

**Patient Centered Medicine (PCM)**

**Loyola University Chicago Interview Feedback Form (LUCIFF)**

Source: <input type="checkbox"/> Faculty <input type="checkbox"/> Peer <input type="checkbox"/> Self	Mode: <input type="checkbox"/> Video <input type="checkbox"/> Live
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<b>Student Name:</b>		<b>SP Case Name:</b>
<b>ITEM</b>	<b>DEFINITION</b>	<b>ASSESSMENT Comment on Strengths/Recommendations for Improvement</b>
<b>Opening</b>		
<ul style="list-style-type: none"> <li>• Initial Greeting:                         <ul style="list-style-type: none"> <li>○ verbal introduction</li> <li>○ shake hands</li> <li>○ address patient as: Mr., Mrs., Ms.</li> </ul> </li> <li>• Puts patient at ease</li> <li>• States purpose of interview</li> </ul>	<p>States name and role on team Greets warmly</p> <p>Minimizes distractions Attends to patient’s comfort and privacy Teaching exercise, consult, etc. Corrects misunderstanding</p>	<b>COMMENTS</b>
<b>Information Gathering</b>		
<ul style="list-style-type: none"> <li>• Questioning: Uses open-to-closed cone</li> <li>• Negotiates priorities for problems to be discussed.</li> <li>• Establishes a narrative thread</li> <li>• Re-directs and /or interrupts (if necessary)</li> <li>• Problem Survey</li> <li>• Segment Summary/Clarification</li> <li>• Transitions smoothly between interview sections</li> </ul>	<p>Starting with multiple open-ended questions followed by closed-ended questions. Avoids multiple and leading questions Avoids the use of jargon/technical language Sets agenda and verifies it with patient, if appropriate.</p> <p>Eliciting a chronological account. Lets patient tell story without unnecessary interruptions and listens carefully. Follows significant leads Recognizes when patient is rambling, circumstantial, tangential, or irrelevant Asks, “What else?” until all major concerns are expressed Paraphrases patient’s story and clarifies as needed</p> <p>Avoids abrupt changes in content areas</p>	<b>COMMENTS</b>

Student Name:		SP Case Name:
ITEM	DEFINITION	ASSESSMENT Comment on Strengths/Recommendations for Improvement
<b>Closing</b>		
<ul style="list-style-type: none"> <li>Encourages patient's questions or invites comments</li> <li>States appreciation for patient's efforts.</li> <li>Specifies next step</li> </ul>	Answers questions clearly and appropriately	<b>COMMENTS</b>
<b>Facilitation Skills</b>		
<ul style="list-style-type: none"> <li>Eye contact</li> <li>Open posture</li> <li>Reinforces patient's responses with nods, "mmhmm" and repeating patient's last statements without being irritating or overbearing.</li> <li>Uses silences when appropriate to facilitate expression</li> </ul>	Conveys interest and attentiveness. Positive body language	<b>COMMENTS</b>
<b>Relationship Skills</b>		
<ul style="list-style-type: none"> <li>Reflection/legitimatization</li> <li>Respect</li> <li>Support/partnership</li> </ul>	Expresses understandability of patient's emotions Being appropriately deferential Willingness to be helpful, to work together	<b>COMMENTS</b>
<b>Patient Education</b>		
<ul style="list-style-type: none"> <li>Delivers diagnostic and instructional statements in simple language</li> <li>Checks patient's understanding.</li> <li>Involves patients in process</li> </ul>	Explains what patient needs to know	<b>COMMENTS</b>
<b>Flow</b>		
<ul style="list-style-type: none"> <li>Overall feeling is that the interview moves smoothly from one component to another, with key points summarized and ending with a smooth closure.</li> </ul>		<b>COMMENTS</b>

<b>History Data Base</b> (Content Area Form, page 4) Completed Satisfactory ✓	YES	NO	<b>Professional Appearance &amp; Conduct</b> Satisfactory? ✓	YES	NO
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**OVERALL INTERVIEW ASSESSMENT**

Please Check only ONE Box in this Row	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Does Not Meet Expectations *</b>	<b>Meets Expectations, but with Concerns *</b>	<b>Meets Expectations</b>
			<input type="checkbox"/>
			<b>Exceeds Expectations *</b>

**Does Not Meet Expectations**

Unprepared for interview, or demonstrates unprofessional behavior, or leaves out multiple major sections of the history, or is inappropriate. **MUST DESCRIBE IN COMMENTS SECTION**

**Meets Expectations**

Is well prepared for the interview, established rapport, puts the patient at ease, and obtains the important information with logical flow. Approaches the patient in a kind, empathic, respectful manner. **DOES NOT REQUIRE COMMENTS**

**Exceeds Expectations**

In addition to the criteria for “meets expectations,” the student demonstrates a superior level of inquisitiveness and curiosity, a superior and natural flow, and clearly demonstrates an exceptional interview at least in the top 10% of all the interviews. **MUST DESCRIBE IN COMMENTS**

**COMMENTS** ( \* These areas, if checked, require comments.)

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<b>Evaluator:</b>	<b>Date:</b>
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**HISTORY DATA BASE OUTLINE: Key Content Areas – check if discussed****A. Chief Complaint** \_\_\_\_\_**B. History of the Present Illness**

1. Characteristics of Symptoms
  - a.  Location
  - b.  Radiation
  - c.  Quality
  - d.  Severity/Intensity
  - e.  Timing (onset, duration)
    - i. Sudden, gradual
    - ii. Acute, chronic
  - f.  Frequency/Pattern (intermittent, continuous, progressive)
  - g.  Setting
  - h.  Aggravating/Exacerbating factors
  - i.  Alleviating factors
  - j.  Associated manifestations
2.  Associated **active medical, surgical or psychiatric problems** which may impact the Chief Complaint
3.  **Past experience** with symptom(s)
  - a.  Prior Treatment? Response? Data from past charts?
  - b.  What has patient done about the symptom(s)
4.  Significant positives and negatives
5.  What was the psychosocial **context** of the onset of the symptoms?
6.  Patient's Perspective of the Illness
  - a.  Patient's **understanding** of the disease? Especially causes/implications/fears
  - b.  **Impact** of the disease and/or its treatment on the patient's life, work, relationships
  - c.  Patient **expectations**
  - d.  Patient's **reason** for visit

**C. Past Medical History**

1.  Childhood illnesses
2.  Immunizations
3.  Adult illnesses/hospitalizations (including psychiatric)
4.  Operations
5.  Injuries/Accidents
6.  Obstetric History
7.  Transfusions

**D. Current Health Status**

1.  Medications
2.  Allergies and Drug Reactions
3.  Health Screening (prior exams, cholesterol, etc.)
4.  Diet, Sleep, Exercise
5.  Tobacco, Alcohol, Drugs
6.  Complimentary/Alternative Medicine
7.  Preferences for End of Life Care (if appropriate)

**E. Psychosocial History**

1.  Marital status
2.  Living arrangements/Family structure  
 How are things at home?
3.  Support/Secondary Gains: are there people you can rely on for help? How have family or friends responded to the illness?
4.  Employment history/job satisfaction
5.  Sexual history/function
6.  Significant life events: deaths, divorce, financial hardships
7.  Anxiety?/Stress?

**F. Family History**

1.  Current health of parents, siblings, children
2.  History of significant illnesses (branching diagram if appropriate)
3.  Deaths: dates and ages at death

**G.  Review of Systems**