STUDENT LOGBOOK

1 week general practice course for the 6th year medical students

Name and Neptun code: ..........................................................

Name of the tutor: ..........................................................

Address of the family practice: ...........................................

Dates of the practice course: ............................................

Please read this booklet on the first day of the practice and show it to your tutor!

INFORMATION ON THE 6TH YEAR COMPULSORY FAMILY MEDICINE COURSE
IMPORTANT!
Your course only will be accepted if your student book is completed and assessed by your tutor!

Objectives of the course:
• to introduce you to medical care outside the hospital giving an opportunity to study the characteristics of work in a general environment
• to help you to manage patients as people and as a member of a family who present with problems (not diseases) along with their physical, psychological and social points of view
• to provide an opportunity to improve your clinical skills

Structure of the course:
1 week = 5 workdays - working together with a tutor in his office (at least 4 consulting hours/day). Accompanying the tutor on home visits is encouraged but not required.

Topics to observe and concentrate on during the course:
• patient-physician communication (structure and methods of interviewing)
• problem based care
• problem oriented solutions
• decision making, responsibility
• common acute problems
• complex care of patients with chronic illnesses

The followings should be practiced independently:
• history taking
• physical examination
• making medical record

Examine a few patients before your tutor; then observe his/her consultation with the patient and spend a few minutes, after the patient has left room, comparing notes. Please prepare a diary on the following pages!

The diary should contain at least 2 short case reports per working day in the form of a medical record (patient’s initials, age, sex, complaints and problems, disorders in physical status and solution/advice, therapy, referral).
Case reports, notes
Case reports, notes
Case reports, notes
Case reports, notes
Case reports, notes
Please choose one of the most interesting cases and make a detailed case report on it! The detailed case report should contain the basic information about the patient (patient profile: age, marital status, family, occupation, housing), the present illness or complaint, the significant family or past history, the problem list, the assessment and the final solution. Please mention why you found the chosen case interesting.

**Detailed case report**

Patient’s initials:
Please summarize your opinion and experiences gained during the course!

Final comment:
TUTOR’S ASSESSMENT

The evaluation of your student’s work will be based on the contents of this handbook and on your assessment.

Name of the student: ……………………………………………………………………………………………………….

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>Medical knowledge</td>
<td>5</td>
</tr>
<tr>
<td>Practical abilities, physical examination</td>
<td>5</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
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<tr>
<td>Documentation</td>
<td>5</td>
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<tr>
<td>Motivation</td>
<td>5</td>
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The general assessment of the students (total points): __________ points

5 Excellent - 4 Good - 3 Fair - 2 Passing - 1 Failure

General comments:

Stamp and signature of the tutor