepare data table |  |  |  |  |  |
| Angiography (Conventional). Prepare data table |  |  |  |  |  |
| Angiography (DSA) |  |  |  |  |  |
| Any others (Please add rows) |  |  |  |  |  |

**D. 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 with percentage of total working days**  **[days ( %)]** | **Phone No.** | **E-mail** | **Signature** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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**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** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

**E. 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:**

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**F. 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:**

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| --- | --- |
| **Name** | **Designation** |
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1. **List of Students:**

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| --- | --- |
| **Name** | **Result**  **(Pass/ Fail)** |
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**d. Details of the Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**G. 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**

**H. 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**

**I. 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.* |