CLINICAL PORTFOLIO

FAMILY MEDICINE

Department of Family Medicine

Faculty of Medicine

Uva Wellassa University of Sri Lanka

1st Batch

2026

CLINICAL PORTFOLIO

Family 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

Version 1 @ 2026 February

Compiled by

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Acknowledgement

Logbook, Department of Family Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura

Contents

(1) Introduction

Dear Student,

Welcome to the clinical attachment in the Department of Family Medicine. During this period, you will have the opportunity to consolidate and refine your clinical knowledge and skills in primary care and family medicine. You are also expected to develop professional attitudes in your interactions with patients and their families, as well as with colleagues, including medical, nursing, and ancillary staff.

Your appointment will be mainly based in family medicine units and primary care settings affiliated with the teaching hospital and community health centres. Clinical teaching will be conducted by family medicine consultants and medical officers attached to each unit. You will participate in outpatient clinics, community-based activities, and teaching sessions conducted by consultants and senior medical officers. In addition to formal teaching, significant learning can be gained through informal discussions with registrars, medical officers, nursing staff, and other members of the primary healthcare team.

You are encouraged to spend as much time as possible with patients and their families in the clinical setting. Learn to obtain a **(1)** comprehensive and patient-centered history, including medical, psychosocial, family, and lifestyle aspects; **(2)** perform focused and relevant clinical examinations; **(3)** analyses symptoms and signs in the context of continuity of care; **(4)** identify common acute and chronic health problems encountered in primary care; and **(5)** formulate appropriate management plans with emphasis on prevention, health promotion, and follow-up. At all times, respect the rights, dignity, and wishes of patients, recognizing that patient safety and holistic care are paramount.

A series of assessments will be conducted during the attachment to evaluate the clinical skills, communication abilities, and professional attitudes you develop throughout the clerkship.

We hope this clinical attachment will assist you in refining your family medicine clinical skills and in acquiring the practical knowledge and professional attributes required to become a competent and responsible junior house officer, particularly in primary care and community-based practice.

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 in this portfolios.

Department of Family Medicine
Uva Wellassa university of Sri Lanka
Feb 2026

(1.1) Clinical Appointment in Family Medicine

1) 1 week in the Family Attachment
2) 2 weeks in Family Center/General Practice & Hospital rotation in the 4th Year

(1.2) Marks Allocation in 3rd MBBS Part 2 Examination

One continuous assessment will be held at the end of 7th semester and another CA at the end of the 8th Semester and then the 3rd MBBS part II Examination will be at the end of 8th Semester after Family Attachment

Continuous Assessment 7 at the end of the 7th semester

Method of Assessment	No of Questions	Time (Minutes)	Total	Total marks allocated to 3rd MBBS Part II
MCQ (TF and SBA)	10+10	60	10	**05**
SEQ	2	60	10	**05**
OSCE	5	15	10	**05**
	Total			**15%**

Continuous Assessment 8 at the end of the 8th semester

Method of Assessment	No of Questions	Time (Minutes)	Total	Total marks allocated to 3rd MBBS Part II
Portfolio viva (End of Family Attachment)		15	7.5	**7.5**
Portfolio viva (End of Family Center/GP Attachment & Hospital Rotation)		15	7.5	**7.5**
	Total			**15%**

3rd MBBS part II Examination – at the end of the 8th semester

Method of Assessment	Number of Questions	Time (minutes)	Total	Total marks allocated to Final MBBS
MCQ+SBA	20+ 20	120	25	25
SEQ	04	120	25	25
OSCE/OSPE	15	45	10	10
Structured Viva		10	10	10
	Contribution to MBBS			**70%**
	Continuous Assessment contribution			**30%**
	Total marks			**100**

(1.3) Award of Distinctions in 3rd MBBS Examination

A candidate who obtains

1) an overall average of **70%** marks in a subject shall be considered to have obtained a Distinction in that subject

2) provided that he/she is sitting that examination for the **first time** and

3) That he/she passes the whole (MBBS) third examination and obtains either a **First or Second Class.**

(1.4) Award of Honours 3rd MBBS Examination

1) First Class (Honours)

1. A candidate who passes the (MBBS) 3rd 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 the (MBBS) 3rd 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 the (MBBS) 3rd examination at the **first 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)

(2) Guide to Daily Clinical Works

During the Family Medicine clinical appointment, medical students contribute to patient care on a daily basis through direct contact with patients, family members, family physicians, nursing staff, and other healthcare workers. Students are expected to actively participate in outpatient clinics, follow-up visits, and preventive care activities.

Students should (1) obtain a focused and relevant history, including presenting complaints, past medical history, medication history, family and social history, and lifestyle factors where appropriate. Students are expected to (2) perform relevant physical examinations respectfully and professionally under supervision and to interpret findings accurately. Students should develop the ability to (3) arrive at a working diagnosis (4) request appropriate basic investigations, and (5) formulate initial management and (6) follow-up plans.

Routine clinical work includes (1) assessing patients with acute and chronic conditions, (2) monitoring treatment response, (3) documenting daily clinical notes, (4) providing patient education, and (5) participating in referral and follow-up planning. Students are encouraged to communicate effectively with patients, family members, and the multidisciplinary team to facilitate patient care.

Daily clinics are conducted under the supervision of the family physician. To gain maximum benefit, students are responsible for reviewing patient records in advance and being familiar with diagnoses, current medications, investigation results, and management plans. Students may be asked to present patient cases during clinics. Presentations should be concise and focused, highlighting key clinical issues and management plans. A complete set of case records must be maintained using the prescribed format and be available for mid-term and final assessments.

(2.1) Guidelines for General Conduct

Attendance

Attendance for the clinical appointment is a statutory requirement and is **compulsory.** Attendance will be recorded at 8.00 a.m. daily 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 have to repeat a 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

Late arrival of students is discouraged as it is disruptive to other students. Latecomers may be refused admission to teaching sessions. Students must arrive at all clinics and ward rounds on time.

Behavior

Students must always be courteous to patients and to the public. They should also be considerate to medical nursing and Para-medical staff. Remember that you will be spending much of your time in contact with patients who will have certain expectations of you as professionals. Avoid noisy, inappropriate conversation in all areas where patients/visitors may overhear.

Dress

In hospital, medical students should be clean and suitably attired e.g. scrubs. It is important that you maintain a clean, neat appearance. Avoid extremes of dress. Jeans, shorts, trainers and slippers are not permitted. Equip yourself with a name tag. Name labels must be always worn.

Conduct

Students will be expected to maintain a high standard of public behavior. You must always demonstrate appropriate attitudes.

Student belongings

On no account must students litter the wards of clinics with rucksacks, helmets etc. Your belongings are your responsibility and should be placed in a secure location.

Consenting – Patients' rights

Patients have the right to decline to be observed or attended to by students without affecting in any way the treatment they receive. Whenever practicable, the student's status and the reason for his/her presence must be explained to the patient and the patient's prior informed.

(3) Objectives

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

1) **Communication** -Describe the doctor-patient relationship and acquire communication skills to elicit biomedical and psychosocial issues to understand the patient's illness experience.

2) **Clinical assessment** - Use the patient-centred clinical method to take a focused history, carry out a relevant clinical examination, use selective investigations and institute a cost-effective management plan after negotiating with the patient to ensure compliance.

3) **Problem-solving** - Acquire problem-solving skills to sort out minor self-limiting illnesses from potentially serious diseases.

4) **Psychosocial** - Understand the psychological, social, behavioral and cultural factors that influence a patient's illness behaviour and presentation for care.

5) **Family dynamics** - Have knowledge and understanding of family dynamics, the individual and family life cycle and factors that have an impact on the family in health and disease.

6) **Comprehensive care** - Provide comprehensive curative and preventive care for common illnesses, non- communicable diseases, psychosocial problems and emergencies in the office, home or hospital.

7) **Coordination** - Coordinate a patient's health care through appropriate referral to specialists and other health resources in the community.

8) **Documentation** - Maintain medical records and provide continuity of care.

9) **Geriatrics** - Have knowledge and skills to care for the elderly and to provide end-of-life care and bereavement care.

10) **Ethics** - Have knowledge of ethical and legal issues in family practice.

11) **Professionalism** - Develop appropriate attitudes towards personal and professional development through reflective practice and life-long learning.

12) **Public health** - Familiar with the National Health Programmed of the Family Health Bureau.

(4) Family Center/General Practice Session

(4.1) Overview

Venue:
General Practice Clinic in your hometown. Please visit the department & request your allocated GP clinic or you may select a GP with a postgraduate qualification (DFM/ MD. MRCGPJINT), MCGP) from your hometown. Please see that you make a prior appointment with the General practitioner for this visit. The letter for the General practitioner should be obtained from the department.

Topic:
Introduction to General Practice: Why people go to the doctor and what happens in the consultation?

Aim:
To orientate students in general practice and to familiarize them with the purpose of the consultation and the process of the clinical interview in a community based primary care setting.

(4.2) Learning Outcomes:

By the end of this session, you should be able to.

- discuss some of the reasons for patients to visit the GP
- describe the doctor-patient interactions observed
- define the core communication skills used in GP consultations and interviews particularly in relation to the opening of a consultation

(4.3) Outline of the visit to Family Center/General Practice

You are expected to visit the selected practice for 2 sessions. This visit should be done in the 4th year Family Medicine appointment. The practice visit should be for about two hours. Student will visit the GP. Prior to the first visit, students are advised to complete the recommended reading and revise their knowledge on communication skills, process of consultation and problem solving in primary care from the Family Medicine lectures.

There will be two sessions with patients, which will include the following:

A short pre-consultation interview with a patient regarding the purpose of the patient's visit to the GP (typically in the waiting room)

Accompany a patient into the consultation room and observe the following:

What brought the patients to the GP - reasons for consultations?

With reference to the "patient centered approach to care" how were the skills of listening, empathy, rapport and question styles (Ex- open, closed, leading and probing questions) used in the consultation?

What were the verbal and non-verbal communications observed?

What might have been done differently?

How do these consultations differ from the hospital-based consultations?

- At the end of the two visits, write a reflection (500 words) on your GP visits. Obtain the signature and the stamp from the GP. Students must treat these encounters confidentially,
- This reflection and the portfolio will be reviewed during the 4th year Family Medicine attachment. By this time the
    - GP visit reflection,
    - minimum of 8 brief histories and
    - Some procedures must be completed.
- Portfolio should also be completed using the training of other clinical appointments during the 3rd & 4th years.

(4.4) Attendance at Family center/General Practice Sessions

(1) Family Center/GP Visit 1

Date:

…….
Signature & stamp of the Family Physician/ General Practitioner

(2) Family Center/GP Visit 2

Date:

……
Signature & stamp of the Family Physician/ General Practitioner

(4.5) Reflective Writing after Family Center/General Practice Sessions

(5) Hospital Rotation

(5.1) Learning Outcomes

At the end of hospital rotation, you should be able to

- Assess common symptoms encountered in primary care and should have adequate knowledge and understanding about the management of the range of problems that are given below.
- Describe the different options that are available for evaluation, treatment and prevention of common problems at a primary care level.

Common clinical problems seen in primary care may be seen in any of the appointments as shown below. (You will see these problems during your Family Medicine clinical appointments as well)

Tasks to be completed prior to final year Family Medicine appointment

1. **Brief case reports** - on 20 selected clinical problems
2. **Detailed case reports -** on 5 selected clinical presentations

(5.2) Brief Case Reports

You should briefly write 20 selected case reports from the clinical problems listed below. Use the space provided to write these.

The case reports should include the following:

- History including initial symptom development/ description of event prior to hospitalization.
- Clinical Examination
- Probable diagnosis/Differential Diagnosis
- Hospital management

Use the format given below, complete the case reports during the Family Medicine hospital rotation and GP attachments and obtain the signature and the stamp from a responsible person.

Example of brief case report 01

Date **14.12.2017**	**Name** **Ms. M. Samarawickrama**	**Age- 23yrs** **Sex- female**	**BHT/clinic No:** **MC/130/19**

A patient with Headache

History – Ms. M came to the medical clinic complaining of a headache for 3 months duration. She is a university student and as this headache is interfering with her studies, she has come to the medical clinic. She has taken paracetamol and has applied some Ayurveda oils without much help.

This headache has been coming once in 10 to 14 days. She doesn't have any visual disturbances or flashes coming, but she gets unusual feeling before the onset of the headache. She feels nauseated, has vomited several times with the headache. It is mainly on the right side of the head, starts behind the eye and goes backwards and throbbing in nature. No specific time of the day, however she gets the headache if she doesn't sleep well and if she goes in the bright sunlight. The headache lasts for few hours and she finds it difficult to perform any task with it. She feels better when she sleeps. Has not noticed any association with food like chocolate, cheese. Does not increase with bending of the head, no tearing with the headache. She doesn't wake up due to headache and has never got it in the night. No visual impairments, doesn't think that she is under stress.

Past Medical History-No significant illnesses

Social History- She is from Anuradhapura and stays in the university hostel. She is unmarried, only daughter in a family of 4. No addictions
She wants to get rid of this headache soon to prepare for her exams.

Examination
Vision normal, no tenderness over sinuses

Diagnosis
Most likely diagnosis is migraine
No investigations requested

Management
Acute episode management
Naproxen 500mg with paracetamol 1000mg and domperidone 10 mg
As she is getting frequent episodes, started on prophylaxis
Propranolol 40 mg daily for one month
Requested to come for a review after a month.

Name of the authenticator	Stamp	Signature

Example of brief case report 02

Date **25/11/19**	**Name of the Patient** **Mr. Nimal Vithange**	**Age 43yrs** **Gender - male**	**BHT/clinic No:1925**

A patient with right side loin pain for 5 days

History - Patient has started R/S loin pain 5 days ago as a dull ache. The intensity of the pain had increased. It comes in episodes and when severe pain is there pain score is 8-9/10. Initially he has taken paracetamol, with severe pain has gone to a nearby GP and had been given a suppository, and it had relieved the pain. But as it is coming back again, he has come to hospital

No vomiting

The pain is colicky in nature, it radiates to the right groin. It lasts several minutes, goes away and comes back again. He has no fever, no dysuria. Has noticed brown discoloration of urine for 2 days.

Past History - He has been treated once for ureteric calculi previously(medication records are not available on him)

Social History- works as a policeman, father of 2.
No addictions.

Examination
Afebrile, not pale, BP-135/80rumHg. PR-70
Abdomen-Soft, Not distended,
R/S renal angle mildly tender to percussion.

Management
Diclofenac Na 100mg Suppository applied,
Advised on proper hydration
urine for full report ordered
Arrange X-ray KUB after preparing bowel
Referral to the surgical clinic has been arranged.

Name of authenticator	Stamp	Signature

(5.3) List of Clinical Problems

Clinical Problem	Appointment
Abnormal menstrual bleeding	Gynaecology & Obstetrics
Accidental trauma	Accidents service
Acute abdominal pain	Surgery
Adult with diarrhea	Medicine
Backache	Rheumatology/Orthopedics
Blocked nose	ENT
Change in bowel habits	Surgery/Medicine
Chest pain	Medicine
Child with diarrhea	Paediatrics
Child with urinary tract infection	Paediatrics
Cough	Medicine/Paediatrics
Deafness	ENT
Depression	Psychiatry
Developmental delay	Paediatrics
Diabetes mellitus	Medicine
Dizziness & lightheadedness	Medicine
Dyspeptic symptoms	Medicine/Surgery
Earache	ENT
Ear discharge	ENT
Eczema/Dermatitis	Dermatology
Fever	Medicine/Paediatrics
Foreign body in the ear/nose or throat	ENT
Foreign body in the eye	Ophthalmology
Fungal infections	Dermatology
Headache	Medicine/Neurology
Heel pain	Rheumatology/Orthopaedics
Hoarseness	ENT/Surgery/Medicine
Immunization	Paediatrics
Impairment of vision	Ophthalmology

Clinical Problem	Appointment
Incontinence	Gynaecology & Obstetrics
Infertility	Gynaecology & Obstetrics
Irregular menstruation	Gynaecology & Obstetrics
Itching	Dermatology
Joint pain	Rheumatology/ Orthopaedics
Knee pain	Rheumatology
Loin pain	Surgery/ Medicine
Loss of vision	Ophthalmology/Medicine
Lump in the breast	Surgery
Lump in the Neck	Surgery
Neck pain	Rheumatology/Orthopedics
Numbness of hands	Neurology/Medicine
Infections of the skin	Dermatology/Medicine/Paediatrics
Pigmented lesions birth mark- naevi	Dermatology/paediatrics
Raised blood pressure	Medicine
Rectal bleeding	Surgery/Medicine
Red eye	Ophthalmology
Request for contraception	Gynaecology & Obstetrics
Sexually transmitted infection	STI clinics
Shortness of breath	Medicine/ Paediatrics
Skin rash	Dermatology
Sleep problems	Psychiatry/ Medicine
Sore throat	ENT/Medicine/Paediatrics
Tiredness	Medicine/Surgery/Paediatrics
Urinary symptoms	Medicine/Surgery/Paediatrics
Warts	Dermatology
Weight change	Medicine/Surgery/Paediatrics
Wheezing	Medicine/Paediatrics

Brief Case Report 01

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 02

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 03

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**

Name of authenticator	Stamp	Signature

Brief Case Report 04

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**

Name of authenticator	Stamp	Signature

Brief Case Report 05

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 06

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 07

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 08

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 09

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 10

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 11

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 12

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 13

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 14

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 15

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 16

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 17

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 18

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 19

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

Brief Case Report 20

Date	**Name of the Patient**	**Age** **Gender**	**BHT/Clinic No**
Name of authenticator	Stamp	Signature	

(5.4) Detailed Case Reports

From the list of common conditions given below select 5 cases and write detailed case histories to include the following aspects

- Presenting problem/symptom
- Differential Diagnosis/list of hypothesis
- events/practices prior to hospital visit, details to exclude the History including initial symptom development/description of differential diagnoses
- Clinical Examination
- Probable/working diagnosis
- Hospital management
- Reasons for consultation (beliefs, concerns, expectations)
- Mention the opportunities for primary and secondary prevention
- How would you manage this patient in a primary care setting with minimal facilities? If you would refer or transfer, on what criteria would you do so?
- Use the format given below to write the detailed histories, complete during your 4th year clinical attachments.

Detailed Case Reports

Date	**Name of the patient**	**Age** - 5yr	**BHT/Clinic No:**
2026/02/06	Malith	**Gender** - Male	2345

A child with high fever for 2 days

History
Master M has had high grade fever for 2 days duration. He has had intermittent fever spikes, but it was responding to Paracetamol.

D/D (hypothesis)
Dengue fever
Respiratory tract infection
Gastroenteritis
Appendicitis
Meningitis
Leptospirosis.
Viral fever

Further history
The fever was associated with 3 episodes of vomiting, arthralgia and myalgia, mild right sided abdominal pain and headache. Appetite had been poor. But there were no rashes or bleeding diatheses, no loose motions, no respiratory symptoms, photophobia or phonophobia, no urinary symptoms. Urine output normal. Well in between fever spikes.
He has been given ORS, coriander water and some soup. No medicine other than paracetamol.

Examination
Temperature 101°F, BP 100/60mmHg, Pulse 100, good volume No tenderness in the abdomen, respiratory system normal.

Probable diagnosis
Dengue fever

Hospital management
Requested for FBC, LFT and NS1 antigen
Input output chart, paracetamol for fever.

Causes for consultation –
Mother's worry about the fever? dengue
Reduced intake of food
History of dengue fever patients in the neighborhood
Not responding to home remedies

Primary prevention
Health education
Proper garbage disposal

keep garden clean and free of water collecting places
use mosquito nets
mosquito repellents
fogging

Secondary prevention
Proper medical care,
Adequate hydration and nutrition
Specific fluid management with relevant investigations
Identify red flag symptoms early

Management at a primary care setting
Request for investigations and review soon with reports/request to inform reports over the phone. Educate about fluid management and to observe the urine output. Educate about red flag symptoms/ what to look for and indications for immediate consultation or admission to hospital Need to decide on referral to hospital according to the test reports (adhere to guidelines) and clinical condition of the patient.

Name of authenticator	Stamp	Signature

(5.5) Clinical Presentation for Detailed Case Reports

1. A patient with fever
2. A patient complaining of cough and cold
3. An adult with diarrhea
4. A patient with dyspeptic symptoms
5. A patient with depressive illness
6. A patient with diabetes mellitus (with or without complications)
7. A patient with bronchial asthma
8. A patient with hypertension
9. A patient with angina
10. A patient complaining of irregular menstruation
11. A patient diagnosed with osteoarthritis
12. A patient complaining of dizziness & lightheadedness
13. A child with diarrhoea
14. A child with a urinary tract infection
15. A child with poor weight gain

Detailed Case Report 01

Date	**Name of the patient**	**Age & Gender**	**BHT/Clinic No:**

Name of authenticator	Stamp	Signature

Detailed Case Report 02

Date	**Name of the patient**	**Age & Gender**	**BHT/Clinic No:**

Name of authenticator	Stamp	Signature

Detailed Case Report 03

Date	**Name of the patient**	**Age & Gender**	**BHT/Clinic No:**

Name of authenticator	Stamp	Signature

Detailed Case Report 04

Date	Name of the patient	Age & Gender	BHT/Clinic No:

Name of authenticator	Stamp	Signature

Detailed Case Report 05

Date	**Name of the patient**	**Age & Gender**	**BHT/Clinic No:**

Name of authenticator	Stamp	Signature

(6) Procedural & Clinical Skills

(6.1) Skills/Procedures – To be performed

(Including 3rd & 4th year clinical appointments)

skill	Date	Name of patient Age Sex	BHT/ Clinic No:	Signature of the supervision doctor
Suturing				
Wound dressing				
Urethral catheterization				
Local anaesthesia				
Bronchodilator or administration through nebulizer				
Bronchodilator or administration through spacer				
Peak flowmetry				
NG tube insertion				
NG feeding				
IV cannulation				
Setting up of an IV infusion				
Performing an ECG				

(6.2) Skills/Procedures – To be Observed

(Including 3rd & 4th year clinical appointments)

skill	Date	Name of patient Age Sex	BHT/ Clinic No:	Signature of the supervision doctor
Removal of callosity				
Wedge resection for an ingrowing toenail				
Removal of a subcutaneous lump/cyst				
Skin scrapings				
Cauterization of warts				
Intra – articular injections				
Ring block digital anesthesia				
Incision & drainage of an abscess				
Cervical Screening				
Eye foreign body removal & examination				
Ear syringing				
Ear foreign body removal				
Aural toilet				
Immobilization of fractures/splinting				
Ankle – brachial pressure index measurement				

(7) Self-Assessment

(7.1) Self-Assessment at the end of 3rd year

Regarding following clinical problems

A – I am confident
B – I need to see more patients to be confident
C – I need to improve in this aspect
D – Relevant clinical problem not done

In managing a patient with

Clinical problem	End of 3rd year No. of cases seen	My assessment A/B/C/D	Plan for improvement
Abnormal menstrual bleeding			
Accidental trauma			
Acute abdominal pain			
Adult with diarrhea			
Backache			
Blocked nose			
Change in bowel habit			
Chest pain			
Child with diarrhea			
Child with UTI			
Cough			
Deafness			
Depression			
Developmental delay			
Diabetes mellitus			
Dizziness & lightheadedness			
Dyspeptic symptoms			
Earache			
Ear discharge			
Eczema/Dermatitis			
Fever			
Foreign body in the ear, nose or throat			
Foreign body in the eye			
Fungal infections			
Headache			

Clinical problem	End of 3rd year No. of cases seen	My assessment A/B/C/D	Plan for improvement
Heel pain			
Hoarseness			
Incontinence			
Infertility			
Irregular menstruation			
Itching			
Joint pain			
Knee pain			
Loin pain			
Loss of vision			
Lump in the breast			
Lump in the neck			
Neck pain			
Numbness of hand			
Infection of the skin			
Pigmented lesions Birthmark – naevi			
Raised blood pressure			
Rectal bleeding			
Red eye			
Request for contraception			
Sexually transmitted infection			
Shortness of breath			
Skin Rash			
Sleep problems			
Sore throat			
Tiredness			
Urinary symptoms			
Warts			
Weight change			
Wheezing			

(7.2) Self-Assessment at the end of 4th year

Regarding following clinical problems

A – I am confident
B – I need to see more patients to be confident
C – I need to improve in this aspect
D – Relevant clinical problem not done

In managing a patient with

Clinical problem	End of 4th year No. of cases seen	My assessment A/B/C/D	Plan for improvement
Abnormal menstrual bleeding			
Accidental trauma			
Acute abdominal pain			
Adult with diarrhea			
Backache			
Blocked nose			
Change in bowel habit			
Chest pain			
Child with diarrhea			
Child with UTI			
Cough			
Deafness			
Depression			
Developmental delay			
Diabetes mellitus			
Dizziness & lightheadedness			
Dyspeptic symptoms			
Earache			
Ear discharge			
Eczema/Dermatitis			
Fever			
Foreign body in the ear, nose or throat			
Foreign body in the eye			
Fungal infections			
Headache			
Heel pain			

Clinical problem	End of 4th year No. of cases seen	My assessment A/B/C/D	Plan for improvement
Hoarseness			
Incontinence			
Infertility			
Irregular menstruation			
Itching			
Joint pain			
Knee pain			
Loin pain			
Loss of vision			
Lump in the breast			
Lump in the neck			
Neck pain			
Numbness of hand			
Infection of the skin			
Pigmented lesions Birthmark – naevi			
Raised blood pressure			
Rectal bleeding			
Red eye			
Request for contraception			
Sexually transmitted infection			
Shortness of breath			
Skin Rash			
Sleep problems			
Sore throat			
Tiredness			
Urinary symptoms			
Warts			
Weight change			
Wheezing			

(8) Recommended Textbooks

1. Lecture Notes in Family Medicine (3rd Edition or latest edition) by Prof. Nandani de Silva
2. Oxford Handbook of General Practice 5th Edition or latest edition
3. Essentials of Family Practice (2nd Edition or latest edition) by Antoinette Perera
4. Murtagh's General Practice (6th Edition or latest edition) by John Murtagh
5. Murtagh's Patient Education by John Murtagh

Portfolio of Family Medicine

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