Appendix A

Preceptor Reference Data (please print)

Last Name:_____ First Name:_____

Credentials:_____

Preceptor Employer: _____

Preceptor Employer Address:_____

Preceptor Agency/Site:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Fax Number:_____

Email Address:_____

Practice Specialty:_____

Certification:_____Expiration Date:_____

Years of Practice in Each Specialty:_____

State(s) in which you are licensed:_____

State License Number(s):_____

Expiration Date:_____

Appendix B

Competency-Based Clinical Evaluation Tool
Preceptor Evaluation of Student

Date: _____

Student: _____ Faculty: _____

Preceptor: _____ Clinical Site: _____

Patient Encounter(s):

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Course	Description
765	Novice student. Focus is on completion of acute visits and well exams.
768	Advanced beginner student. Focus is on the enhancement of acute visits and well exams
771	Competent student. Focus is the addition of chronic diseases to previously learned acute content
776	Proficient student. Focus is the addition of complex disease processes to previously learned content.

**Students may not utilize the EMR templates during the clinical site evaluation.*
**If students are going to access electronic databases for reference during the site visit evaluation (i.e. UpToDate, Epocrates, etc.), this must be done in conjunction with the site visit evaluation faculty.*

Criteria	Did Not Meet Expectations	Met Expectations	Not Observed	Comments (required if criteria/expectations are not met)
Obtains a comprehensive and/or problem focused HPI from the patient and/or family.				
Obtains a comprehensive and/or problem-focused ROS from the patient and/or family.				
Obtains a comprehensive and/or problem focused PMH, FH, SH from the patient and/or family.				
Performs a comprehensive and/or				

problem-focused physical examination using correct assessment technique and equipment.				
Differentiates between normal, variations of normal, and abnormal findings.				
Demonstrates critical thinking in diagnostic ordering and interpretation.				
Organizes clinical information to arrive at appropriate differentials and final diagnosis.				
Formulates and prioritizes a plan of care based on scientific rationale, evidence-based standards of care, and clinical practice guidelines.				
Safely prescribes appropriate patient-centered pharmacological treatment modalities.				
Integrates and counsels the patient on the use of non-pharmacologic therapies based on patient-centered characteristics.				
Develops and implements patient-centered health promotion/disease prevention plans.				
Provides anticipatory guidance and counseling for patients and/or families.				
Verbally communicates the patient's health status accurately to the preceptor in a timely and succinct manner.				
Evaluates results of previous or current interventions and revises plan appropriately.				
Collects, maintains, and documents the patient's health care information in a confidential and timely manner.				
Assesses the patient's and/or family's need and readiness for learning based on personal characteristics.				
Provides appropriate teaching, educational materials, guidance, and counseling regarding management of health/illness conditions.				
Communicates with the patient and faculty using effective and appropriate techniques.				
Uses available community resources in designing patient-centered plans of care.				
Consults and refers appropriately with the preceptor and other health care team				

members.				
Demonstrates behaviors of self-efficacy, ethics, and advocacy in patient encounters.				
Demonstrates professional behavior.				
Engages in self-evaluation concerning practice.				
Uses strategies to reduce common errors.				
Considers barriers to access, cost, efficacy, and quality when making health care decisions.				
Utilizes informatics appropriately.				

1. Strengths of student:

2. Areas for improvement:

_____ _____

Signature & Date of Preceptor Signature & Date of Student

Appendix C

Competency-Based Clinical Evaluation Tool
Faculty Evaluation of Student

Date: _____

Student: _____ Faculty: _____

Preceptor: _____ Clinical Site: _____

Patient Encounter(s):

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Patient age: _____ Gender: _____ CC/Diagnoses: _____

Course	Description
765	Novice student. Focus is on completion of acute visits and well exams.
768	Advanced beginner student. Focus is on the enhancement of acute visits and well exams
771	Competent student. Focus is the addition of chronic diseases to previously learned acute content
776	Proficient student. Focus is the addition of complex disease processes to previously learned content.

**Students may not utilize the EMR templates during the clinical site evaluation.*
**If students are going to access electronic databases for reference during the site visit evaluation (i.e. UpToDate, Epocrates, etc.), this must be done in conjunction with the site visit evaluation faculty.*

Criteria	Did Not Meet Expectations	Met Expectations	Not Observed	Comments (required if criteria/expectations are not met)
Obtains a comprehensive and/or problem				

focused HPI from the patient and/or family.				
Obtains a comprehensive and/or problem-focused ROS from the patient and/or family.				
Obtains a comprehensive and/or problem focused PMH, FH, SH from the patient and/or family.				
Performs a comprehensive and/or problem-focused physical examination using correct assessment technique and equipment.				
Differentiates between normal, variations of normal, and abnormal findings.				
Demonstrates critical thinking in diagnostic ordering and interpretation.				
Organizes clinical information to arrive at appropriate differentials and final diagnosis.				
Formulates and prioritizes a plan of care based on scientific rationale, evidence-based standards of care, and clinical practice guidelines.				
Safely prescribes appropriate patient-centered pharmacological treatment modalities.				
Integrates and counsels the patient on the use of non-pharmacologic therapies based on patient-centered characteristics.				
Develops and implements patient-centered health promotion/disease prevention plans.				
Provides anticipatory guidance and counseling for patients and/or families.				
Verbally communicates the patient's health status accurately to the preceptor in a timely and succinct manner.				
Evaluates results of previous or current interventions and revises plan appropriately.				

Collects, maintains, and documents the patient's health care information in a confidential and timely manner.				
Assesses the patient's and/or family's need and readiness for learning based on personal characteristics.				
Provides appropriate teaching, educational materials, guidance, and counseling regarding management of health/illness conditions.				
Communicates with the patient and faculty using effective and appropriate techniques.				
Uses available community resources in designing patient-centered plans of care.				
Consults and refers appropriately with the preceptor and other health care team members.				
Demonstrates behaviors of self-efficacy, ethics, and advocacy in patient encounters.				
Demonstrates professional behavior.				
Engages in self-evaluation concerning practice.				
Uses strategies to reduce common errors.				
Considers barriers to access, cost, efficacy, and quality when making health care decisions.				
Utilizes informatics appropriately.				

1. Strengths of student:

2. Areas for improvement:

Student has met expectations of the site visit. **Yes _____** **No_____**

_____ _____

Signature & Date of Evaluator Signature & Date of Student

Appendix D

SDSU College of Nursing NURS N765/771/768/776 Clinical Hour Face Sheet							
Tentative schedule must be provided in the dropbox ***prior*** to starting clinical hours.		If you schedule changes, you must provide an updated Clinical Hours Face Sheet to the dropbox within 24 hours.		Students are required to keep a running total of all hours to be submitted at mid-term and final evaluations. The clinical Hours Face Sheet must match the hours logged in Medatrax.		For this sheet: 15 mins=.35, 30 mins=.5, 45 mins=.75, 20 mins=.33 1 hour 20 mins=1.33 (take amount of time and dive by 60)	For Medatrax: 15 mins=0:15 30 mins=0.30, 45 mins=0:45 20 mins=0:20 1 hour 20 mins=1:20 (Listed in clock hours)
Date Submitted/Updated							
				Preceptor 1	Preceptor 2	Preceptor 3	Add more columns as needed
Student Name			Preceptor Name and Credentials				
Student Cell Number			Preceptor Clinical Site and Address				
Student Home Number			Preceptor Phone				

			Number				
Course Number			Type of Practice (Family, Derm., etc.)				
Course Faculty Name			Total Hours Spent with Preceptor				
Day/Date	Preceptor Name & Credentials	Scheduled Clinical Hours (Example: 8AM- 2PM and 1PM-5PM)	Total Clinical Hours for the Day (subtract lunch and personal time)	Cumulative Hours			
				0			
				0			
				0			
				0			
				0			

Appendix E

South Dakota State University College of Nursing
Psychiatric and Mental Health Nurse Practitioner Program
Preceptor Observed History and Mental Status Exam

The Preceptor Observed History and Mental Status Exam should be completed as the culminating assignment for N736. Your preceptor should observe the evaluation and provide constructive feedback. After you have completed the assessment and your preceptor has offered comments, evaluation, and signature on this document, please send to your clinical faculty. As part of this assignment, your written psychiatric evaluation/assessment should accompany this document after reviewed by your preceptor. All patient identifiers must be deleted/blackened

Date of Observation_____

Patient Age and Sex_____

Preceptor Signature_____

PMH Student Signature_____

TOPIC TO BE ASSESSED	PRECEPTOR INITIAL AS STUDENT COMPLETES	PRECEPTOR COMMENTS
Introduction to client including review of role, confidentiality, and limits of		
A. Client History and Mental Status Exam **Identifying information**, presenting problem, and referral source.		
History of Present Illness (location, quality, severity, duration, timing, context, modifying factors, associated signs, and symptoms)		
Psych Single System & pertinent		
Mood		
Anxiety		
Temperament		
Sleep/Initiation/maintenance		
Energy		
Interest		
Concentration		
Memory		
Psychomotor changes		
Appetite changes		
Thought patterns (guilt, delusions, hallucinations)		
Suicidal Thoughts		
Self-injurious		
Aggressive/homicidal thoughts/behaviors		

TOPIC TO BE ASSESSED	PRECEPTOR INITIAL AS STUDENT COMPLETES	PRECEPTOR COMMENTS
Social Impact of symptoms		
Other		
Psychiatric Review of Past Symptoms **Affective Disorders** **Anxiety:** **GAD, OCD, Phobias, etc.** **Trauma History** **PTSD** **Thought Disorders** **ADHD** **Head injury** **TBI**		
Past Psychiatric History *Inpatient and Outpatient History* Age- Duration- Reason- Treatment - Comments - Suicidal gestures Self-injurious gestures Violence history		
Previous Psych Meds Dose and Length of Treatment Reasons for Discontinuation Side Effects etc.		
Other Therapies		
Medical History: Allergies-- *Surgeries*		
OB/GYN *Onset to Menses* *Para /Gravida* *Problems/Complications*		
Present Medications (psych and medical) Prescribed by-		
Social and Developmental History:		
Pertinent Family History		
Significant Stressors not Previously Described		
Mental Status Exam		
Appearance		
Cognition		

TOPIC TO BE ASSESSED	PRECEPTOR INITIAL AS STUDENT COMPLETES	PRECEPTOR COMMENTS
Affect		
Mood		
Speech		
Thought Processes		
Insight		
Motor Abilities		
Suicidal Thought		
DSM 5 Diagnoses and Code		
GOALS of Care		
MED Teaching done on -		
NEW ORDERS		
Records Requested/Release/Exchange of Information		
Other		
B. Interview Techniques		
Ability to establish rapport		
Use of Communication skills		
Support and empathy		
Summary and feedback to patient		
Follows up incomplete comments and seeks clarification		
Begins to establish a therapeutic alliance		
Voice and manner encourage trust		
Makes pertinent physical observations and describes appearance		
Other		
C. Organization		
Proceeds in orderly manner		
Proceeds in an efficient and smooth manner		
Approaches stress areas gently and with tact		
D. Summary of Report		

TOPIC TO BE ASSESSED	PRECEPTOR INITIAL AS STUDENT COMPLETES	PRECEPTOR COMMENTS
Provides organized, concise written and /or oral conclusions to history and MSE including:		
Summary of Findings		
DSM5 Diagnosis		
Differential Diagnosis		
Recommended Medications and Therapies/Treatments/Placements		
Referrals		
Duration_____Minutes		
E. Additional Comments		

TOPIC TO BE ASSESSED	PRECEPTOR INITIAL AS STUDENT COMPLETES	PRECEPTOR COMMENTS
F. Conclusions on Student Performance **Perceptor –**		
G. Student Comments		