**STANDARD ASSESSMENT FORM FOR PG COURSESYEAR 2019-20**

**SUBJECT –INTERVENTIONAL RADIOLOGY**

**SUMMARY**

**Date of Assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Assessor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| 1. **Name of Institution**   *(Private / Government)* | ***Director / Dean / Principal***  *(Who so ever is Head of Institution)* | |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree  *(Recognized/Non-R)* |  |
| Subject |  |

|  |  |  |
| --- | --- | --- |
| 1. **Department inspected** | **Head of Department** | |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree /subjects  *(Recognized/Non-R)* |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. (a). **Number of UG seats** | Recognised  (Year: ) | Permitted  (Year: ) |  | First LOP date when MBBS course was first permitted |
|  |  |  |  |
| (b). **Date of last inspection for** | UG | PG | Super specialty |  |
| Purpose: | Purpose: | Purpose: |  |
| Result: | Result: | Result: |  |

4. Total Teachers available in the Department: (Count only those who have super speciality degree or 2 years special training in the subject before appointment )

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Designation** | **Number** | **Name** | **Total Teaching Experience** | **Benefit of Publications in Promotion** |
| Professor |  |  |  |  |
| Addl./Assoc Professor |  |  |  |  |
| Asstt. Professor |  |  |  |  |
| Senior Resident |  |  |  |  |

*Note: Count only those who are physically present.*

**5.**  Number of Units with beds in each unit:

**6.** Clinical workload of the Institution and Department concerned:

|  |  |  |  |
| --- | --- | --- | --- |
| **S.no.** | **Parameter** | **Department of Interventional Radiology** | |
| On the Day of Assessment | Average of 3 Days Random |
|  | **Total Procedures** |  |  |
| A | **Vascular Interventions** |  |  |
|  | * Angiography |  |  |
|  | * Angioplasty / Stenting |  |  |
|  | * Arterial Thrombolysis / ThromBectomy / Aspiration |  |  |
|  | * Angioembolzation |  |  |
|  | * Central venous access |  |  |
|  | * Venograms / Portogram |  |  |
|  | * Inferior Vena Cava Filter Deployment |  |  |
|  | * Venous Thrombolysis |  |  |
|  | * Venous Plasty /Stenting |  |  |
|  | * Hepatic vein interventions |  |  |
|  | * Portal Vein / Mesenteric vein interventions |  |  |
|  | * Foreign Body removal |  |  |
|  | * Varicose Vein Ablation |  |  |
|  | * Sclerotherapy |  |  |
| **B** | **Non Vascular Interventions** |  |  |
|  | * CT Guided Biopsy / FNAC |  |  |
|  | * USG Guided Biopsy / FNAC |  |  |
|  | * Biliary interventions |  |  |
|  | * Urologic Interventions |  |  |
|  | * Fluid Collection / Abscess Drainage |  |  |
|  | * Foreign Body removal |  |  |
|  | * Chest Tube Placement |  |  |
|  | * Osteoplasty (Vertebroplasty/Kypholplasty/ CementoPlasty |  |  |
|  | * Tumor Ablation |  |  |

*Put N.A. whichever is not applicable to the Department.*

**Note:**

* *OPD attendance is to be considered only upto 2 p.m. Bed occupancy is to be considered at 10 a.m. only.*
* *Investigative Data to be verified with Physical Registers in Radiodiagnosis & Central Clinical Laboratory.*
* *Data to be verified with Physical Registers in Blood Bank.*

**7. Investigative Workload of entire hospital and Department Concerned.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parameter** | | **Entire Hospital** | **Department of Interventional Radiology** | |
| On the Day of Assessment | On the Day of Inspection | Average of 3 Random Days |
| **Radio-diagnosis** | MRI |  |  |  |
|  | CT |  |  |  |
|  | USG |  |  |  |
|  | Plain X-rays |  |  |  |
|  | IVP/Barium etc |  |  |  |
|  | Mammography |  |  |  |
|  | DSA |  |  |  |
|  | CT guided FNAC |  |  |  |
|  | USG guided FNAC |  |  |  |
|  | Any other |  |  |  |
| **Pathology** | Histopath |  |  |  |
|  | FNAC |  |  |  |
|  | Hematology |  |  |  |
|  | Others |  |  |  |
| **Bio-Chemistry** |  |  |  |  |
| **Microbiology** |  |  |  |  |
| **Blood Units Consumed** | |  |  |  |

**8. Year-wise available clinical materials (during previous 3 years) for department of Interventional Radiology**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No.** | **Parameters** | **Year 1** | **Year 2** | **Year 3**  **(Last Year )** |
|  | **Total Procedures** |  |  |  |
| A | **Vascular Interventions** |  |  |  |
|  | * Angiography |  |  |  |
|  | * Angioplasty / Stenting |  |  |  |
|  | * Arterial Thrombolysis / ThromBectomy / Aspiration |  |  |  |
|  | * Angioembolzation |  |  |  |
|  | * Central venous access |  |  |  |
|  | * Venograms / Portogram |  |  |  |
|  | * Inferior Vena Cava Filter Deployment |  |  |  |
|  | * Venous Thrombolysis |  |  |  |
|  | * Venous Plasty /Stenting |  |  |  |
|  | * Hepatic vein interventions |  |  |  |
|  | * Portal Vein / Mesenteric vein interventions |  |  |  |
|  | * Foreign Body removal |  |  |  |
|  | * Varicose Vein Ablation |  |  |  |
|  | * Sclerotherapy |  |  |  |
| B | **Non Vascular Interventions** |  |  |  |
|  | * CT Guided Biopsy / FNAC |  |  |  |
|  | * USG Guided Biopsy / FNAC |  |  |  |
|  | * Biliary interventions |  |  |  |
|  | * Urologic Interventions |  |  |  |
|  | * Fluid Collection / Abscess Drainage |  |  |  |
|  | * Foreign Body removal |  |  |  |
|  | * Chest Tube Placement |  |  |  |
|  | * Osteoplasty (Vertebroplasty/Kypholplasty/ CementoPlasty |  |  |  |
|  | * Tumor Ablation |  |  |  |

*Note : Put N.A. for those coloumns not applicable to the department*

**9**. Publications from the department during last 3 years:

*(Give only full articles published in indexed journals. No case reports or review articles be given)*

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **10** | **Blood Bank** | License valid | Yes / No  (enclose copy) |
|  | Blood component facility available | Yes / No  (enclose copy) |
| Number of blood units stored on the inspection day |  |
| Average units consumed daily (entire hospital) |  |

**11**. Specialized services provided by the department: Adequate / not adequate

**12**. Specialized Intensive care services provided by the Dept: Adequate / not adequate

**13**. Specialized equipment available in the department: Adequate / Inadequate

**14**. Space (OPD, IPD, Offices, Teaching areas) Adequate / Inadequate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **15** | **Library** |  | Central | Departmental |
|  |  | Number of Books pertaining toInterventional Radiology |  |  |
|  |  | Number of Journals |  |  |
|  |  | Latest journals available upto |  |  |

**16**. Casualty Number of Beds\_\_\_\_\_\_\_Available equipment \_\_\_\_Adequate / Inadequate

**17**. Common Facilities

* Central supply of Oxygen / Suction**:** Available / Not available
* Central Sterilization Department Adequate / Not adequate
* Laundry: Manual/Mechanical/Outsourced:
* Kitchen Gas / Fire
* Incinerator:Functional / Non functional Capacity: Outsourced
* Bio-waste disposal Outsourced / any other method
* Generator facility Available / Not available
* Medical Record Section: Computerized / Non computerized
* ICD10 classification Used / Not used

18. Total number of OPD, IPD and Deaths in the Institution and department concerned during the last one year:

|  |  |  |  |
| --- | --- | --- | --- |
| In the entire hospital | | In the department of Interventional Radiology | |
| OPD |  | OPD |  |
| IPD (Total Number of Patients admitted) |  | IPD (Total Number of Patients admitted) |  |
| Deaths |  | Deaths |  |

19. Number of Births in the Hospital during the last one year:

*Note :1) The data be verified by checking the death/birth registration forms sent by thecollege/hospital to the Registrar, Deaths & Births (Photocopy of all such forms be provided.)*

*2) Year means calendar year (1st January to 31st December )*

20. Accommodation for staff Available / Not available

21. Hostel Accommodation

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **S.**  **No** | **Number** | UG | | PG | | Interns | |
| Boys | Girls | Boys | Girls | Boys | Girls |
| 1 | No. of Students |  |  |  |  |  |  |
| 2 | No. of Rooms |  |  |  |  |  |  |
| 3 | Status of Cleanliness |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **22** | **Total number of PG seats in the concerned subject** |  | Recognized seats | | Date of recognition | Permitted seats | Date of permission |
| Degree |  |  | |  |  |
| Diploma |  |  | |  |  |

**23.** Year wise PG students admitted (in the department inspected) during the last 5 years and available PG teachers

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Year | | No. of PG students admitted | | | No. of PG Teachers available in the dept.  (give names) | | |
| Degree | Diploma | |
| 2016 | |  |  | |  | | |
| 2015 | |  |  | |  | | |
| 2014 | |  |  | |  | | |
| 2013 | |  |  | |  | | |
| 2012 | |  |  | |  | | |
| 24 | Other PG courses run by the institution | | | Course Name | | No. of seats | Department |
| DNB | |  |  |
| M.Sc. | |  |  |
| Others  (Superspecialities) | |  |  |

25. Whether other medical superspecialty Medical Oncology and Radiotherapydepartments exits in the institution …………… Yes/No

(If yes give details)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of department | Beds/Units | When LOP for DM seats granted & Number of seats | Available faculty  (Names & Designation) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*I have physically verified the beds, faculty and patients of above Super specialty departments and they have not been counted in Interventional Radiology, department inspection.*

26**. Stipend paid to the PG students, year-wise:**

|  |  |  |
| --- | --- | --- |
| **Year** | **Stipend paid in Govt. colleges by State Govt.** | **Stipend paid by the Institution\*** |
| Ist Year |  |  |
| IInd Year |  |  |
| IIIrd Year |  |  |

\* **Stipend shall be paid by the institution as per Govt. rate shown above.**

27. List of Departmental Faculty joining and leaving after last inspection:

|  |  |  |  |
| --- | --- | --- | --- |
| Designations | Number | Names | |
| Joining faculty | Leaving faculty |
| Professor |  |  |  |
| Associate Prof. |  |  |  |
| Assistant Prof. |  |  |  |
| SR/Tutor/Demons. |  |  |  |
| Others |  |  |  |

28. Faculty deficiency, if any

|  |  |  |  |
| --- | --- | --- | --- |
| **Designation** | **Faculty available**  **(number only)** | **Faculty required** | **Deficiency, if any** |
| Professor |  |  |  |
| Assoc Professor |  |  |  |
| Asstt. Professor |  |  |  |
| Sr. Residents |  |  |  |
| Jr. Residents |  |  |  |
| Tutor/ Demonstrator |  |  |  |
| Any Other |  |  |  |

\* **Faculty Attendance Sheet duly signed by concerned faculty must be enclosed.**

1. **REMARKS OF ASSESSOR**

1. please do not repeat information already provided
2. please do not make any recommendation regarding granting permission/recognition
3. if you have noticed or come across any irregularity during your assessment like fake or dummy faculty, fake or dummy patients, fudging of data of clinical material etc., please mention them here)