

CLINICAL PORTFOLIO



MEDICINE

Department of Medicine
Faculty of Medicine
Uva Wellassa University of Sri Lanka

1st Batch
2026

CLINICAL PORTFOLIO



MEDICINE

Faculty of Medicine

Uva Wellassa University of Sri Lanka

Personal details

Full Name :

Reg No : UWU/MBBS/ /

MED Number :

Signature of the Student :

*Paste your photograph
here*

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Acknowledgement

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(1) Introduction

Dear Student,

Welcome to your medicine appointments in the University Medical Unit. This period provides an opportunity to consolidate your clinical knowledge and skills in clinical medicine. You are encouraged to use this appointment to further develop professional attitudes towards patients and their relatives, as well as towards colleagues, including medical, nursing, and ancillary staff.

Your appointment will be mainly based in the medical wards of Teaching Hospital Badulla. Clinical teaching will be conducted by the consultants in each ward. In addition to these formal teaching sessions, valuable learning can be gained through informal discussions with senior registrars, registrars, senior house officers, house officers, and nurses in the unit.

Spend as much time as possible with patients in the ward. Learn to take a comprehensive history, perform a thorough clinical examination, analyze symptoms and signs, identify medical and social problems, and plan appropriate management. Always respect patients' wishes, as the patient comes first in the hospital setting.

A series of assessments will be conducted during these medicine appointments to evaluate the clinical skills and professional attitudes you develop.

Patient confidentiality is a core obligation of medical professionals and an integral part of their training. As such, **medical students bear full responsibility** for safeguarding patient information included in this portfolio.

We hope this medicine appointment will help you perfect your clinical skills and learn the practical aspects required to become a very good junior house officer.

Department of Medicine
Faculty of Medicine
Uva Wellassa University of Sri Lanka

(1.1) Marks Allocation in Final MBBS Examination

One continuous assessment will be held at the end of the pre-professorial appointments at 8th semester.

At the end of the 10th semester the final MBBS examination will be held.

Continuous Assessment 8 - at the end of the 8th semester

Method of Assessment	Time (Minutes)	Total	Total marks allocated to Final MBBS
Pre professorial portfolio assessment & Viva	15	5	5%
OSCE – 15 Stations	60	10	10%
Total			15%

Continuous Assessment 9 - at the end of the professorial appointment

Method of Assessment	Time (Minutes)	Total	Total marks allocated to Final MBBS
Professorial Portfolio assessment & Viva	15	5	05%
Total			05%

Final MBBS Examination

Method of Assessment	Number of Questions	Time Allocated (minutes)	Total	Total marks allocated to Final MBBS
Paper 1 –MCQ (T/F +SBA)	20+30	120	20	20%
Paper 2 – SEQ	6	180	20	20%
Long case –	1 case	40	20	20%
*Short case	4	30	20	20%
	Contribution from summative examination			80%
	Continuous Assessment contribution			20%
	Total marks			100%

(1.2) Award of Distinctions in Final MBBS Examination

A candidate who obtains

- 1) an overall average of **70%** marks in a subject and
- 2) **65% for the clinical component** in the following subjects in the (MBBS) Final examination (i) Medicine, (ii) Surgery, (iii) Obstetrics and Gynecology, (iv) Pediatrics, (v) Psychiatry and (vi) Family Medicine
- 3) shall be considered to have obtained a Distinction in that subject
- 4) provided that he/she is sitting that examination for the **first time** and
- 5) that he/she passes the whole (MBBS) Final examination and obtains either a **First or Second Class**

(1.3) Award of Honours in Final MBBS Examination

1) First Class (Honours)

1. A candidate who passes (MBBS) Final examination at the **1st scheduled attempt** and
2. obtains an overall average mark of **70% or above** at that examination shall be eligible for First Class (Honours)

2) Second Class Upper Division (Honours)

1. A candidate who passes (MBBS) Final examination at the **1st scheduled attempt** and
2. obtains an overall average mark of **65% - 69%** at that examination shall be eligible for Second Class Upper Division (Honours)

3) Second Class Lower Division (Honours)

1. A candidate who passes (MBBS) Final examination at the **1st scheduled attempt** and
2. obtains an overall average mark of **60% to 64%** at that examination shall be eligible for Second Class Lower Division (Honours)

4) 64% but 2nd class upper Division (Honours)

1. A candidate who has passed the MBBS Final examination at the **first scheduled attempt** and
2. obtains an average of **64%** marks at that examination shall be eligible for Second Class Upper Division (Honours) provided he/she has obtained
3. **Second Class Upper or First Class Honours in both the (MBBS) second and (MBBS) third examinations** and
4. has a **cumulative average** mark of **65%** or above at the **(MBBS) second and (MBBS) third examinations and (MBBS) Final examinations.**

5) 59% but 2nd class lower Division (Honours)–

1. A candidate who has passed the (MBBS) Final examination at the **First scheduled attempt** and
2. obtains an average mark of **59%** or above at the (MBBS) Final examination shall be eligible for 2nd Class Lower Division (Honours)
3. provided that he/she obtained Honours **in both (MBBS) 2nd examination and (MBBS) 3rd examination** and
4. has a **cumulative average** mark of **60%** or above at the **2nd MBBS examination, 3rd MBBS examination, and Final MBBS examination**

(2) Guide to Daily Clinical Work

During the clinical appointment, you will contribute to patient care on a daily basis through direct contact with patients, other members of the medical team, and family members.

Your **clinical responsibilities** include (1) obtaining a detailed history, (2) performing a relevant physical examination, and (3) arriving at a differential diagnosis or diagnosis. You are expected to develop the ability to (4) request appropriate investigations and (5) formulate management plans. As part of routine clinical work, you should gather daily information on the patient's clinical status and treatment progress, (6) document daily progress, and plan for discharge. You should also take the initiative to (7) meet with family members and (8) other team members eg: Physiotherapists, Occupational Therapists, Pharmacists etc. to facilitate and implement treatment and discharge planning.

Ward rounds are conducted each morning. During ward rounds, the consultant and the medical team review each patient, discuss the illness, and decide on the diagnostic and therapeutic plan for the day. To obtain maximum benefit from ward rounds, it is the student's responsibility to gather relevant clinical data in advance. Depending on the number of patients and the complexity of their clinical problems, you may need to (1) arrive in the ward early. You should always have immediate access to each patient's (2) case summary, (3) medication details, and (4) current laboratory results. This will enable you to actively participate in discussions during ward rounds. You will be required to (5) present your patient's case during ward rounds; in such situations, a concise summary rather than a detailed presentation is expected, in accordance with the preferences of the consultant in charge.

You are encouraged to adopt the attitude of a junior doctor responsible for the care of assigned patients, as this will enhance your learning experience. You are also required to maintain a set of case notes for each patient using the format provided on the following page.

All case records should be available at your assessments.

Format For Case History Documentation

- 1) **Preliminary data**
 - Patient's name
 - Age
 - Address
 - Date of admission & BHT
- 2) **History**
 - Document
 - Presenting complaint and ancillary complaints with duration
 - History of the presenting complaint
 - Past medical history
 - Past surgical history
 - Drug history: Current medications, any drug allergy
 - Allergy History
 - Family history
 - Personal and social history
 - D/DD - Discuss relevant diagnosis or differential diagnoses according to the history, giving reasons for your conclusions.
 -
- 3) **Examination** - Clinical examination findings
- 4) **Summary** - Give a summary of your history and examination.
- 5) **D/DD** - Give the most likely diagnosis or differential diagnoses.
 - When the diagnosis or differential diagnoses is unknown, state the problems
 - When the patient has multiple diagnoses/problems, list them according to priority
- 6) **Investigations**
 - Discuss the plan of investigations.
 - Give relevant investigations and
 - document the results.
 - Document ECG, CXR findings.
- 7) **Management** - Give the comprehensive plan of management.
- 8) **Daily status** - Continue patient follow up with documentation of daily status which would include patient's
 - daily clinical status and
 - any changes in the management.
- 9) **Charts** - Maintain observation charts e.g. dengue observation charts, fluid balance charts, peak flow charts etc.
- 10) **Plan for discharge**
 - Document the discharge medication and
 - follow-up plan.
 - Formulating a comprehensive discharge summary which must be necessarily legible

Guidelines For General Conduct

Attendance

Attendance at the clinical appointment is a statutory requirement and is compulsory. Attendance will be recorded daily at 8.00 a.m. and on casualty nights. This includes public holidays unless otherwise stated. Leave for any reason must be obtained from the Head of the Department. If attendance is unsatisfactory, you will be required to repeat part or the entire appointment.

Illness

If you are absent from teaching due to illness, **inform** the Head of the Department **within 3 days** via dean.office.fomed@uwu.ac.lk, and you must submit a **Medical Certificate** within **7 days** to the HOD **through UMO**. At the discretion of the Head of the Department, the appointment may be prolonged to cover the days of absence.

Punctuality

It is essential, as late arrival is disruptive to other students. Latecomers may be refused admission to teaching sessions. Students are expected to arrive on time for all clinics & ward rounds.

Behavior

Students must be courteous to patients and the general public at all times, and considerate towards medical, nursing, and para-medical staff. As you will spend much of your time in contact with patients who have professional expectations of you, noisy or inappropriate conversations must be avoided in all areas where patients or visitors may overhear.

Dress Code

Medical students must be clean and suitably attired in the hospital setting (e.g., scrubs) and maintain a neat appearance. Extremes of dress should be avoided eg. Jeans, shorts, trainers, and slippers are not permitted. Students must always wear a name tag.

Student Belongings

Must not leave backpacks, helmets, or other personal belongings in wards or clinics. Personal belongings remain the responsibility of the student and should be kept in a secure location.

Conduct

Students are expected to maintain a high standard of public behavior and demonstrate appropriate professional attitudes at all times.

Consenting and Patients' Rights

Patients have the right to decline being observed or attended to by students without any effect on the treatment they receive. Whenever practicable, the student's status and the reason for their presence must be explained, and the patient's prior informed consent should be requested.

(3) Medicine Long Appointment - 01

(3.1) Objectives

1. **History Taking** - Learn the proper method of history taking, including the identification of symptoms and their evaluation.
2. **Clinical Examination** - Learn and practice a systematic examination of body systems and recognize common physical signs.
3. **Case Summary Writing** - Develop the ability to write a clear and concise patient summary.
4. **Problem Identification** - Learn to recognize and list the important clinical problems.
5. **Differential Diagnosis** - Attempt to work out possible diagnoses based on clinical findings.
6. **Investigations** - Become familiar with investigations used for common diseases, including how and where they are performed.
7. **Management** - Learn principles of management, with particular emphasis on prioritizing emergencies.
8. **Case Presentations** - Present cases during ward rounds and case discussions, and observe presentations by house officers, registrars, and other senior staff.
9. **Clinical Skills** - Observe clinical procedures and perform simple procedures such as venipuncture and nebulization.
10. **Ethics and Communication** - Learn about the doctor–patient relationship and the professional responsibilities of a doctor.

(2) Cases Presented (Minimum 3 Cases should be presented by the student)

Date	Name & BHT	Diagnosis /System Examined	Presented to	Remarks/Signature of the Consultant

(3) Interesting Patients Seen

Date	Name/BHT	Diagnosis

(4) Clinical Procedures

Skill Level

A - Can perform independently

B - Can perform under supervision

C - Has observed the procedure

No	Procedure	Skill Level	Date	Name of the supervisor & sign
1)	Maintaining fluid balance chart	A		
2)	Maintaining temperature chart	A		
3)	Maintaining GCS	A		
4)	Maintaining peak flow rate (PEFR)	A		
5)	Perform Venipuncture	A/B		
6)	Inserting an IV cannula	A/B		
7)	Setting up an IV drip	A/B		
8)	Intramuscular injection	B		
9)	Nebulization	B		
10)	IV injection	B		
11)	Bladder catheterization	B		
12)	Arterial blood gas analysis (ABG)	B		
13)	Venous blood gas analysis (VBG)	B		
14)	Withdraw blood for culture	C		
15)	Taking and 12 lead ECG	C		
16)	Pleural aspiration/ Biopsy	C		
17)	Bronchoscopy	C		
18)	Abdominal paracentesis	C		
19)	Liver biopsy / Renal biopsy	C		
20)	Bone marrow biopsy	C		

(5) Emergencies Observed

Name	BHT	Problem & diagnosis	Date

6) Clinic Attendance

Date	Clinic	Signature of the Consultant/SR

(7) Casualty Attendance

Date	Signature Reg/SHO	Interesting Patients seen

(8) Seminars/Meetings/Presentations

Date	Seminars/Meetings/Presentations	Signature

(3.3) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment medicine under me. I have given a grade based on his/her performance of the appointment.

Medicine Long Appointment 1 From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(4) Medicine Long Appointment - 02

(4.1) Objectives

1. **History Taking** - Improve skills in obtaining a comprehensive patient history.
2. **Clinical Examination** - Perform systematic and methodical examinations of body systems, elicit physical signs, and understand their relevance.
3. **Summary Writing** - Learn to write a clear and accurate patient summary.
4. **Problem Recognition** - Identify and list important clinical problems.
5. **Differential Diagnosis** - List differential diagnoses in order of priority.
6. **Investigations** - Interpret the results of relevant clinical investigations.
7. **Management:** Outline management plans for common diseases and recognize emergencies.
8. **Case Presentations** - Present cases during ward rounds and case discussions, and improve overall presentation skills.
9. **Clinical Skills** - Observe clinical procedures and carry out procedures under supervision.
10. **Ethics and Communication** - Learn effective communication with patients and relatives, and with doctors, nurses, and other members of the health care team.

(2) Cases Presented (Minimum 3 cases should be presented by the student)

Date	Name & BHT	Diagnosis /System Examined	Presented to	Remark/Signature of the consultant

(3) Interesting Patients Seen

Date	Name/BHT	Diagnosis

(4) Clinical Procedures

Skill Level

A - Can perform Independently

B - Can perform under supervision

C - Has seen the procedure

No	Procedure	Skill Level	Date	Name of the supervisor & sign
1)	Maintaining fluid balance chart	A		
2)	Maintaining temperature chart	A		
3)	Maintaining GCS	A		
4)	Maintaining peak flow rate (PEFR)	A		
5)	Perform Venipuncture	A/B		
6)	Inserting an IV cannula	A/B		
7)	Setting up an IV drip	A/B		
8)	Intramuscular injection	B		
9)	Nebulization	B		
10)	IV injection	B		
11)	Bladder catheterization	B		
12)	Arterial blood gas analysis (ABG)	B		
13)	Venous blood gas analysis (VBG)	B		
14)	Withdraw blood for culture	C		
15)	Taking and 12 lead ECG	C		
16)	Pleural aspiration/ Biopsy	C		
17)	Bronchoscopy	C		
18)	Abdominal paracentesis	C		
19)	Liver biopsy / Renal biopsy	C		
20)	Bone marrow biopsy	C		

(5) Emergencies Observed

Name	BHT	Problem & diagnosis	Date

(6) Clinic Attendance

Date	Clinic	Signature of the Consultant/SR

(7) Casualty Attendance

Date	Signature Reg/SHO	Interesting Patients seen

(8) Seminars/Meetings/Presentations

Date	Seminars/Meetings/Presentations	Signature

(4.3) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in medicine under me. I have given a grade based on his/her performance of the appointment.

Medicine Long Appointment 2 From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(5) Medicine Long Appointment - 03

(5.1) Objectives

- 1) **History Taking** – Able to take a proper history and recognize important symptoms and understand their relevance.
- 2) **Clinical Examination** – Competent in performing systematic examinations. Able to interpret abnormal signs in a holistic manner and document and present findings effectively.
- 3) **Summary Writing** – Able to write a clear and concise patient summary.
- 4) **Problem Recognition** – Able to list and prioritize important clinical problems.
- 5) **Differential Diagnosis** – Able to discuss the likely diagnosis and consider differential diagnoses.
- 6) **Investigations** – Able to decide on relevant investigations and discuss the expected findings.
- 7) **Management** – Able to discuss management plans for commonly seen conditions and respond appropriately to emergencies.
- 8) **Case Presentations** – Able to present concise summaries during ward rounds and present a clinical case in detail for discussion.
- 9) **Clinical Skills** – Able to perform and observe procedures as listed in the clinical skills table. Practice writing diagnosis cards and completing investigation forms.
- 10) **Ethics and Communication** – Able to educate patients about disease conditions, break bad news, obtain consent for procedures and post-mortems, and maintain professional communication with patients, relatives, and healthcare team members.

(2) Cases Presented (Minimum 3 cases should be presented by the student)

Date	Name & BHT	Diagnosis /System Examined	Presented to	Remark/Signature of the consultant

(3) Interesting Patients Seen

Date	Name/BHT	Diagnosis

(4) Clinical Procedures

Skill Level

A - Can perform Independently

B- Can perform under supervision

C- Has seen the procedure

No	Procedure	Skill Level	Date	Name of the supervisor & sign
1)	Maintaining fluid balance chart	A		
2)	Maintaining temperature chart	A		
3)	Maintaining GCS	A		
4)	Maintaining peak flow rate (PEFR)	A		
5)	Perform Venipuncture	A		
6)	Inserting an IV cannula	A		
7)	Setting up an IV drip	A		
8)	Intramuscular injection	A		
9)	Nebulization	A		
10)	IV injection	A		
11)	Bladder catheterization	A		
12)	Arterial blood gas analysis (ABG)	B		
13)	Venous blood gas analysis (VBG)	B		
14)	Withdraw blood for culture	B		
15)	Taking and 12 lead ECG	C		
16)	Pleural aspiration/ Biopsy	C		
17)	Bronchoscopy	C		
18)	Abdominal paracentesis	C		
19)	Liver biopsy / Renal biopsy	C		
20)	Bone marrow biopsy	C		

(5) Emergencies Observed

Name	BHT	Problem & diagnosis	Date

(6) Clinic Attendance

Date	Clinic	Signature of the Consultant/SR

(7) Casualty Attendance

Date	Signature Reg/SHO	Interesting Patients seen

(8) Seminars/Meetings/Presentations

Date	Seminars/Meetings/Presentations	Signature

(5.3) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in medicine under me. I have given a grade based on his/her performance of the appointment.

Medicine Long Appointment 3 From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6) Medicine 8 Short Appointments

(6.1) Cardiology

(6.1.1) Objectives

At the end of the cardiology appointment, student should be able to,

1. **History Taking** – Take a comprehensive patient history and perform an appropriate cardiac examination.
2. **Emergencies** – Recognize common cardiac emergencies and discuss their management.
3. **Diagnosis and Management** – Describe the diagnostic approach and outline appropriate management strategies for common cardiac conditions.
4. **Investigations** – Interpret and correlate ECG findings with clinical diagnoses of common cardiac conditions. Briefly describe the principles of exercise ECG and echocardiography.
5. **Caring Doctor** – Interact with patients with cardiac diseases in a humane, compassionate, and professional manner.

Common cardiac conditions students should know. Students are also expected to know other diseases encountered in the ward.

1. Acute coronary syndrome
2. Stable angina
3. Arrhythmias
4. Hypertension
5. Heart failure
6. Valvular heart disease

(6.1.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in cardiology under me. I have given a grade based on his/her performance of the appointment.

Cardiology From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.2) Neurology

(6.2.1) Objectives

At the end of the neurology clerkship, student should be able to,

1. **History Taking and Examination** – Take a detailed history from a patient with a neurological problem and perform an accurate neurological examination.
2. **Planning Investigations** – Make a diagnosis and plan appropriate investigations for common neurological problems.
3. **Management** – Recognize conditions that require referral to a specialist for further management.
4. **Diagnosis** – Briefly describe special diagnostic procedures used for the diagnosis of neurological diseases.

Common neurological conditions students should know. Students are also expected to know other diseases encountered in the ward.

1. Stroke
2. Epilepsy
3. Meningitis, encephalitis
4. Cranial nerve palsies
5. Guillain Barre Syndrome
6. Cerebral space occupying lesions
7. Peripheral neuropathy
8. Myasthenia gravis

(6.2.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in neurology under me. I have given a grade based on his/her performance of the appointment.

Neurology From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.3) Pulmonology

(6.3.1) Objectives

At the end of the rheumatology clerkship, student should be able to

1. **History and Examination** - Take a comprehensive respiratory history and perform an appropriate respiratory system examination.
2. **Emergencies** - Recognize common respiratory emergencies and discuss the basics of management of such conditions.
3. **Diagnosis**-Describe the diagnostic approach and appropriate management of common respiratory conditions.
4. **Investigations**- Interpret and correlate chest X-ray, arterial blood gas, and spirometry findings with clinical diagnosis of common respiratory diseases. Briefly describe the principles of pulmonary function testing, bronchoscopy, and oxygen therapy.
5. **Caring Doctor** - Interact in a humane, compassionate, and professional manner with patients with respiratory diseases.

Common respiratory conditions students should know. Students are also expected to know other diseases encountered in the ward.

1. Asthma
2. COPD
3. Respiratory tract infections (Pneumonia, Tuberculosis etc.)
4. Bronchiectasis
5. Interstitial lung disease
6. Lung malignancies

(6.3.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in pulmonology under me. I have given a grade based on his/her performance of the appointment.

Pulmonology From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.4) Nephrology

(6.4.1) Objectives

At the end of the rheumatology clerkship, student should be able to

1. **History and Examination** - Take a comprehensive history and perform an appropriate renal system examination, including assessment of fluid status.
2. **Emergency** - Recognize common renal emergencies and discuss the basics of management of such conditions.
3. **Diagnosis** - Describe the diagnostic approach and appropriate management of common renal conditions.
4. **Investigations** - Interpret and correlate renal function tests, urine analysis, and electrolyte abnormalities with clinical diagnosis of common renal diseases. Briefly describe the principles of renal imaging, renal biopsy, and dialysis modalities.
5. **Caring Doctor** - Interact in a humane, compassionate, and professional manner with patients with renal diseases.

Common renal conditions students should know. Students are also expected to know other diseases encountered in the ward.

1. Chronic kidney disease
2. Acute kidney injury
3. Glomerular diseases
4. Tubulointerstitial diseases
5. Urinary tract infections
6. Diabetic kidney disease

(6.4.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in nephrology under me. I have given a grade based on his/her performance of the appointment.

Nephrology From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.5) Rheumatology

(6.5.1) Objectives

At the end of the rheumatology clerkship, student should be able to

1. **Clinical Features** - Describe the clinical features and basic principles of management of common rheumatological conditions.
2. **Examination** - Examine a patient with a rheumatological problem and document the findings accurately.
3. **Investigations** - Discuss the basic principles of investigations in patients with musculoskeletal problems.
4. **Disability Assessment** - Assess disease activity to determine damage and functional disability. Explain the principles of rehabilitation through observation of physiotherapy and occupational therapy units.
5. **Management** - Explain the basic principles of management of common rheumatological problems and the side effects of commonly used drugs.

Common rheumatological problems students should know. Students are also expected to know other diseases encountered in the ward.

1. Rheumatoid arthritis
2. Osteoarthritis
3. Sero-negative arthritis
4. Spondyloarthritis
5. Systemic lupus erythematosus & other connective tissue diseases

(6.5.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in rheumatology under me. I have given a grade based on his/her performance of the appointment.

Rheumatology From To

Name of the Consultant:

Grade

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Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.6) Oncology

(6.6.1) Objectives

At the end of the medical oncology clerkship, student should be able to,

1. **Cancer Prevalence in Sri Lanka** - List the common cancers seen in adults and children, and briefly discuss cancer prevalence in Sri Lanka.
2. **Symptoms and Signs** - Recognize the common presenting symptoms and physical signs of these cancers.
3. **Treatment Modalities** - Briefly describe available treatment modalities, including radiotherapy, chemotherapy, and surgery, and how these treatments are delivered to patients.
4. **Management** - Discuss approaches to relieve pain and ameliorate suffering in patients with malignant diseases.
5. **Caring Doctor** - Communicate in a humane and compassionate manner with patients with malignant diseases and their relatives.
6. **Prevention** - Briefly discuss preventive strategies for malignant diseases.

(6.6.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in oncology under me. I have given a grade based on his/her performance of the appointment.

Oncology From To

Name of the Consultant:

Grade

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Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.7) Dermatology

(6.7.1) Objectives

At the completion of the dermatology clerkship student should

1. **Common Skin Conditions** - Be able to diagnose common skin disorders.
2. **Management** - Be able to discuss the management of common skin disorders.
3. **Diagnosis and Referral** - Recognize conditions that require referral to a specialist for management. Observe the technical procedures used in dermatology clinics for diagnosis and treatment of skin disorders.

Common skin disorders students should know. Students are also expected to know other diseases encountered in the ward.

1. Eczema
2. Dermatitis
3. Psoriasis
4. Lichen planus
5. Acne vulgaris
6. Urticaria
7. Drug eruptions
8. Pigmentary disorders
9. Erythema multiforme
10. Erythema nodosum
11. Miliaria

(6.7.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in dermatology under me. I have given a grade based on his/her performance of the appointment.

Dermatology From To

Name of the Consultant:

Grade

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Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(6.8) Sexually Transmitted Diseases (STD)

(6.8.1) Objectives

At the end of the appointment student should be able to,

1. **Identify Clinical Features** - Recognize common STDs and obtain a relevant history. Identify specific clinical features in gonorrhoea, genital herpes, HIV and its complications, syphilis, and chancroid.
2. **Consent** - Describe the consent procedure prior to clinical examination and the patient counselling process.
3. **Investigations** - Describe investigations, treatment, follow-up, and contact tracing performed in the STD clinic.
4. **Confidentiality** - Maintain strict confidentiality and respect patient autonomy during clinical encounters.
5. **Prevention** - Describe strategies for HIV prevention in Sri Lanka and globally.

(6.8.2) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her appointment in Sexually Transmitted Diseases (STD) under me. I have given a grade based on his/her performance of the appointment.

Sexually Transmitted Diseases (STD) From To

Name of the Consultant:

Grade

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Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(7) Medicine Professorial Appointment

(7.1) Objectives

At the end of the professorial medicine appointment, students should be able to:

- 1) **History taking** - Demonstrate the ability to obtain a comprehensive medical history, including identification of medical, psychological, and social problems. Students are encouraged to obtain histories within a stipulated time, and such practice will be beneficial in the Final MBBS Examination.
- 2) **Clinical examination** - Perform a complete and systematic physical examination and elicit common physical signs accurately.
- 3) **Scientific knowledge** - Possess the necessary scientific knowledge and understanding required to practice medicine safely and effectively.
- 4) **Clinical reasoning and problem identification** - Construct logical differential diagnoses and identify medical and psychosocial problems following a comprehensive clinical assessment.
- 5) **Interpretation of investigations** - Interpret commonly performed medical investigations and prioritize them appropriately according to individual patient needs.
- 6) **Requesting investigations** - Request and arrange relevant medical investigations in accordance with local protocols and guidelines.
- 7) **Patient management** - Formulate rational, patient-centered management plans for both acute and long-term care.
- 8) **Practical and procedural skills** - Perform practical procedures for investigative and therapeutic purposes to the expected level of competency.
- 9) **Documentation and record keeping** - Accurately, clearly, and legibly document case notes and prepare appropriate discharge summaries.
- 10) **Communication skills** - Communicate confidently and effectively with patients and their families from diverse socio-cultural backgrounds, including providing information, obtaining informed consent, and breaking bad news.
- 11) **Ethics and professionalism** - Identify, analyze, and appropriately address ethical issues related to the practice of clinical medicine.
- 12) **Teamwork and leadership** - Recognize and respect the roles of other healthcare professionals, collaborate effectively within the healthcare team, and demonstrate leadership when required in patient care.
- 13) **Research and evidence-based practice** - Develop a commitment to research and evidence-based practice, with the ability to retrieve, manage, and utilize biomedical information to solve clinical problems.

- 14) **Public health and preventive medicine** - Recognize risk factors for disease and threats to health in vulnerable populations and understand strategies to modify these risks at the community level.
- 15) **Screening and community collaboration** - Implement appropriate screening programs and collaborate with relevant professionals and organizations.
- 16) **Lifelong learning and self-reflection** - Recognize and accept limitations in personal knowledge and clinical skills, and demonstrate commitment to continuous professional development throughout one's career.

(2) Long Case Presentation Assessment Sheets

Clinical case presentations are clearly different from ward round presentations and therefore mandate a different style of presentation. You will be given opportunity to present clinical cases to the teaching consultant. The cases you have documented during daily clinical work will be used for case presentations.

Most teachers expect the student to recount the history in detail and give a differential diagnosis based on the history alone. They may expect you to list the entire physical examination, including both normal and abnormal findings, and discuss whether examination findings have narrowed down the differential diagnosis. You should be able to present and interpret the investigation results and discuss the management of the patient in detail.

Mastering the oral presentation takes time and experience. Take your free time to practice; while at home, during free time in hospital, in front of friends, etc. Take the opportunity to present as many cases as possible.

You are expected to get at least **two (2) case presentations** evaluated during the professorial medicine appointment. The supervisor will assess you and award marks according to the rating scale given in the next page.

3. What are the strengths of the student?

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4. What needs to improve?

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5. Total marks out of 10 -

6. Assessor information

Name -

Designation -

Signature -

Date -

(2.2) Long Case Presentation 02: Assessment Sheet

Please complete this after presentation of a long case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-6 should be filled up by the assessor.

1. Summary of the case presentation

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2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
History					
Clinical Examination					
Identification of Problems					
Differential diagnosis					
Formulation of management plan					
Overall performance					

3. What are the strengths of the student?

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4. What needs to improve?

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5. Total marks out of 10 -

6. Assessor information

Name -

Designation -

Signature -

Date -

(2.3) Long Case Presentation 03: Assessment Sheet

Please complete this after presentation of a long case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-6 should be filled up by the assessor.

1. Summary of the case presentation

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2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
History					
Clinical Examination					
Identification of Problems					
Differential diagnosis					
Formulation of management plan					
Overall performance					

3. What are the strengths of the student?

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4. What needs to improve?

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5. Total marks out of 10 -

6. Assessor information

Name -

Designation -

Signature -

Date -

(3) Short Case Presentation Assessment Sheets

Short case presentations will help you improve your skills in system examination. Present as many cases as possible to registrars and senior registrars in the unit. You must document **four** cases (each from cardiovascular, neurology, respiratory and abdominal) you have presented and obtain signatures. **One of the presentations should be assessed by a consultant and marks given according to a rating scale**

(3.1) Short Case Presentation 01: Assessment Sheet

Please complete this after presentation of a short case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-4 should be filled up by the assessor.

1. System Examined		Signs Elicited and Differential Diagnosis
Cardiovascular system		
Respiratory System		
Abdominal System		
Nervous System		

2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
Interaction and rapport with patient					
Examination technique					
Correct identification of physical signs					
Correct interpretation of physical signs					
Appropriate confidence in presentation					
Discussion of findings and management					

3. Total marks out of 10 -

4. Assessor information

Name - Designation -

Date - Signature -

(3.2) Short Case Presentation 02: Assessment Sheet

Please complete this after presentation of a short case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-4 should be filled up by the assessor.

1. System Examined		Signs Elicited and Differential Diagnosis
Cardiovascular system		
Respiratory System		
Abdominal System		
Nervous System		

2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
Interaction and rapport with patient					
Examination technique					
Correct identification of physical signs					
Correct interpretation of physical signs					
Appropriate confidence in presentation					
Discussion of findings and management					

3. Total marks out of 10 -

4. Assessor information

Name - Designation -

Date - Signature -

(3.3) Short Case Presentation 03: Assessment Sheet

Please complete this after presentation of a short case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-4 should be filled up by the assessor.

1. System Examined		Signs Elicited and Differential Diagnosis
Cardiovascular system		
Respiratory System		
Abdominal System		
Nervous System		

2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
Interaction and rapport with patient					
Examination technique					
Correct identification of physical signs					
Correct interpretation of physical signs					
Appropriate confidence in presentation					
Discussion of findings and management					

3. Total marks out of 10 -

4. Assessor information

Name - Designation -

Date - Signature -

(3.4) Short Case Presentation 04: Assessment Sheet

Please complete this after presentation of a short case. This assessment can be done by a consultant, a post graduate trainee (a registrar or a senior registrar). Please ensure that all the fields are filled up. Section 1 should be filled by medical student. Section 2-4 should be filled up by the assessor.

1. System Examined		Signs Elicited and Differential Diagnosis
Cardiovascular system		
Respiratory System		
Abdominal System		
Nervous System		

2. Assessment

	Below Expectations	Borderline	Meets Expectations	Above Expectations	Well above Expectations
Interaction and rapport with patient					
Examination technique					
Correct identification of physical signs					
Correct interpretation of physical signs					
Appropriate confidence in presentation					
Discussion of findings and management					

3. Total marks out of 10 -

4. Assessor information

Name - Designation -

Date - Signature -

(4) Clinical Procedures

During your medicine appointment you will see a wide variety of procedures performed in ward patients. Whenever possible you should try to observe, or actively take part in such procedures under the guidance of a senior doctor. Acquisition of clinical skills is an important aspect of becoming a good house officer. Your knowledge and technique in performing basic clinical procedures will be tested in the OSCE examination.

The following is a list of some important procedures that should be **performed**.

1. Venipuncture and inserting I.V. cannula
2. IM/ SC/ IV injections
3. Nebulization
4. Chest, limb physiotherapy
5. Passing a nasogastric tube
6. Urinary catheterization
7. Taking an ECG
8. Drawing of blood for culture
9. Arterial blood gas analysis

The following procedures should be **observed**.

1. Blood transfusion
2. Lumbar puncture
3. Bone marrow biopsy
4. Liver biopsy
5. Pleural biopsy
6. Renal biopsy
7. Endotracheal intubation
8. Gastric lavage
9. Bowel wash and enema
10. Pleural fluid aspiration
11. Peritoneal fluid aspiration
12. Joint aspiration
13. Mantoux test
14. Peritoneal dialysis/ Hemodialysis
15. Insertion of CVP line
16. Skin biopsy/ scrapings/ smear

A minimum of 10 procedures should be entered into the portfolio.

Enter the procedures observed/ performed under the following format.

Skill Level

A - Can perform Independently

B- Can perform under supervision

C- Has seen the procedure

No	Procedure	Skill Level	Date	Name of the supervisor & sign
1)	Maintaining fluid balance chart	A		
2)	Maintaining temperature chart	A		
3)	Maintaining GCS	A		
4)	Maintaining peak flow rate (PEFR)	A		
5)	Perform Venipuncture	A		
6)	Collect and dispatch samples to hospital Laboratory	A		
7)	Inserting an IV cannula	A		
8)	Setting up an IV drip	A		
9)	Administer Intramuscular injection	A		
10)	Nebulization	A		
11)	Administer IV injection	A		
12)	Carry out inward urine test	A		
13)	Types of insulin, injection device and how to give insulin	A		
14)	Collection and transport of specimens for microbiology	A		
15)	Measure capillary blood sugar	A		
16)	Perform a 12 lead ECG	A		
17)	Perform 20-minute WBCT	A		
18)	Estimating hematocrit using capillary tube	A		
19)	Perform direct ophthalmoscopy	A		

20)	Perform otoscopy	A		
21)	Bladder catheterization	A		
22)	Instructing patient to use inhaler device	A		
23)	Arterial blood gas analysis (ABG)	A		
24)	Venous blood gas analysis (VBG)	A		
25)	Withdraw blood for culture	A/B		
26)	Cardio-pulmonary resuscitation	A/B		
27)	Abdominal paracentesis	C		
28)	Pleural aspiration/ Biopsy	C		
29)	Bronchoscopy	C		
30)	Bone marrow biopsy	C		
31)	Liver biopsy / Renal biopsy	C		
32)	Lumbar puncture	C		
33)	Hemodialysis	C		
34)	Insert a peritoneal catheter	C		
35)	Insert a central venous line	C		

(4.1) Procedure 01

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.2) Procedure 02

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.3) Procedure 03

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.4) Procedure 04

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.5) Procedure 05

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.6) Procedure 06

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.7) Procedure 07

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.8) Procedure 08

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.9) Procedure 09

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(4.10) Procedure 10

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Performed/ Observed:

Patient's name: Age:

BHT No: Date of admission:

Indication for procedure:	Pre procedure preparation:
Contraindications looked for:	Instruments used:
Localization of site:	Potential complications:
Method:	
Any complications during this procedure:	Transport of specimen

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Name & Signature of doctor who performed /oversaw the procedure being performed

Date:

(5) Clinic Attendance

Date	Clinic	Signature of the Consultant/SR

(6) Casualty Attendance

Date	Signature Reg/SHO	Interesting Patients seen

(9) Emergency Medicine

Patients with acute illnesses that require immediate medical attention will be admitted to the wards on casualty days which fall on every third day. During the clinical appointment you will have the opportunity to see how the doctors undertake acute interventions to resuscitate and stabilize these patients. Emergency Medicine is a very important aspect of your training. Your knowledge in this area will be tested in many components of your final examination including the viva.

You are expected to keep a record of patients admitted with acute medical emergencies. You should be able to perform a focused history, examination and plan out the management of all common medical emergencies including:

1. Acute coronary syndrome
2. Left ventricular failure
3. Cardiac arrest
4. Acute severe asthma
5. Acute respiratory failure
6. Acute gastrointestinal hemorrhage
7. Unconscious patient
8. Stroke
9. Seizures
10. Confused and aggressive patient
11. Diabetic ketoacidosis
12. Hypoglycemia
13. Acute renal failure
14. Hypotensive patient
15. Acute poisoning
16. Snake bite
17. Anaphylaxis
18. Sepsis/septic shock

A minimum of 10 cases must be recorded in your portfolio.

All notes on emergency medical cases should be recorded under the given format.

6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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(9.2) Emergency Medicine Case 02

Patient's Name: Age:

Sex: M / F BHT No: Date of Admission:

1. Presenting complaint:

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2. Brief history and examination findings:

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3. Urgent investigations and results:

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4. Diagnosis:

5. Acute management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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(9.4) Emergency Medicine Case 04

Patient's Name: Age:

Sex: M / F BHT No: Date of Admission:

1. Presenting complaint:

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2. Brief history and examination findings:

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3. Urgent investigations and results:

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4. Diagnosis:

5. Acute management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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9. Long term plan of management:

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(9.10) Emergency Medicine Case 10

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Patient's Name: Age:

Sex: M / F BHT No: Date of Admission:

1. Presenting complaint:

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2. Brief history and examination findings:

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3. Urgent investigations and results:

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4. Diagnosis:

5. Acute management:

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6. Problems encountered during the acute management and steps taken to overcome them:

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7. Management after stabilization:

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8. Further Investigations requested and results:

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9. Long term plan of management:

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(10) Shadow House Officer Assessment

Shadow house officer attachment is a key feature of this clinical appointment. In this attachment you will extend the clinical skills already acquired and gain experience in the practice of acute general medicine. During this one week you will function as an apprentice house officer, joining in with the in-patient work of the unit. The unit staff will help you as necessary. You will be given the responsibility of a limited number of patients admitted to the unit. You are expected to write brief case notes, daily follow up notes and may be asked to present few cases during the ward rounds.

This attachment gives you an insight into the daily life of a house officer and can be useful in preparing for your future internship appointment. It will be considered as a part of your professional development and feedback on your work will be obtained.

Following objectives should be fulfilled during the attachment.

1) Emergency medicine:

1. To carry out a rapid assessment of illness severity
2. To identify the most significant symptom.
3. To ask pertinent questions to assist differential diagnosis.
4. To determine presence or absence of relevant physical signs.
5. To establish priorities in investigation and management.
6. To carry out a diagnostic assessment of the unconscious patient.
7. To prioritize resuscitation.

2) Non acute medicine:

1. To develop an appropriate initial approach to the patient.
2. To obtain a detailed history.
3. To distinguish major symptoms from others.
4. To ascertain all necessary ancillary information about the major symptoms.
5. To carry out a critical examination of all systems.
6. To interpret abnormal physical signs & construct a differential diagnosis.
7. To construct an appropriate investigation and management plan.
8. To be aware of principles of long term management of disease.

3) Knowledge objectives:

- 1) Differential diagnosis of all common emergencies.
- 2) Clinical presentations of all common emergencies.
- 3) Safe prescribing of drugs on the care formulary.
- 4) Time management by house officers.

Obtain the signature from the ward round consultant on the last day of your shadow HO attachment.

I certify that the student has satisfactorily / unsatisfactorily completed his/her shadow house officer attachment in medicine under me. I have given a grade based on his/her performance.

Shadow House Officer Attachment: From To

Name of the Consultant:

Grade

Comments:

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Consultant's signature

[with rubber stamp]

Grade –

A – Excellent, B – Good, C- Poor

(7.3) Assessment by the Consultant

I certify that the student has satisfactorily / unsatisfactorily completed his/her professorial medicine appointment under me. I have given a grade based on his/her performance of the appointment.

Professorial Medicine Appointment From To

Name of the Consultant:

Grade

.....
Consultant's signature
[with rubber stamp]

Grade –
A – Excellent, B – Good, C- Poor

(8) Recommended Text Books

1. Kumar and Clark's Clinical Medicine – 11th Edition
2. Macleod's Clinical Examination – 15th Edition
3. Hutchison's Clinical Methods – 25th Edition
4. Davidson's Principles and Practice of Medicine - 21st Edition
5. Oxford Handbook of Clinical Medicine - 8th Edition

*The latest edition is always recommended for the books stated above



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