**Advanced Training Committee in Endocrinology**

**Site Survey Form**

This form is used to collect background information of a training site. It should be used in conjunction with the [*Criteria for Accreditation of Training Sites in Endocrinology*](http://www.racp.edu.au/docs/default-source/pdfs/at-criteria-accreditation-endocrinology.pdf?sfvrsn=4).

Please complete this form electronically and return to the College as a Word document via email to [endocrinology@racp.edu.au](mailto:endocrinology@racp.edu.au) prior to an accreditation assessment. Please do not alter the format of this document; it has been locked from editing.

If you have any questions or require assistance, please contact the Education Officer to Endocrinology at [endocrinology@racp.edu.au](mailto:endocrinology@racp.edu.au) or call +61 2 8247 6280.

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| **General Information** | | | |
| Date of accreditation assessment | | **/** **/** | |
| Hospital name | |  | |
| Address | |  | |
| Phone number |  | Fax number |  |
| Head of Department/Service (HOD/HOS) | |  | |
| Medical Co-Director | |  | |
| Director of Medical Services (DMS) or equivalent | |  | |
| Associated Network *(*if applicable) | |  | |

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| **Accreditation Information** | | | |
| Current accreditation status (if applicable) |  | | |
| Number and type of current approved positions |  | | |
| Date of last accreditation review (if applicable) |  | | |
| **Indicate type of accreditation required** | | | |
| New proposed training position |  | Routine reaccreditation |  |
| Request for accreditation upgrade |  |  |  |
| Position type: *Required Clinical training (RCY)* |  | Position type: *Core training* |  |
| Position type: *Non-Core Training* |  |  |  |

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| 1. Please specify the name and number of endocrinologists (visiting, academic, full-time or proportion of full-time) at the site. | | |
| **Name** | **Type of Position** | **Proportion of FTE (%)** |
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| 1. Number of inpatient beds with acute endocrine and diabetes admissions, which are/will be managed by the advanced trainee: | | |
| 1. Does the site have an inpatient consultation service in endocrinology? Yes  No   Please provide details: | | |
| 1. Has the site established policies to permit direct involvement by the advanced trainee in the management of acute endocrine emergencies? Yes  No   Please provide details: | | |

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| **Surveyor Comments (RACP use only)** | |
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| Action(s) Required | To be actioned by (date) |
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| 1. Describe the outpatient facilities in endocrinology available at the site: | | | | | | |
| What clinics will the new/additional advanced trainee be involved in? | | | | | | |
| **Clinic** | | | **Clinic duration** | | **No. of patients seen by trainee** | |
| **New** | **Review** |
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| Comments: | | | | | | |
| 1. Will the advanced trainee have exposure to current diagnostic testing protocols and an opportunity for reporting endocrine diagnostic tests? Yes  No   Please provide details: | | | | | | |
| 1. Does the site have facilities for: | | | | | | |
| **Facilities** | **Yes** | **No** | | **Comment** | | |
| Nuclear Medicine studies |  |  | |  | | |
| Radioactive Iodine therapy |  |  | |  | | |
| Radiology |  |  | |  | | |
| Endocrine Surgery |  |  | |  | | |
| 1. Does the site provide trainees with exposure to post-operative pituitary care? Yes  No   Please provide details: | | | | | | |
| 1. Does the site have a diabetes centre with diabetes education staff, exposure to insulin pump therapy and involvement in outpatient stabilisation? Yes  No   Please provide details: | | | | | | |
| 1. Does the site have an identified endocrinology department with office space for the use of the advanced trainee? Yes  No   Please provide details: | | | | | | |
| 1. Does the advanced trainee have access to a well-equipped library containing core endocrine reference materials and journals and current general reference material? Yes  No   Please provide details: | | | | | | |
| 1. Please outline the regular clinical, research and journal club meetings in endocrinology: | | | | | | |
| 1. Does the advanced trainee attend formal clinical handover sessions at the site? Yes  No   Please provide details: | | | | | | |

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| **Surveyor Comments (RACP use only)** | |
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| Action(s) Required | To be actioned by (date) |
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| 1. Please provide a weekly timetable for each trainee. The timetable should outline what each trainee is doing each day (*attach if necessary)* | | | | | | |
| **Position 1** | | | | | | |
|  | **Monday** | **Tuesday** | | **Wednesday** | **Thursday** | **Friday** |
| **AM** |  |  | |  |  |  |
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| **PM** |  |  | |  |  |  |
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| **Position 2** | | | | | | |
| **AM** |  |  | |  |  |  |
|  |  |  | |  |  |  |
| **PM** |  |  | |  |  |  |
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| **Position 3** | | | | | | |
| **AM** |  |  | |  |  |  |
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| **PM** |  |  | |  |  |  |
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| **Please detail facilities provided for training in the following areas:** | | | | | | |
| Type 1 Diabetes | | |  | | | |
| Type 2 Diabetes | | |  | | | |
| Gestational Diabetes | | |  | | | |
| Hyperthyroidism | | |  | | | |
| Other thyroid diseases | | |  | | | |
| Adrenal | | |  | | | |
| Metabolic bone disease | | |  | | | |
| Pituitary adenomas | | |  | | | |
| Growth disorders | | |  | | | |
| Paediatric endocrinology | | |  | | | |
| Menopause | | |  | | | |
| Androgen replacement | | |  | | | |
| Pituitary replacement | | |  | | | |
| Obesity | | |  | | | |
| Fertility | | |  | | | |
| I131 therapy | | |  | | | |
| Lipids/CV risk | | |  | | | |
| Thyroid biopsy | | |  | | | |
| Endocrine stimulation | | |  | | | |
| Insulin pump | | |  | | | |
| Medical management of pituitary and perioperative patients | | |  | | | |
| Bone density reporting | | |  | | | |

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| I confirm that the proposed position does not impact upon the quality of clinical exposure and supervision of any current advanced trainees in any accredited RCY and/or core training positions at the included site.  I confirm that this is a true and accurate record at the time of signature and if any changes are made in future that impact on the quality of training accredited, I will advise the ATC in Endocrinology of these changes.  *Form completed and submitted by:*  **Name:**       **Date:** |

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| **Surveyor Comments (RACP use only)** | |
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| Action(s) Required | To be actioned by (date) |
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| **Accreditation Decision (RACP use only)** | | | | |
| **Overall recommendations:** | | | | |
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| **Accreditation Status** | | | | |
| Accredited |  | Conditional (action/s required) | |  |
| Not accredited |  |  | | |
| **Action(s) required** | | | **To be actioned by (date)** | |
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| **Accreditation length** | | |  | |
| **Year of next review** | | |  | |

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| **RACP Assessor One** |  |
| **RACP Assessor Two** |  |
| **Date report completed** | **/       /** |