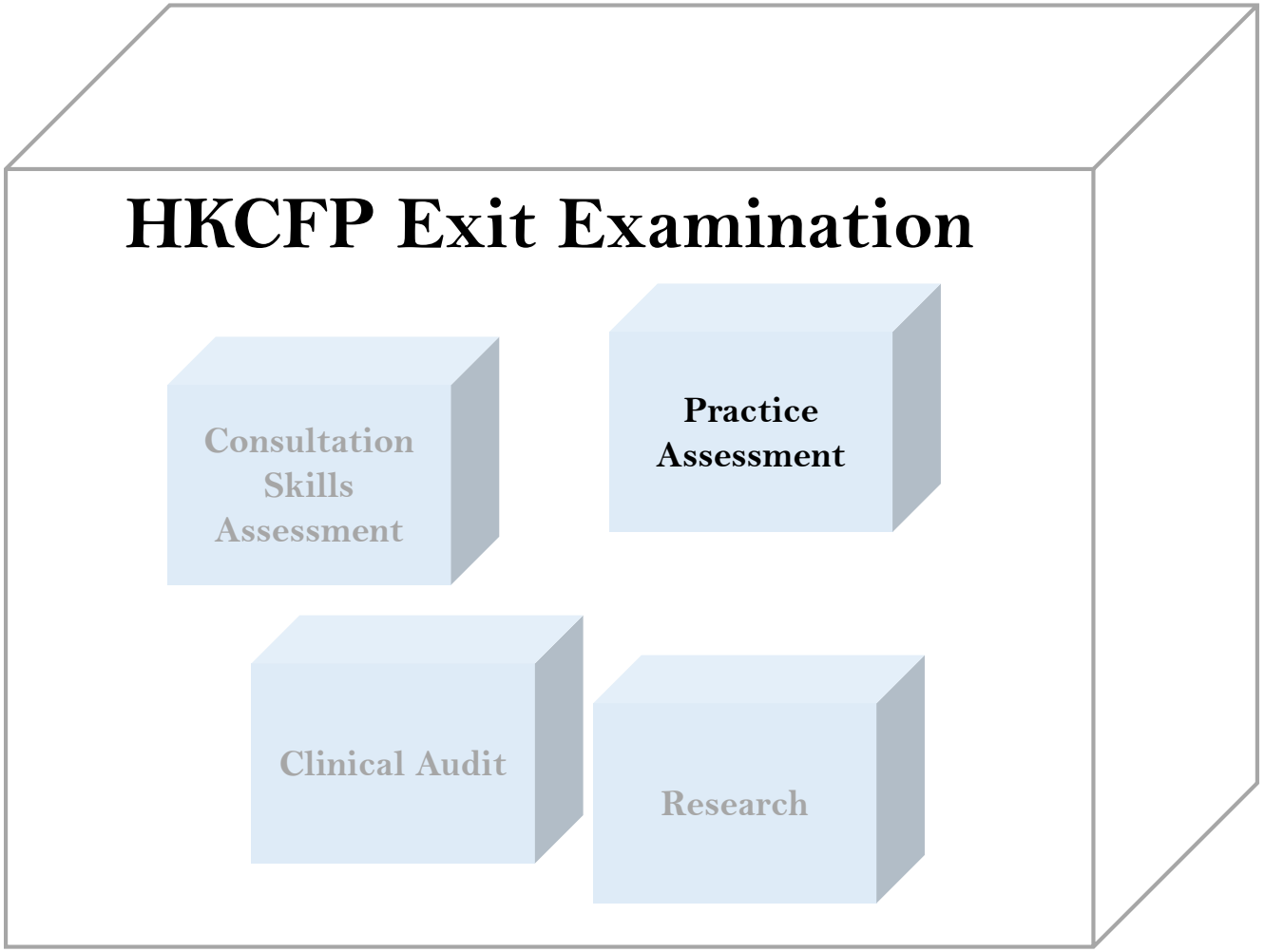
2025 Exit Examination
Pre-examination Workshop for candidates

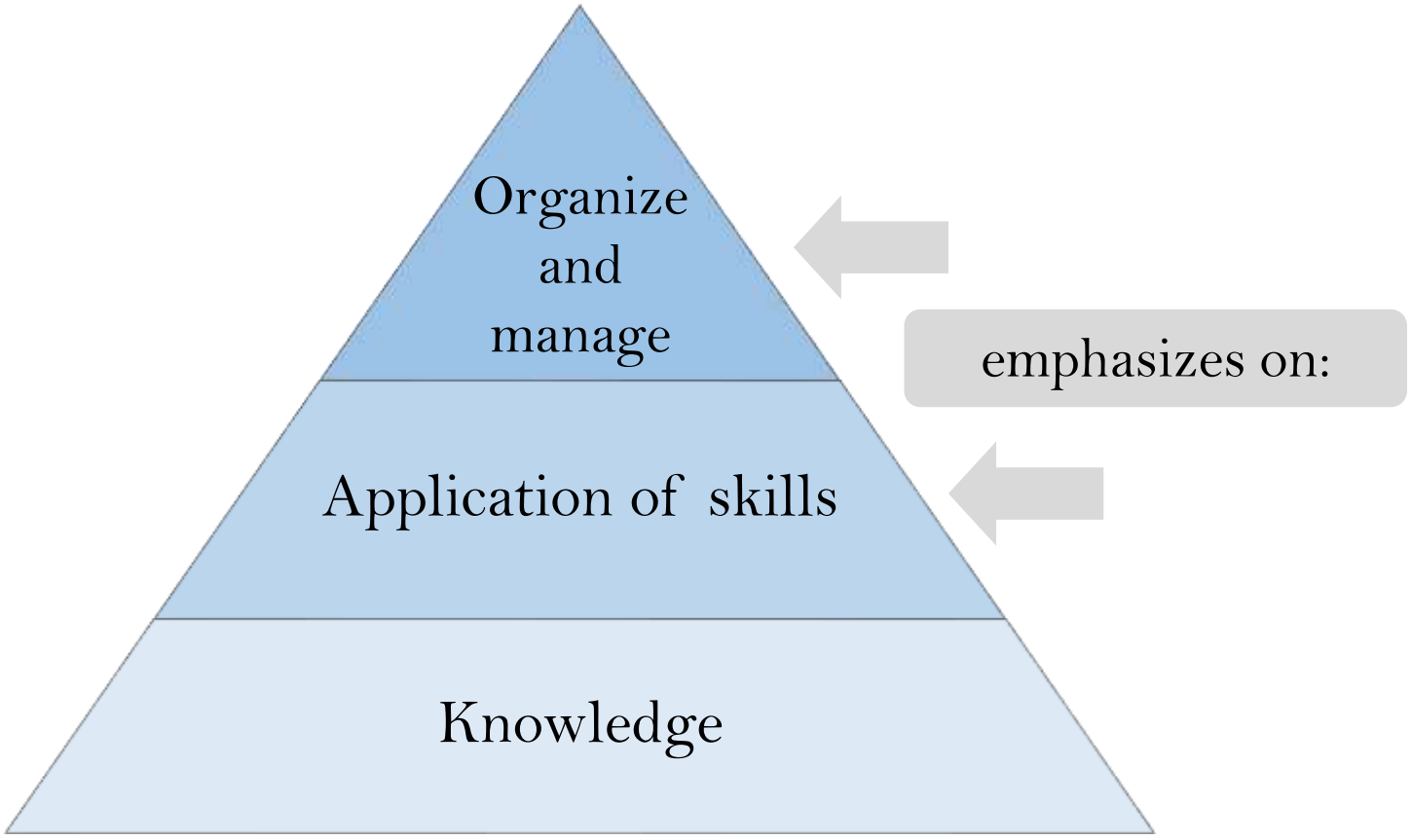
Practice Assessment

30 August 2024



Candidate can choose to take either Clinical Audit or Research

Practice Assessment (PA) tests the candidates':

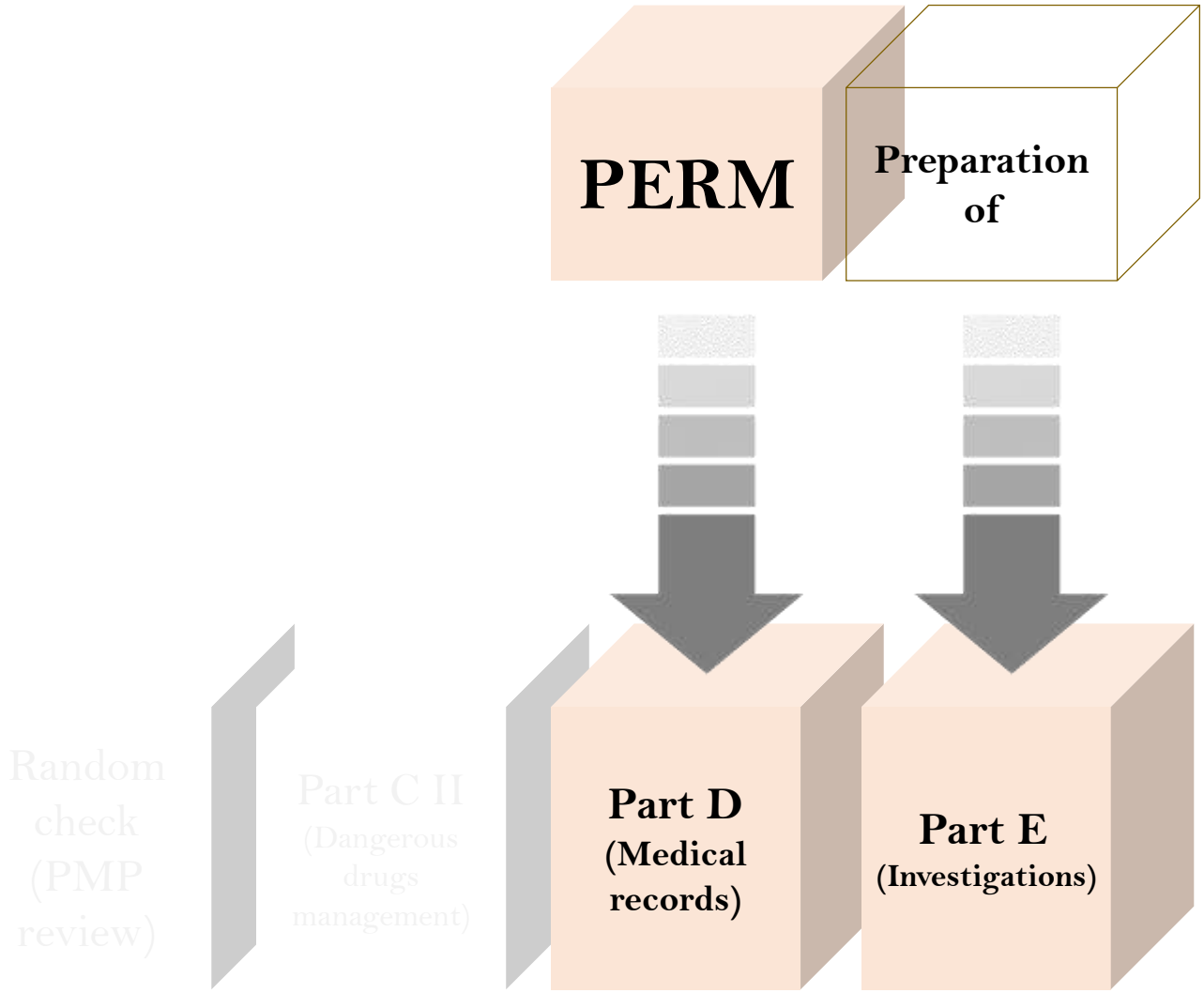


Workplace-based (family medicine clinic)

Practice Assessment consists of 4 Parts

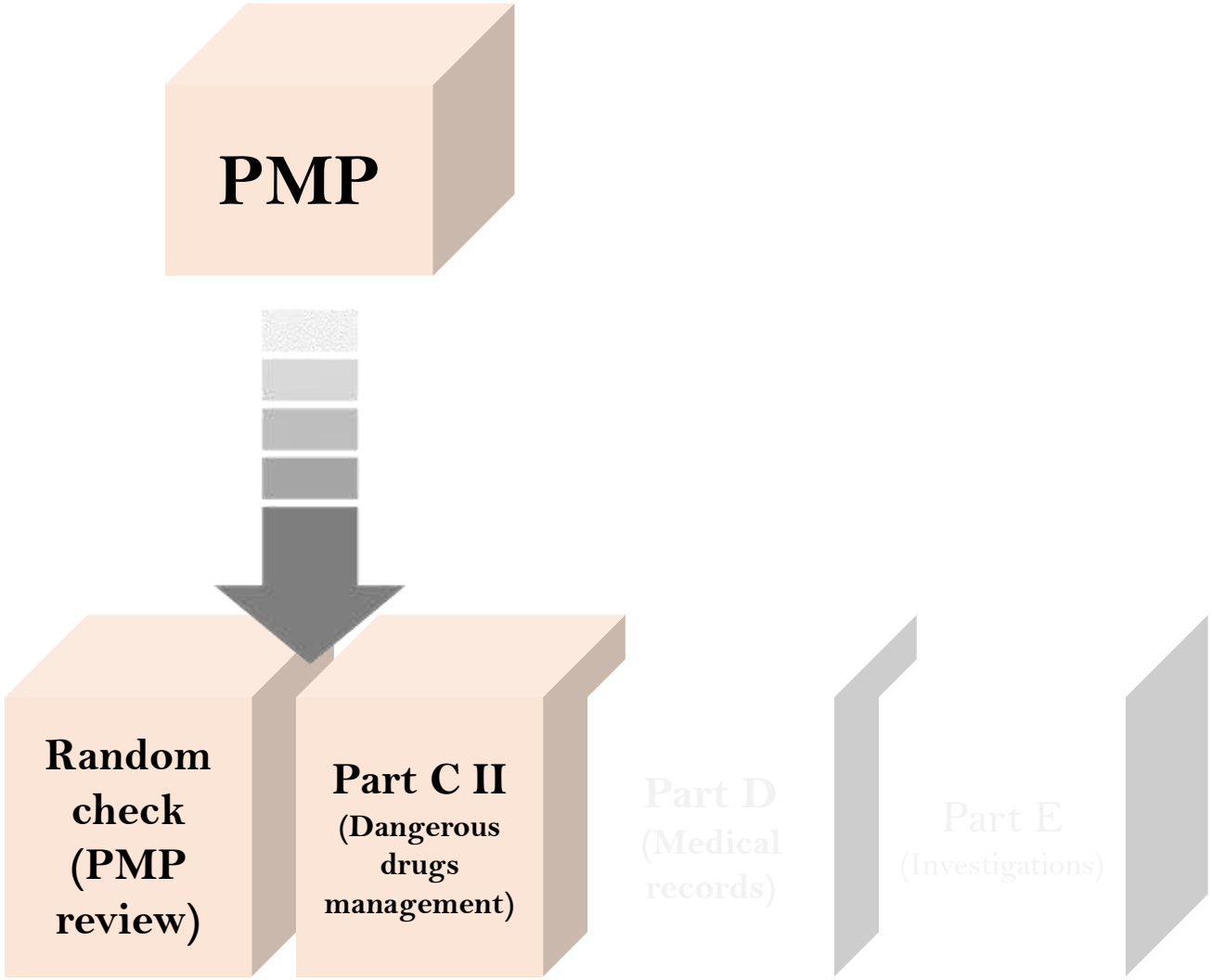
- **Random check (PMP review)**
- **Part C II** (Dangerous drugs management)
- **Part D** (Medical records)
- **Part E** (Investigations)

PERM Workshop (22 March 2024)



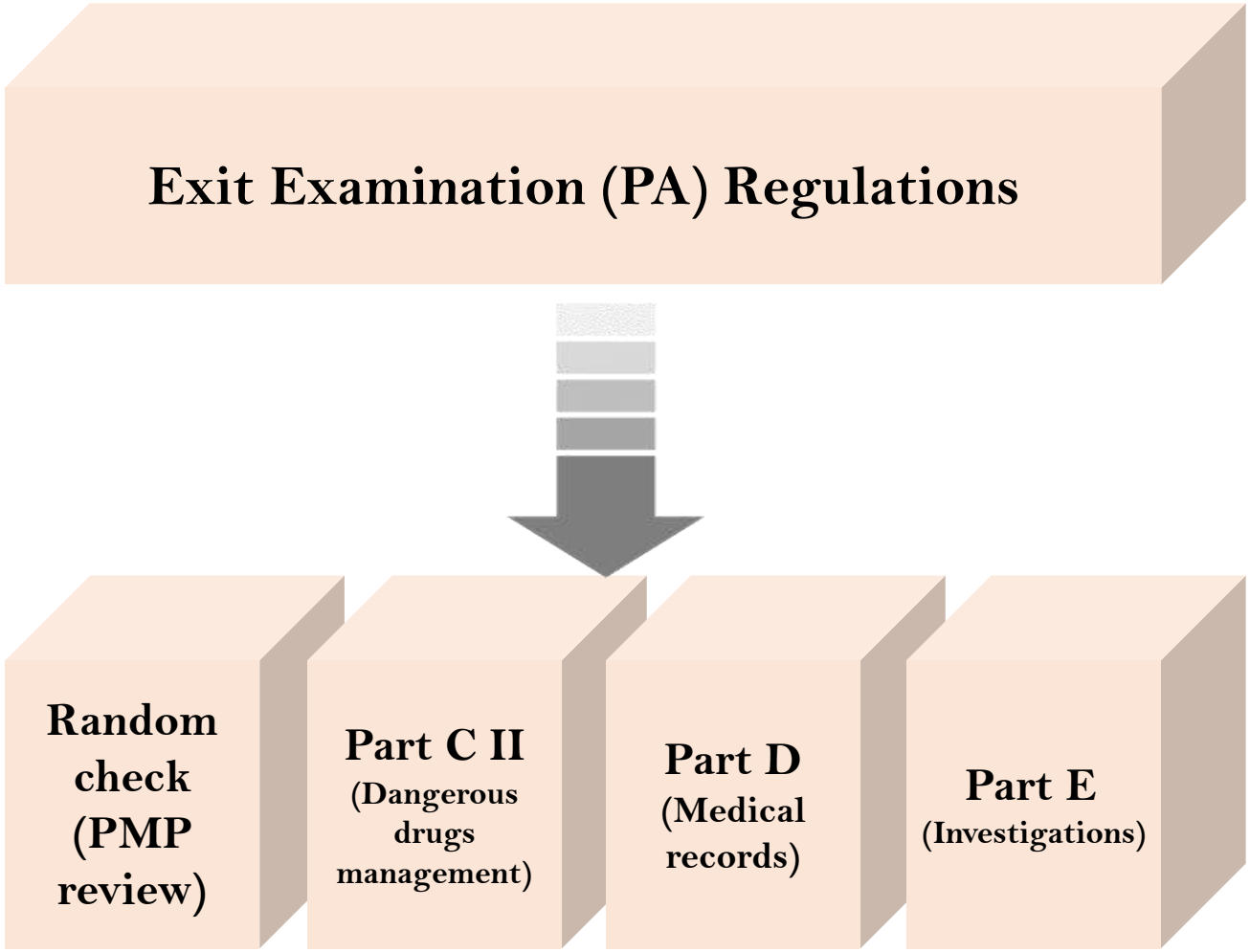
PERM: pre-exit review of medical records

Preparatory Workshop (26 April 2024)



PMP: practice management package

Pre-Exit Examination Workshop (today)



PA Documents

Submit:

PMP report

Attachment
1 to 11
(4 copies)

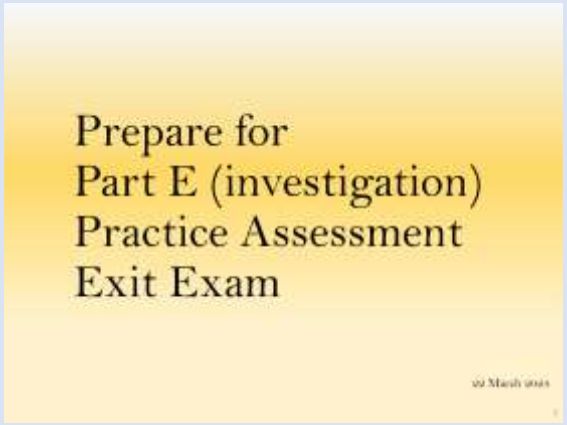
PERM report

Attachment
12
(4 copies)

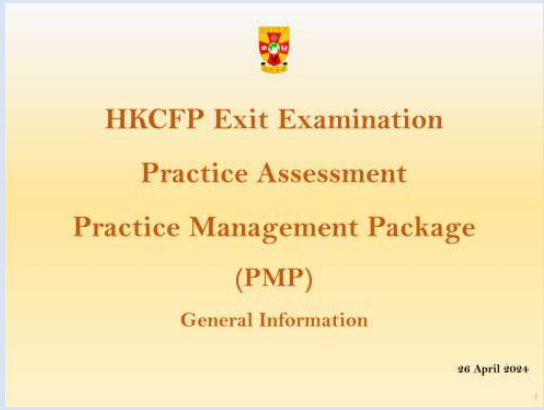
Attachment
13
(4 copies)

with your Exit Examination application
(deadline: 1st November 2024)

22 March 2024



26 April 2024

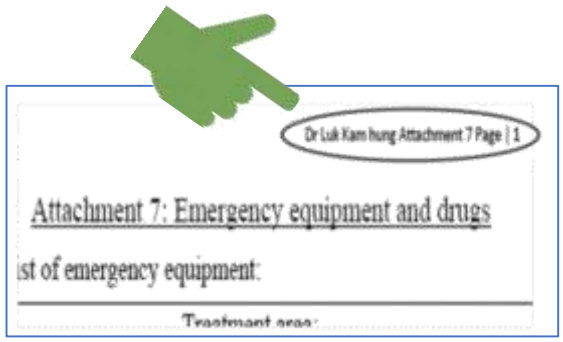


The presentation materials are available at the College *internet website:*

Hong Kong College of Family Physicians (hkcfp.org.hk)

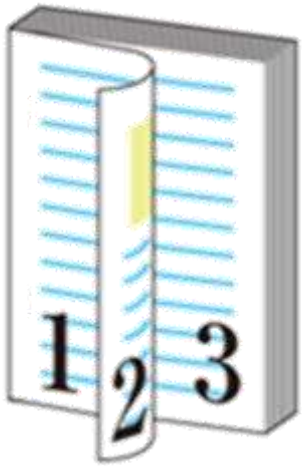
(Education & Examinations > Exit Examination)

Suggestion on printing and binding your PA Documents

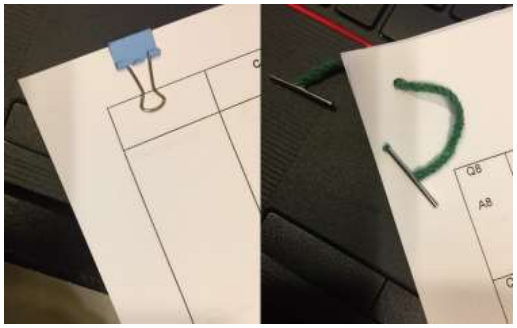


Insert header/ footer on the pages; indicating:

- Candidate number / name
- Attachment no.
- Page number



2-sided printing preferred



Detachable binding preferred

Attachment 12

and

Part D (Medical Records)

Attachment 12

A list of

medical records on

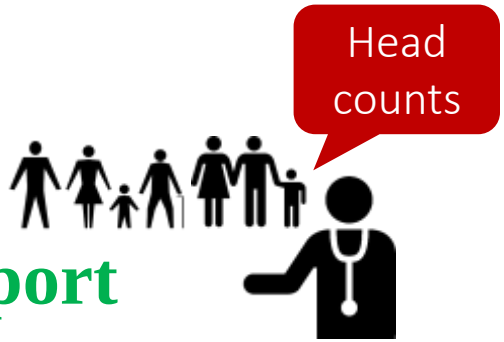
the patients consulted you

during the cases collection period

(17 September 2024 to 31 October 2024 inclusive)

The patients / cases can source from more than one clinic that you are working

The patients in Attachment 12



- Number of patients (Cases) needed:
  - ❖ If you can submit a **valid PERM report**

    at Exit Examination Application: 100 patients
  - ❖ Otherwise: 300 patients
- Health Screening / Medical Assessment excluded

The medical records in Attachment 12 (i)

The format

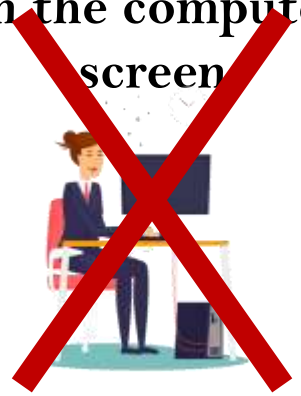
paper

Print-out from computer system

or / with

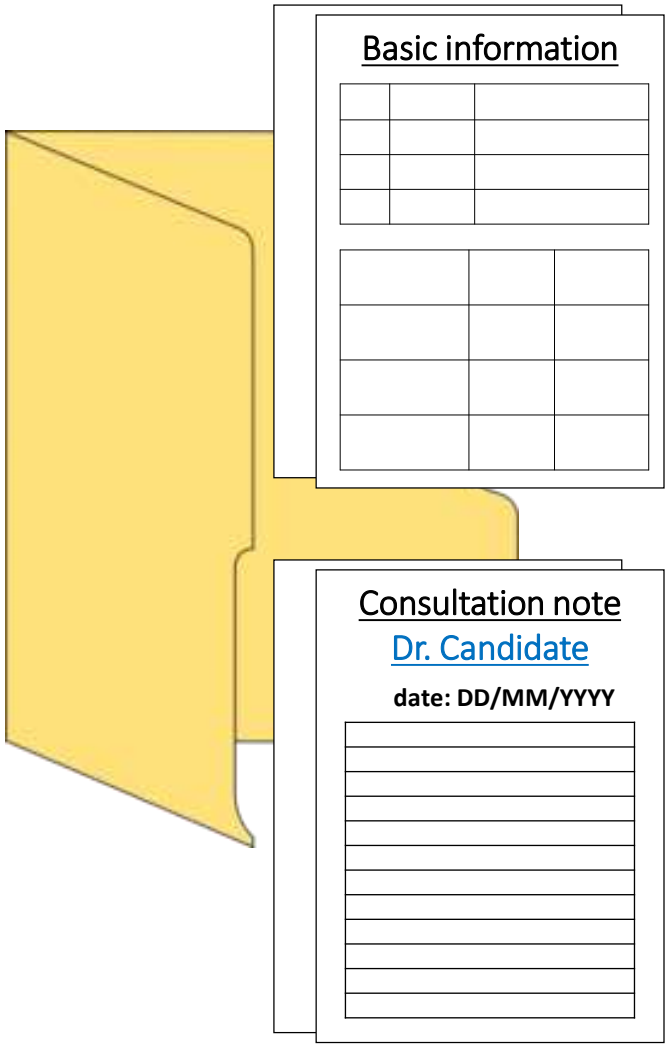
Handwritten records

on the computer screen



The medical records in Attachment 12 (ii)

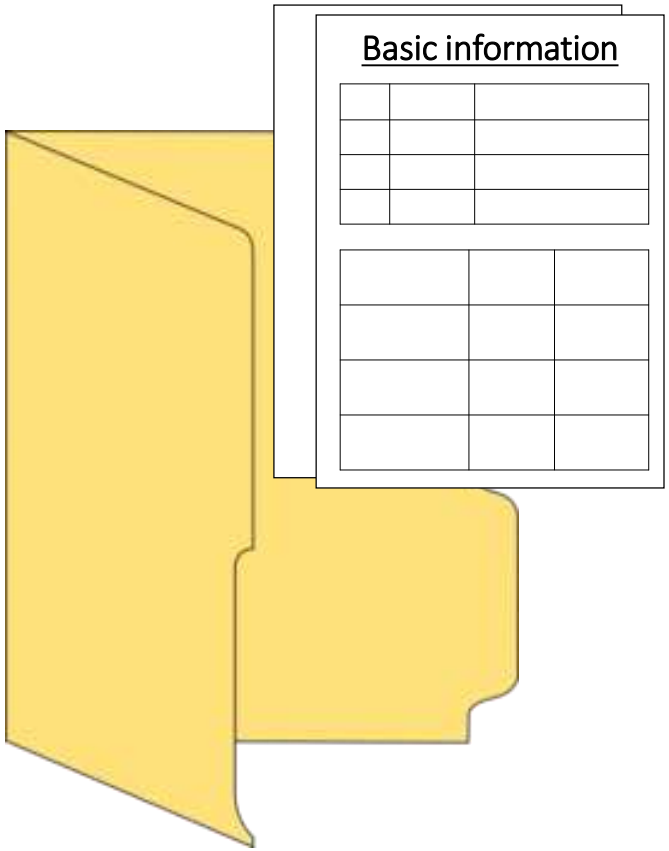
The content of each medical record for assessment should **at least include**:



Basic information

Consultation notes

The medical records in Attachment 12 (iii)



Basic information

On following areas

as appropriate and as applicable

- Allergy / Adverse drug reactions
- Current medication list
- Problem list (Current / Past health)
- Family history (with genogram as appropriate)
- Social history, occupation
- Height, weight, BMI/ growth chart, blood pressure
- Immunization
- Tobacco & alcohol use; physical activity

Please note:
It is not mandatory to have full documentation on all the areas in every record

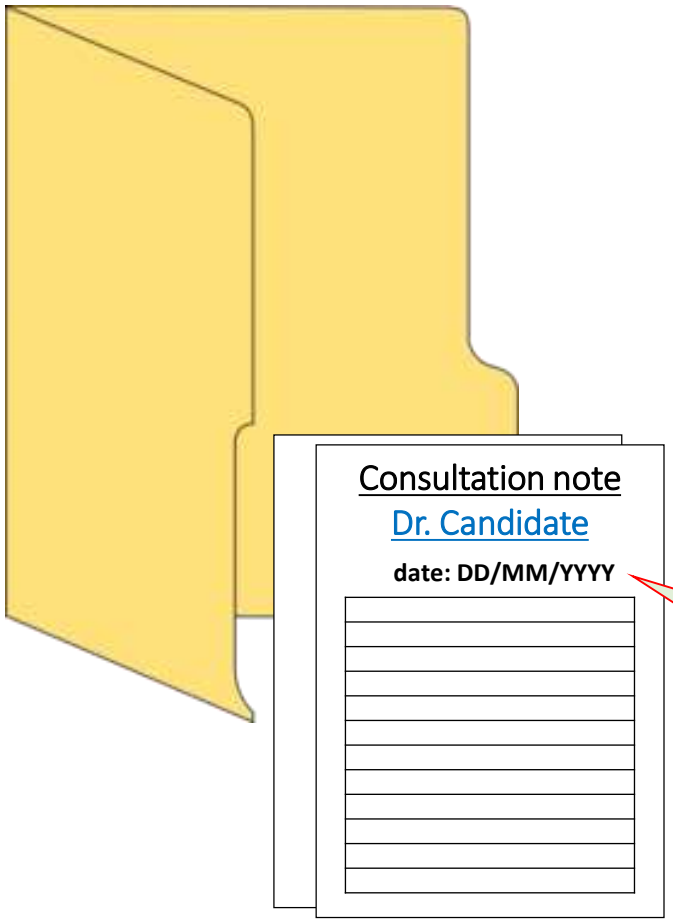
The medical records in Attachment 12 (iv)

Consultation notes

On following areas

as appropriate and as applicable

- Main reason(s) of consultation
- Clinical findings
- Diagnosis / working diagnosis
- Management
- Anticipatory care advice

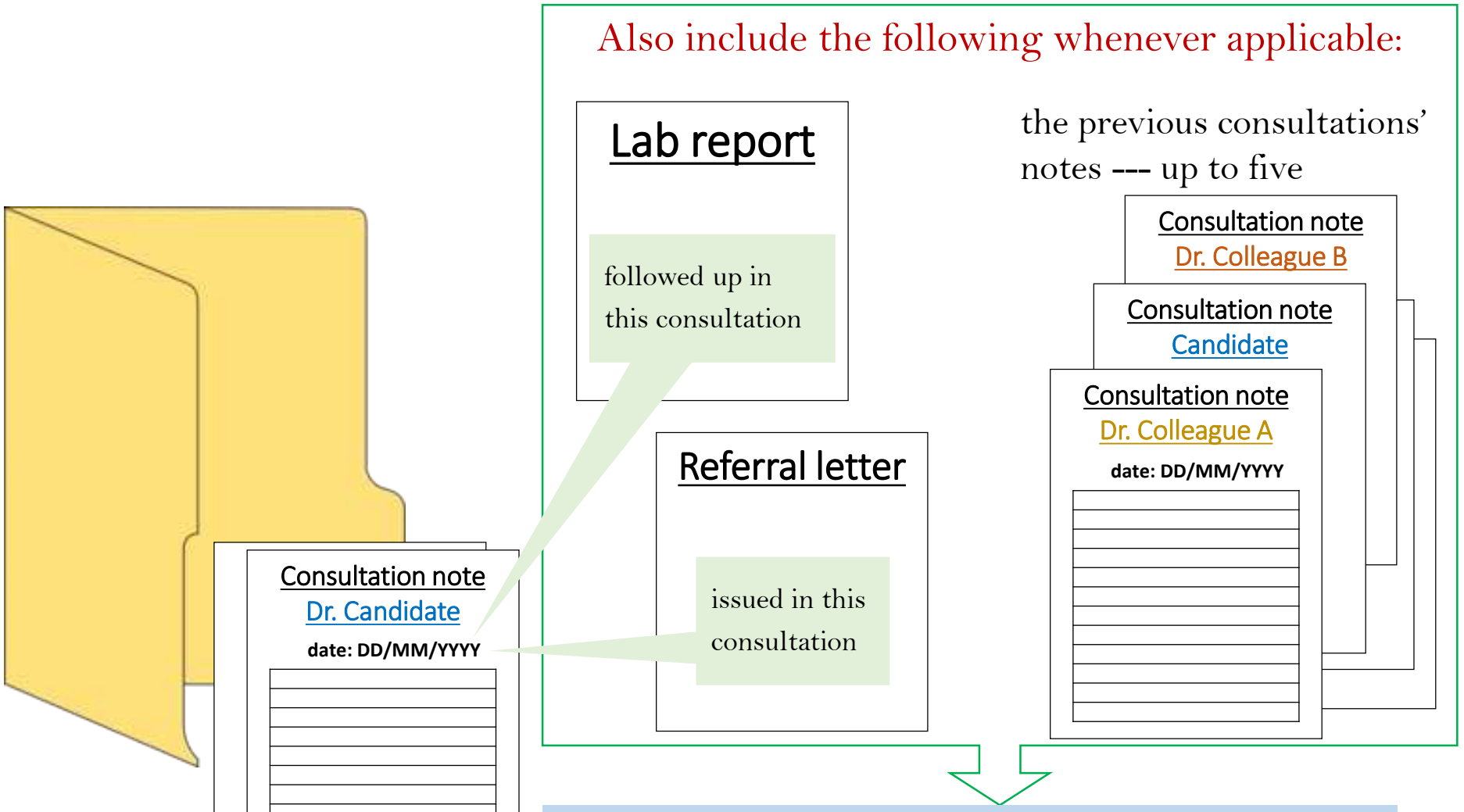


Please note:

- **As appropriate and as applicable**
- **Not mandatory in every consultation**

Date of the consultation: to be stated in the **Attachment 12**

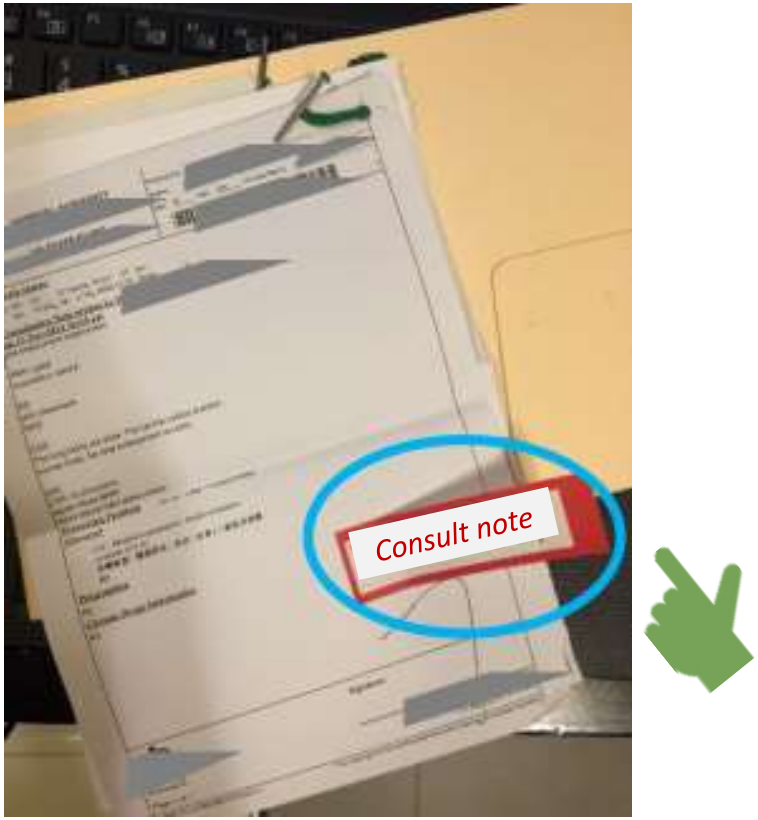
The medical records in Attachment 12 (v)



- Will not be marked directly
- Information in the previous consultation notes e.g. Blood pressure, BMI; chronic medications usage, control of medical condition(s) under your clinic's attention can help the Assessors to understand your consultation note

The medical records in Attachment 12 (vi)

Suggest paper-flag the pages for Examiners



The medical records in Attachment 12 (vii)

- **Keep in your clinic**
- **To be assessed by PA examiner on the Examination Day**

The medical records in Attachment 12 (viii)

Readily retrievable and available upon the Examiners' request

May be required to verify the genuineness e.g. through the clinic computer record system/ relevant persons

Attachment 12: format

Standard format

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 SEP 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 SEP 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21SEP 2022	18 SEP 1999
4	6677	CHL	F	12	ALLERGIC RHINITIS	21 SEP 2022	12 MAY 2011
5	4454	CHC	M	67	HT	21 SEP 2022	12 JAN 2011
…	…	….	…	…	…	….	….
100	2323	LKH	M	38	URTI	24 OCT 2022	24 OCT 2011

Confidentiality: Do not include patient's name, HKID

Sample layout of Attachment 12

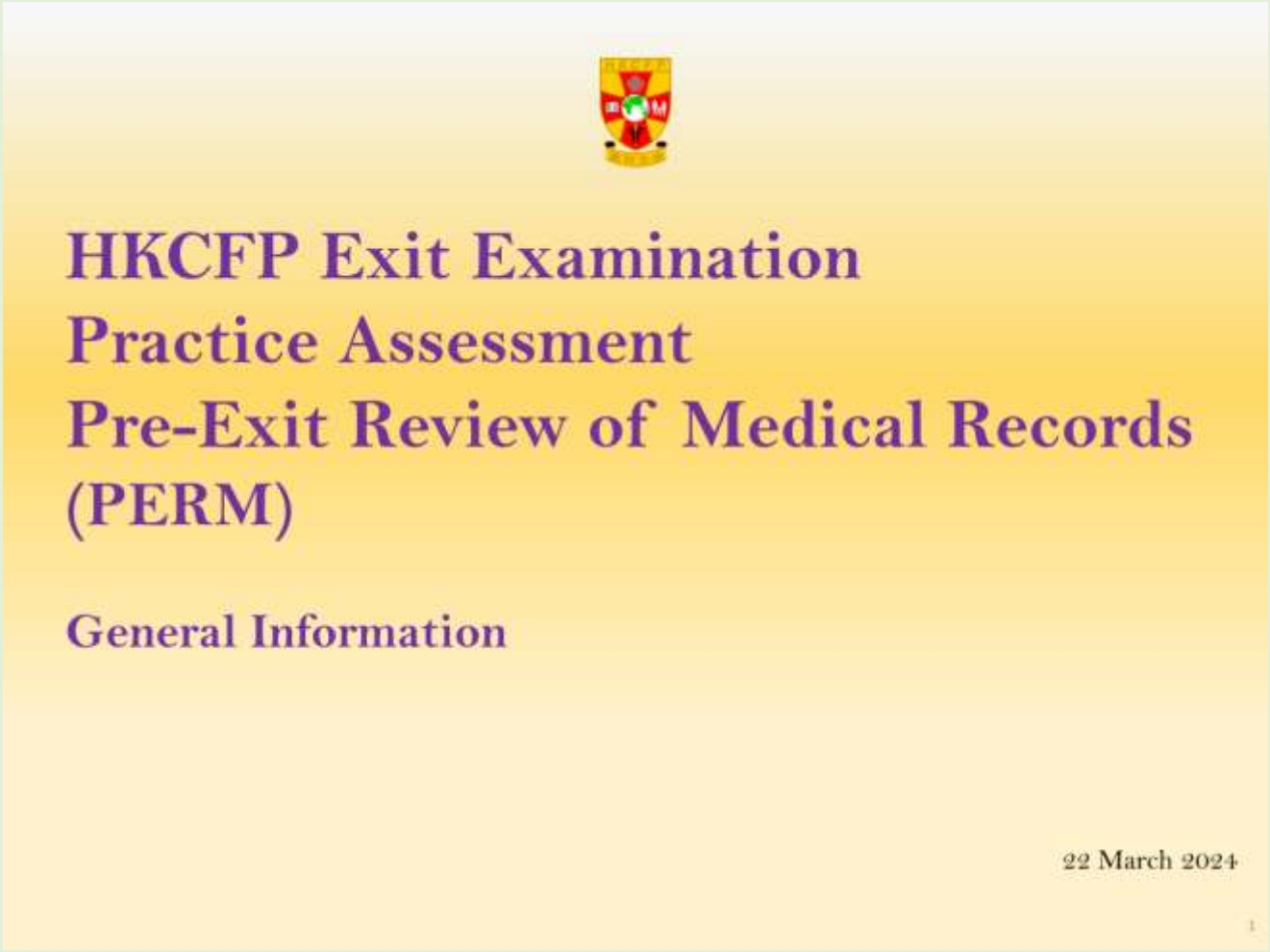
HKCFP [redacted] Exit Exam [redacted] Dr [redacted] ID [redacted]
Attachment 12

Name List of 300 patients

[redacted]

Case	Medical Record no.	Patient initials	Sex	Age	Diagnosis	Date of consultation	Date of first consultation in the clinic
1	[redacted]	LCL	F	72	Allergic dermatitis	2/5/2018	11/9/2001
2	[redacted]	CCL	M	80	URI	2/5/2018	12/9/2001
3	[redacted]	YHL	M	16	IBM	4/5/2018	9/11/2011
4	[redacted]	LFH	M	54	DM, HT, high lipid, URI	2/5/2018	3/3/2015
5	[redacted]	TLF	F	37	GERD, Hepatitis	4/5/2018	16/4/2013
6	[redacted]	HHP	F	59	HT	3/5/2018	10/12/2003
7	[redacted]	SYK	M	81	URI	5/5/2018	5/5/2018
8	[redacted]	YYC	F	88	URI, aplebotus ulcer	5/5/2018	8/10/2001
9	[redacted]	CKT	M	65	HT with LVH, AR	5/5/2018	20/2/2004
10	[redacted]	LTW	M	58	HT	5/5/2018	15/8/2011
11	[redacted]	LKH	F	72	HT, high lipid	2/5/2018	16/2/2001
12	[redacted]	NLW	F	94	High lipid	2/5/2018	2/5/2018
13	[redacted]	YCP	F	51	HT with WC, IFG	3/5/2018	3/11/2011
14	[redacted]	CKF	M	74	HT, BPH, lipid, IFG	3/5/2018	23/4/2004
15	[redacted]	DKM	F	64	HT with LVH	3/5/2018	28/9/2001
16	[redacted]	LHY	M	82	HT, IFG, high lipid	3/5/2018	3/10/2001
17	[redacted]	LYK	F	49	HT, borderline TH, obesity	3/5/2018	25/11/2014
18	[redacted]	HTF	M	77	DM, high lipid, HT, AR	3/5/2018	19/9/2002
19	[redacted]	APY	F	55	URI	3/5/2018	26/10/2001
20	[redacted]	TYY	F	66	URI, OA knee	3/5/2018	3/5/2018

Some practice tips in preparing Attachment 12 and Part D (Medical Records)



Attachment 13

and

Part E (Investigations)

Attachment 13

Case summaries & a summary Table of

medical records of ten patients .

The ten patients had

investigations ordered by you;

and followed up by you during the cases collection period

(17 September 2024 to 31 October 2024 inclusive)

The patients / cases can source from more than one clinic that you are working

The ten patients

The ten patients

Cannot be

those you submitted for Attachment 12 (Part D)

The date you see the patient and order investigations

Can be

before OR within the cases collection period

Follow up of the investigations

Must

- **Occur within the cases collection period**
- be **documented by the candidate** on the medical records

Can be

in the form of:

- Face to face consultations ;
  if not feasible,
- Telephone / electronic communications

Types of clinical problems requiring investigations submitted for PA (Part E)

Can be

- Patient's complaint(s) in episodic/ regular visit
- Monitoring of existing / chronic medical condition

Cannot be, solely, for the purpose of

- Health screening / Medical assessment
- Monitoring of potential side effects of medication / treatment in asymptomatic patients,
  e.g.
  RFT after using ACEI;
  Blood liver enzymes after statins;
  CBP to screen neutropenia on carbimazole

The ten cases have to show a variety of clinical problems (i)

Must

follow the regulations listed below:

For each case

- give **one** ICPC-2 code to the Provisional diagnosis / main condition that requiring the investigation(s); e.g. T90, R74
- show the code on your Case Summaries and the Summary Table (Attachment 13)

Suggest:
code according to the ‘body / system’ as possible

The ten cases have to show a variety of clinical problems (ii)

Must

follow the regulations listed below:

Among the ten cases

- No more than two cases should be the same **ICPC - 2 "Chapter" (the alphabet)**
- No more than one T-90 (type II diabetes mellitus) is allowed
- No more than one K-86 (uncomplicated hypertension) is allowed

Point of Care Tests (POCT)

Must

follow the regulations listed below:

Cases using point of care tests (POCT) ONLY,

except ECG,

are not eligible for Part E exam

Some examples of Point of care tests (POCT) in primary care settings:

Type of POCT	Example	Results format	Remarks / comments
A. Strip-based	Urine pregnancy test Urine dipstick analyses Detection of stool occult blood Detection of infectious agents in swab material	Simple visualization / readout from the test strip	
B. Unit-use analyzer (Single-use test strips + Reader)	Glucometers	Readout from the analyzer / device	
	HemoCue Hb 301 System	Printout	
C. Bench-top analyzer	Spectrophotometry: e.g. Reflotron	Printout	
D. ECG		Printout	
E. Spirometry		Printout	
F. Imaging	Point of care Ultrasound scan	Printout Video recording	

The medical records in Attachment 13 (i)

The format

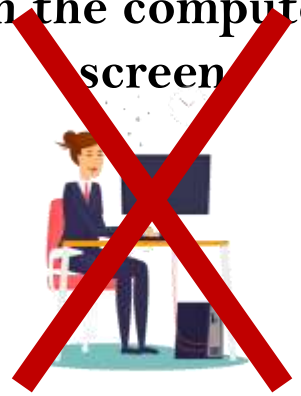
paper

Print-out from computer system

or / with

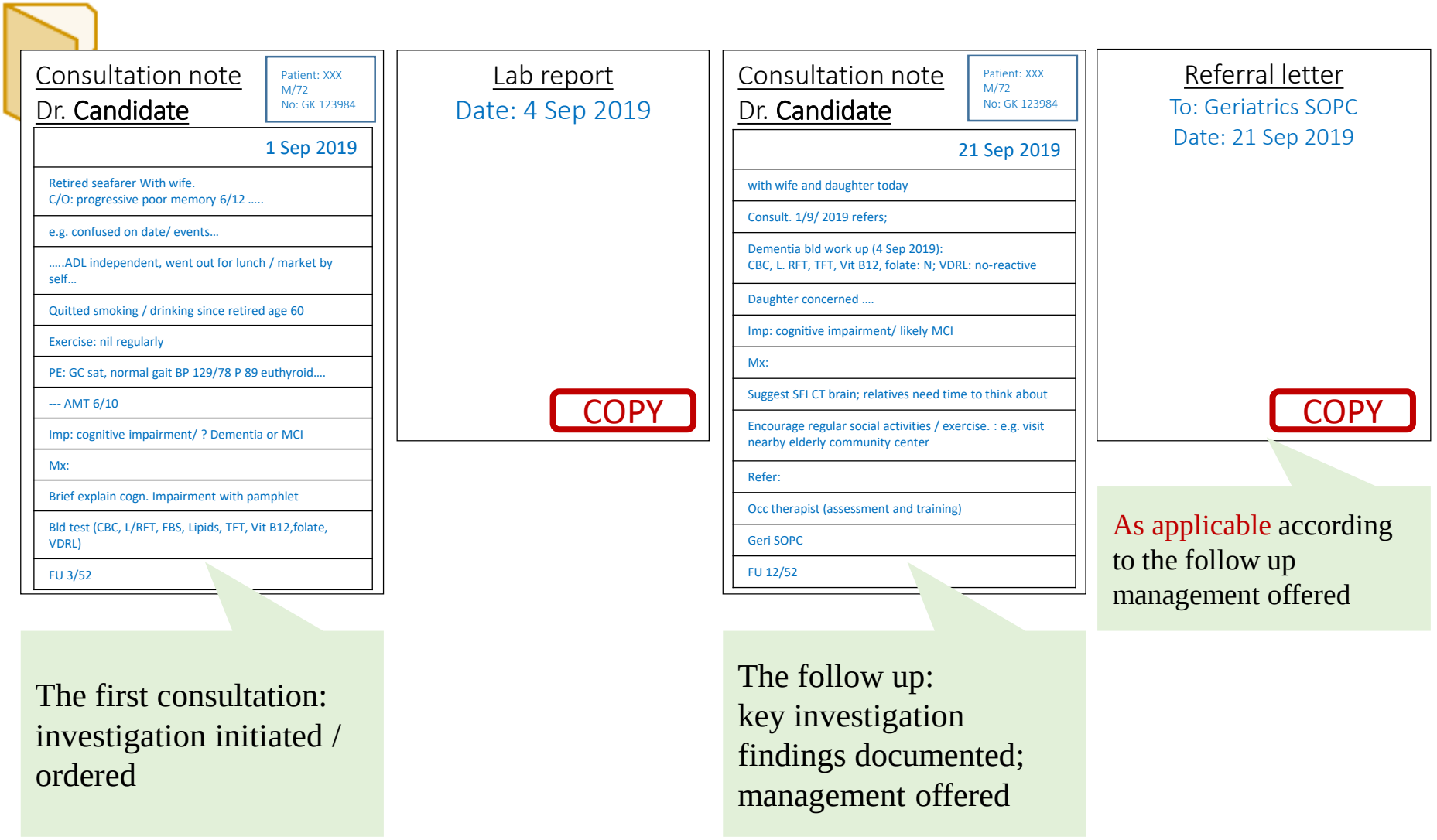
Handwritten records

on the computer screen



The medical records in Attachment 13 (ii)

The content of each medical record for assessment should at least include:



Please note: the consultation notes content are simulated and not implying a standard of pass or fail in the Exam

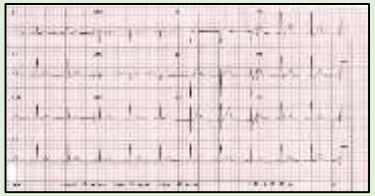
The medical records in Attachment 13 (iii)

About the investigation reports:

Lab report
Date: 4 Sep 2019

COPY

Copy of investigation reports can be:

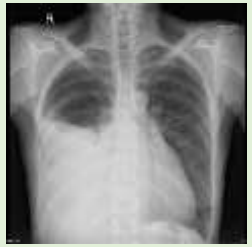


CT scan Report

Ultrasound scan report

X-ray report

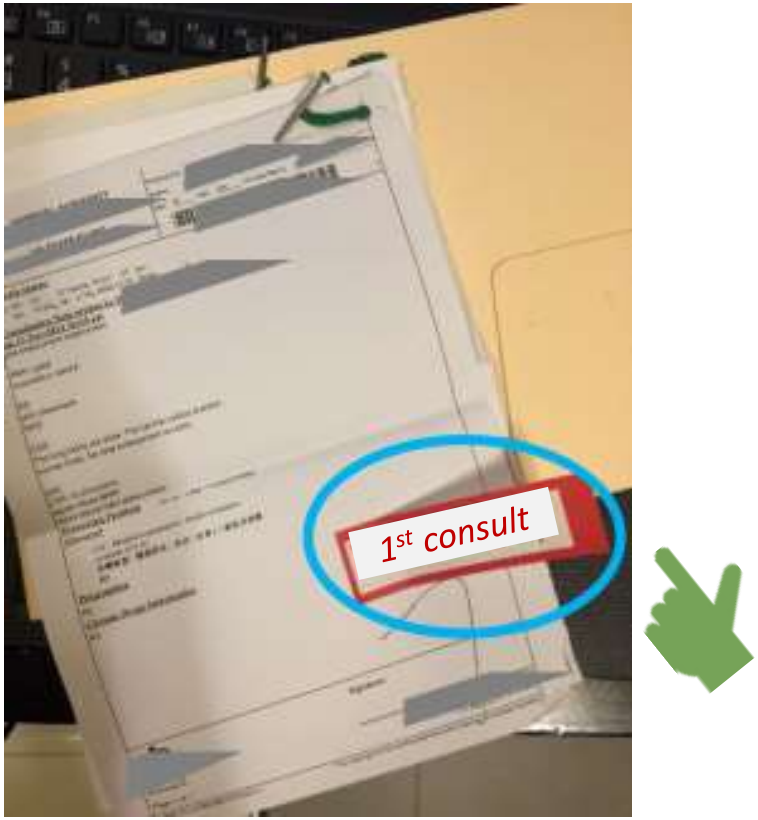
For plain X-Ray: if report not available



OR

The medical records in Attachment 13 (iv)

Suggestions paper flags the pages for Examiners



The medical records in Attachment 13 (v)

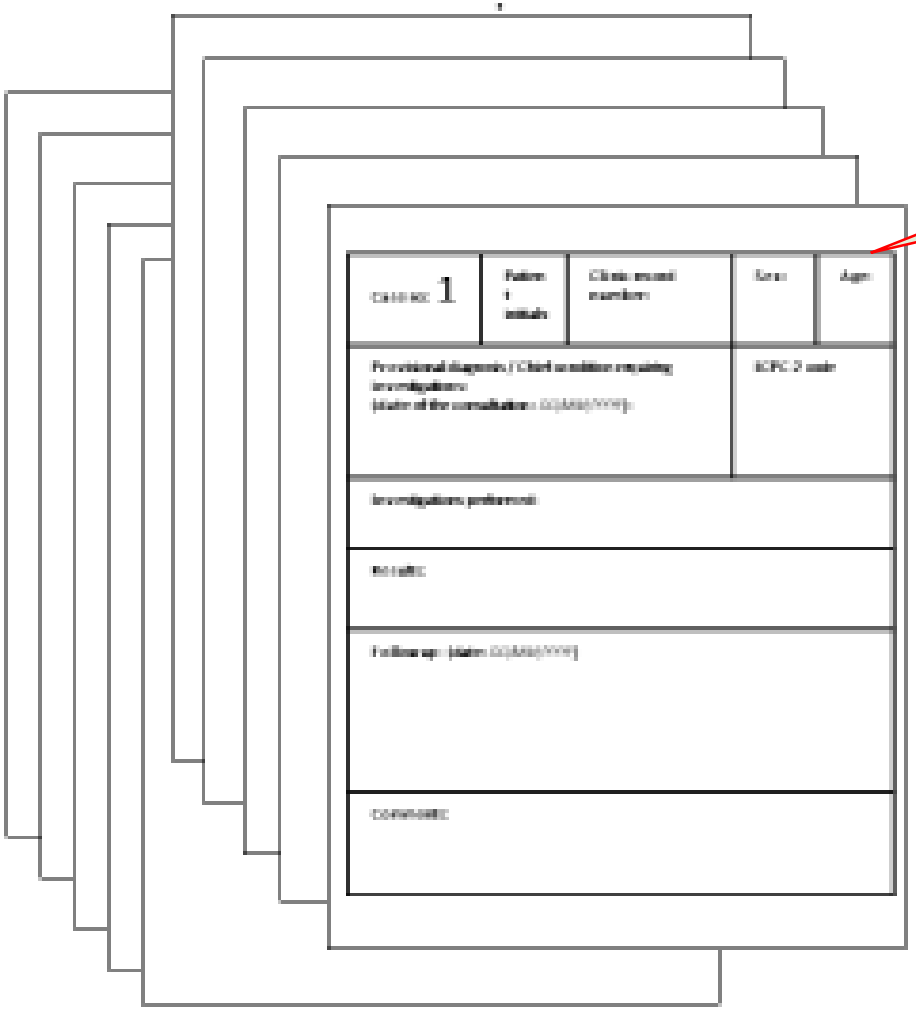
- **Keep in your clinic**
- **To be assessed by PA examiner on the Examination Day**

The medical records in Attachment 13 (vi)

Readily available upon the Examiners' request

May be required to verify the genuineness e.g. through the clinic computer record system/ relevant persons

Attachment 13: Case summary



Standard format

Confidentiality:
Do not include
patient's name, HKID

sample

Sample Case Summary for each patient (Attachment 13)

Case No: *6*	Patient initials: *LKH*	Clinic record number: *GOSY 1810XY21*	Sex: *M*	Age: *83*

Provisional diagnosis / Chief condition requiring investigations:
(date of the consultation: *DD/MM/YYYY*):
Weight loss, ? Bowel pathology
C/O Weight loss 6 to 7 Ib in last 3/12
B O change from daily to once every 3/7
PE GC sat, mild pallor, abd soft non-tender / no mass….PR: empty no mass felt

- Concise summary from the medical record
- Less than 300 words #

ICPC-2 code
T08 (weight loss)

- Appropriate coding
- Also put down description of the code

Investigations performed:
CBC, CEA, thyroid function (TSH), stool Occult blood X 3

Results:
CBC: Hb 9.8 (low), WBC 4.8, Platelet count 345, CEA 2.0 (ref < 3.0), TSH normal, Stool OB +ve X 1

Section(s) grossly exceed the words limit may be blocked and cannot be seen by Examiners

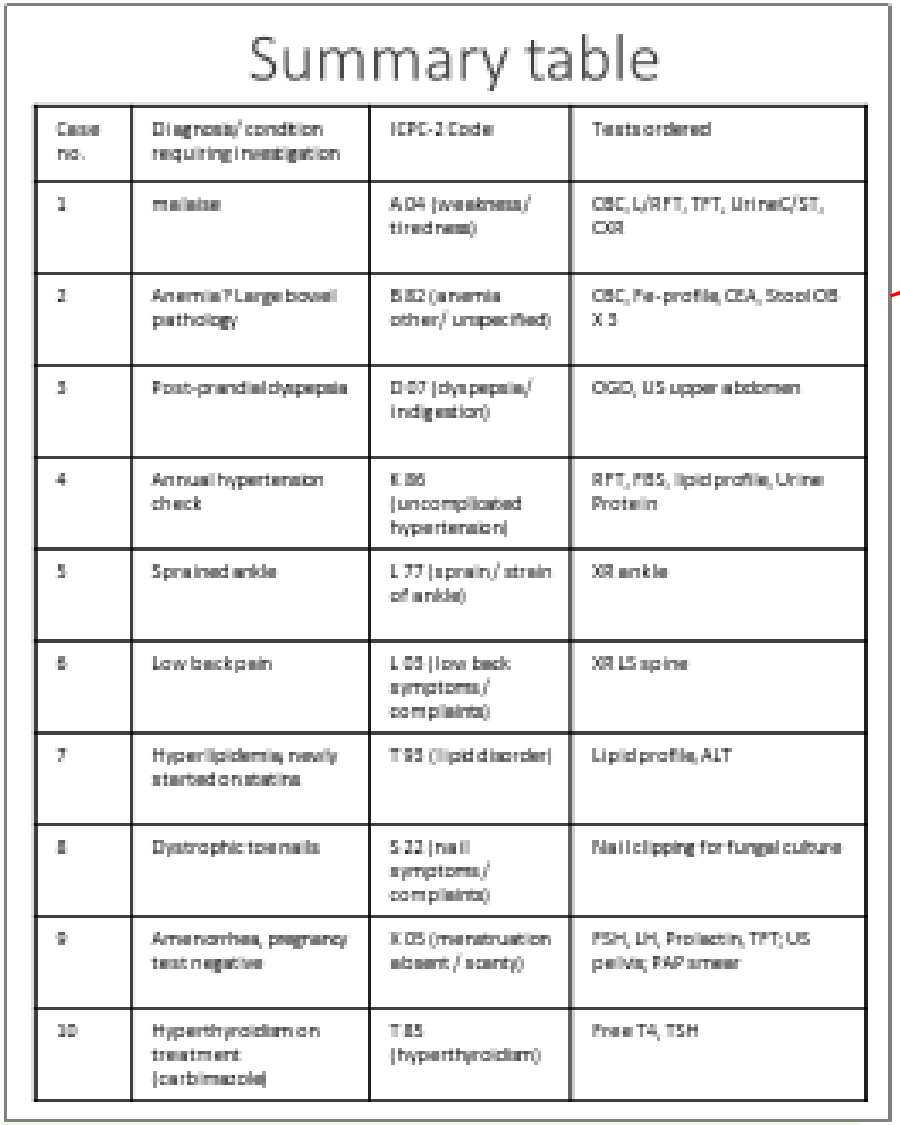
Follow up: (date: *DD/MM/YYYY*)
Results informed
Discussed with patient and daughter…
Mx: referral to Surgical SOPC (seek early appointment)

- Concise summary from the medical record
- Less than 300 words #

Comments:

- Optional; marks will not be deducted for leaving this section blank
- For discussion on investigation justification, limitations of the performance, area of improvement, possible remedial actions
- *clinic protocols, departmental guidelines, literature references, expert opinions; or general summary from the medical record*: to be avoided here
- Less than 300 words #

Attachment 13: Summary Table



Summary table

Case no.	Diagnosis/ condition requiring investigation	ICPC-2 Code	Tests ordered
1	malaise	A04 (weakness/ tiredness)	CBC, L/RFT, TPT, UrineC/ST, CXR
2	Anaemia? Large bowel pathology	B82 (anaemia other/ unspecified)	CBC, Fe-profile, CEA, Stool OB X 3
3	Post-prandial dyspepsia	D07 (dyspepsia/ indigestion)	OGD, US upper abdomen
4	Annual hypertension check	K86 (uncomplicated hypertension)	RFT, FBS, lipid profile, Urine Protein
5	Sprained ankle	L77 (sprain/ strain of ankle)	XR ankle
6	Low back pain	L03 (low back symptoms/ complaints)	XR LS spine
7	Hyperlipidemia, newly started on statins	T93 (lipid disorder)	Lipid profile, ALT
8	Dystrophic toenails	S22 (nail symptoms/ complaints)	Nail clipping for fungal culture
9	Amenorrhea, pregnancy test negative	X05 (menstruation absent / scanty)	FSH, LH, Prolactin, TPT; US pelvis; PAP smear
10	Hyperthyroidism on treatment (carbimazole)	T85 (hyperthyroidism)	Free T4, TSH

Standard format

Confidentiality:
Do not include
patient's name, HKID

sample

Sample Summary table (Attachment 13)

Summary table

Case no.	Diagnosis/ condition requiring investigation	ICPC-2 Code	Tests ordered
1	malaise	A 04 (weakness / tiredness)	CBC, L/RFT, TFT, Urine C/ST, CXR
2	Anemia ? Large bowel pathology	B 82 (anemia other/ unspecified)	CBC, Fe-profile, CEA, Stool OB X 3
3	Post-prandial dyspepsia	D 07 (dyspepsia / indigestion)	OGD, US upper abdomen
4	Annual hypertension check	K 86 (uncomplicated hypertension)	RFT, FBS, lipid profile, Urine Protein
5	Sprained ankle	L 77 (sprain / strain of ankle)	XR ankle
6	Low back pain	L 03 (low back symptoms / complaints)	XR LS spine
7	Hyperlipidemia, newly started on statins	T 93 (lipid disorder)	Lipid profile , ALT
8	Dystrophic toe nails	S 22 (nail symptoms / complaints)	Nail clipping for fungal culture
9	Amenorrhea, pregnancy test negative	X 05 (menstruation absent / scanty)	FSH, LH, Prolactin, TFT; US pelvis; PAP smear
10	Hyperthyroidism on treatment (carbimazole)	T 85 (hyperthyroidism)	Free T4, TSH

Monitoring of possible side effects of medication/ treatment in asymptomatic patients **added**

OK

Health screening **added**

OK

Attachment 13 will be reviewed by the Examiners before the Exam Day

Attachment 13 serves to assist the Examiners

- to have some basic understanding on the ten cases
- to note if the candidate has, if any, special consideration about the investigation ordering and management of the cases

The content of Attachment 13 have to be consistent with the respective medical records

The actual marking will be based on the medical records presented

Please carefully choose the cases and give appropriate ICPC coding

- Unsuitable case(s)
- Non-compliance with the ICPC-coding requirements

Penalty!

Pro-rata deduction of Part E total Score

- Usually Examiners will not drill on the accuracy of the ICPC-2 coding given in the ten cases
- Unless special situation occurs

Non-compliance with ICPC coding requirement (i)

10 investigation list

Case	Provisional diagnosis / chief condition requiring investigations	ICPC-2 code	Investigation performed:
1	Bronchitis	R78	NPS for respiratory virus
2	Fish bone ingestion	D79	Xray neck
3	Cystitis	U71	MSU
4	Small joint pain	L20	Blood test
5	Fever	A03	NPS for respiratory virus
6	Pregnancy	W78	PT test
7	Fractuer little toe	L17	Xray
8	Kidney stone	U14	Urogram
9	Colitis	D06	USG abd
10	Appandicitis	D88	CT abd

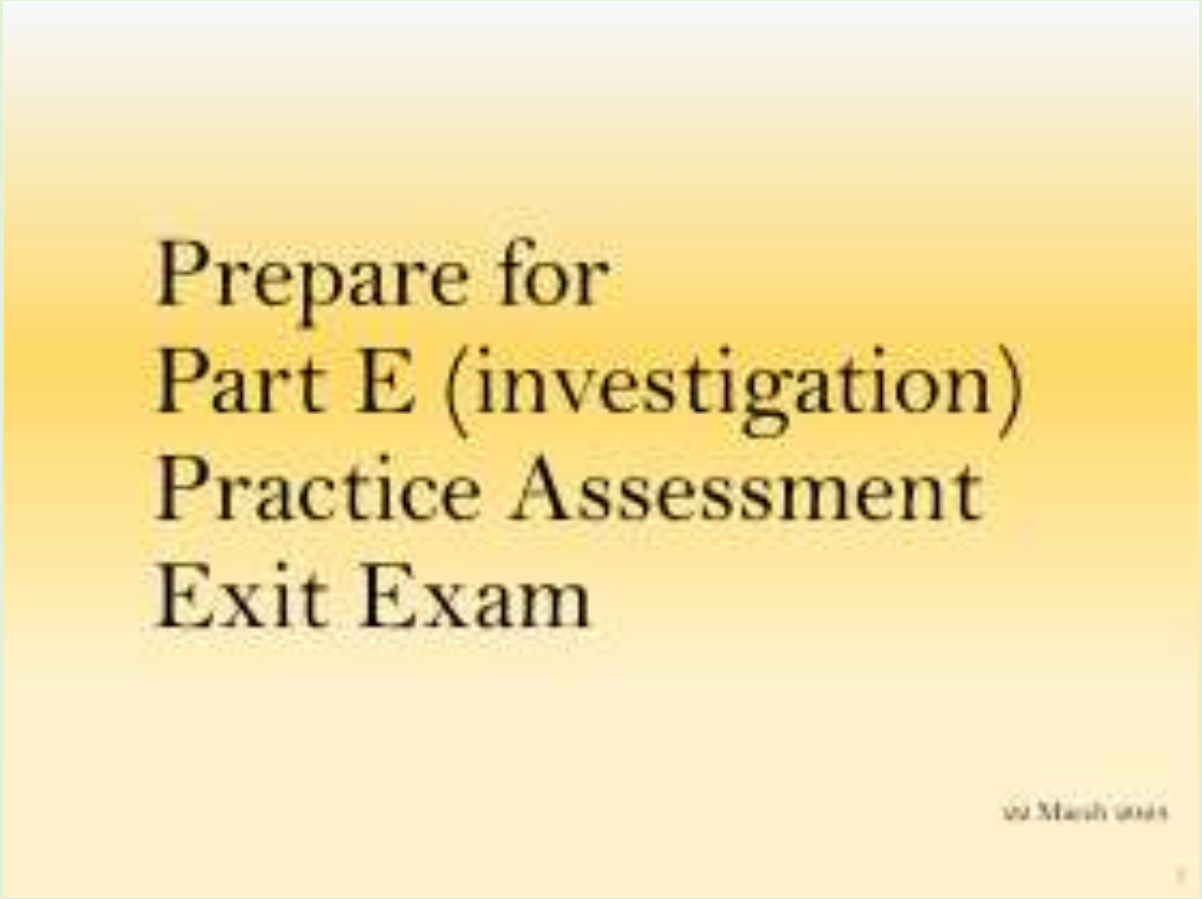
Three Cases coded the same ICPC-2 ‘Chapter’ (D);
→ Pro-rata deduction of total mark of Part E

Non-compliance with ICPC coding requirement (ii)

Case	Provisional diagnosis / chief condition requiring investigations	ICPC-2 code	Investigation performed:
1	Hyperthyroidism	T85	Thyroid function test (TSH and free T4)
2	Left little finger injury	L76	X-ray left little finger
3	Hypokalaemia	A91	Re al fu
4	Vulvar itchy , provisional diagnosis was Genital candidiasis	X72	hig vagi en ocerv
5	Increased vaginal discharge	X14	hig vagi en ocerv
6	Low back pain	L03	X-r y lu
7	Finger nodule	S04	X-r y left
8	Impaired liver function	D97	Blo d for GG , HBs
9	Proteinuria hypokalaemia	U98 A91	Mic -strea mic oscopy and culture, ren l function test, urine mic oalbumin
10	Left hand injury	A80	X-ray left hand and thumb

- These two Cases were considered the same ICPC-2 'Chapter' (either L or A)
- In the presence of Case 3 (A91) and Case 6 (L03);
- → Pro-rata deduction of total mark of Part E

Some practice tips in preparing Attachment 13 and Part E (Investigations)



Carefully choose the cases

Choose cases that show your competency , not weakness

Not sure if the case on hand is good to be presented for Exam?

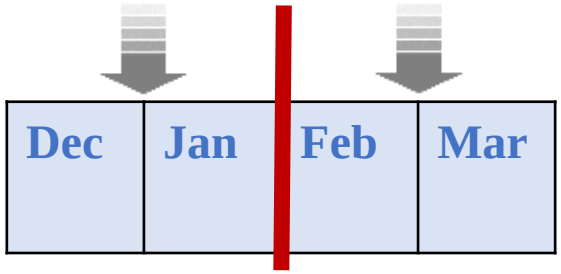
Choose another case

Exam Day

Exam Date arrangement

Will be within either:

Period A **OR** Period B

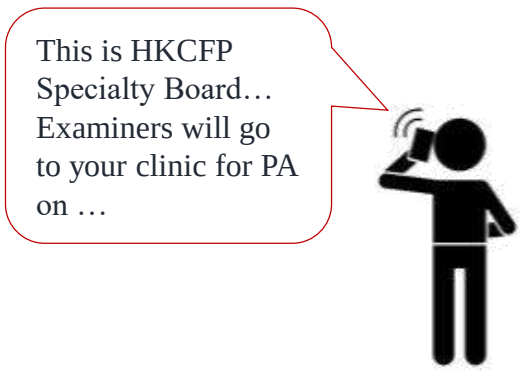


Exact dates of each period: please refer to the updated Exam Announcement

No exam on public holidays

Candidates will be notified of the Examination period:

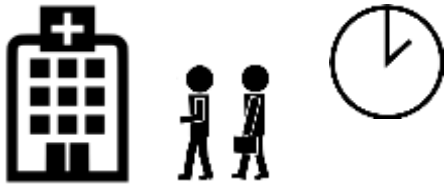
Candidate will be informed **2 working days before** the exam



Exam date once confirmed cannot be changed

Your cooperation appreciated!

Examiners will usually visit on **Mondays - Fridays (daytime) or Saturdays (morning)** with reference to the Candidate's clinic hours



Three PA Examiners

will be arranged

to visit the candidate's clinic

When Examiners arrive

Introduction

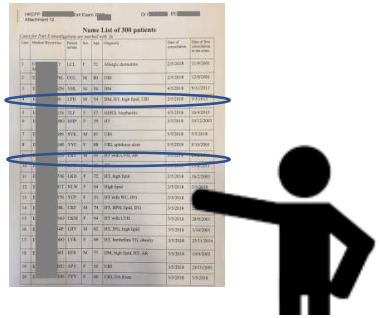
In addition to the three PA Examiners, other delegates may be present, such as:

- Trainee examiner
- Observing examiner
- Exam observer
- QA examiner

Identification and assurance of confidentiality

Candidate

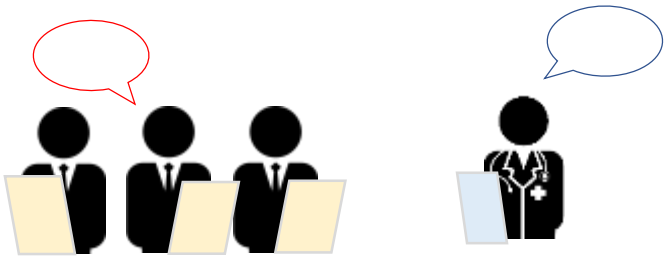
Examiners choose eight records from the Attachment 12



Candidate (clinic staff can help) fetches the records

Clinic inspection with the candidate (Random check and Part C II)

Examiners mark according to the
PA Rating Form



Same as PMP visit
candidate answers and demonstrates

Examiners give marks independently

Examiners may cross check candidate's answers with the clinic staff if needed

Random check (PMP Review)

Random Check (PMP review)

- Selected items from your PMP report , and
- the relevant Attachment(s) you submitted

The Hong Kong College of Family Physicians
香港家庭醫學學院

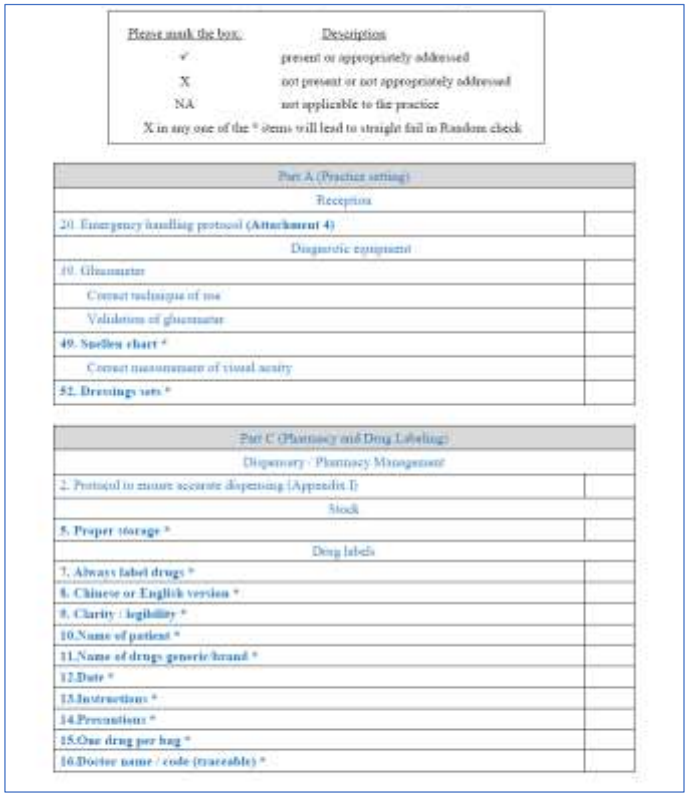
Practice Management Package (PMP)

Candidate	
Practice name & address	(working in the practice since ___/___)
Assessor	
Date of assessment	

Items and relevant Attachment(s) selected from:

1. *Parts A or/ and B; AND*
2. *Part C*

Making sheet (PA rating form)



Please mark the box:	Description
✓	present or appropriately addressed
X	not present or not appropriately addressed
NA	not applicable to the practice

X in any one of the * items will lead to straight fail in Random check

Part A (Practice setting)	
Reception	
20. Emergency handling protocol **(Attachment 4)**	
Diagnostic equipment	
40. Glucometer	
Correct technique of use	
Validation of glucometer	
49. Snellen chart *	
Correct measurement of visual acuity	
52. Dressings sets *	

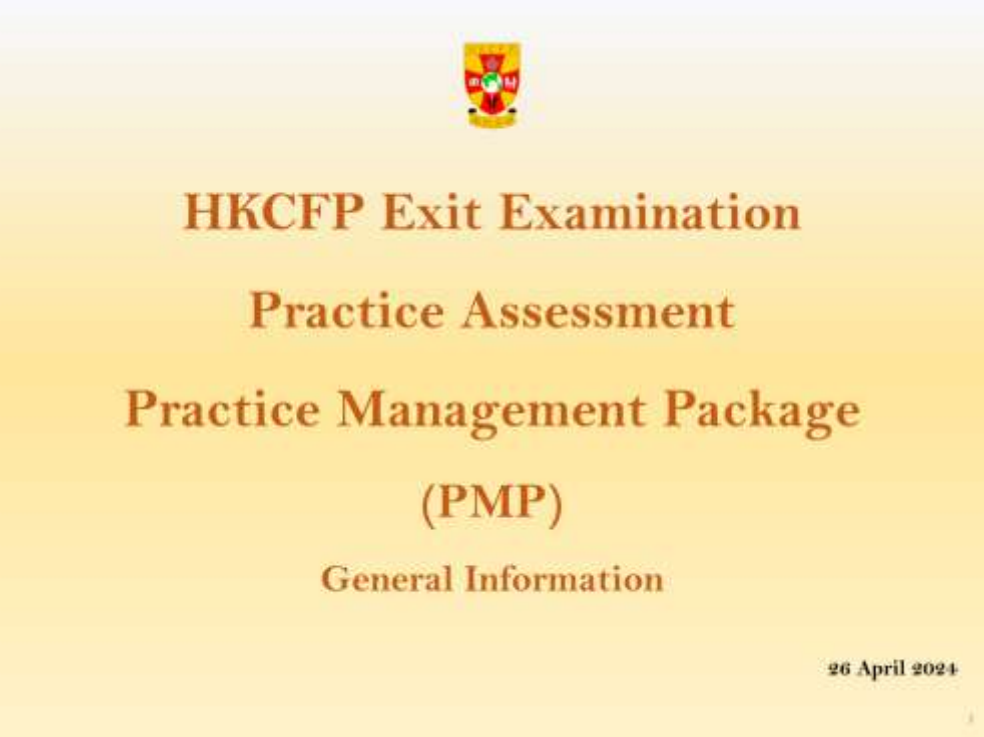
Part C (Pharmacy and Drug Labeling)	
Dispensary - Pharmacy Management	
2. Protocol to ensure accurate dispensing (Appendix I)	
Stock	
5. Proper storage *	
Drug labels	
7. Always label drugs *	
8. Chinese or English version *	
9. Clarity / legibility *	
10.Name of patient *	
11.Name of drugs generic/brand *	
12.Date *	
13.Instructions *	
14.Precautions *	
15.One drug per bag *	
16.Doctor name / code (traceable) *	

Random Check (PMP review)

For:

- the format of marking (same as PMP visit)
- some examiners' comments on candidate's performance in Random Check in the previous years

Please refers to:



Passing Random Check (PMP review)

Candidate Number: EE XXXXX

Random Check (PMP review)

Grade *(please tick one)*			Description
Pass	**A**		*Mastery of most components and capability*
	C		*Satisfactory standard in most components*
Fail	**E**		*Demonstrates several major omissions and/or defects (or deficiency in area with *)*
	N		*Unsafe practice*

Part C II
(Dangerous drugs management)

Part C II (Dangerous Drugs management)

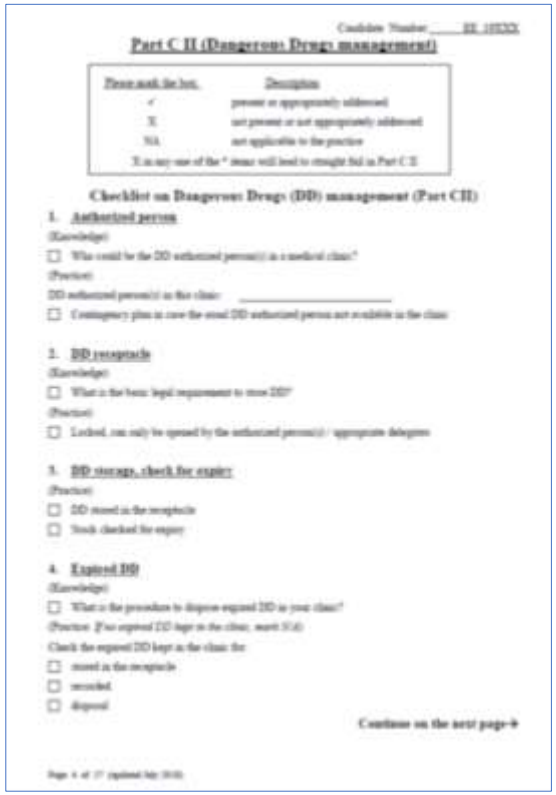
Part C II of your PMP report

The Hong Kong College of Family Physicians
香港家庭醫學學院

Practice Management Package (PMP)

Candidate	
Practice name & address	(working in the practice since ____/____)
Assessor	
Date of assessment	

Making sheet (PA rating form)



Candidate Number: _____ EE 19XXX

Part C II (Dangerous Drugs management)

Please mark the box	Description
√	present or appropriately addressed
X	not present or not appropriately addressed
NA	not applicable to the practice

X in any one of the * items will lead to straight fail in Part C II

Checklist on Dangerous Drugs (DD) management (Part CII)

1. Authorized person

(Knowledge)

☐ Who could be the DD authorized person(s) in a medical clinic?

(Practice)

DD authorized person(s) in the clinic: _____

☐ Contingency plan in case the usual DD authorized person not available in the clinic

2. DD receptacle

(Knowledge)

☐ What is the basic legal requirement to store DD?

(Practice)

☐ Locked, can only be opened by the authorized person(s) / appropriate delegates

3. DD storage, check for expiry

(Practice)

☐ DD stored in the receptacle

☐ Stock checked for expiry

4. Expired DD

(Knowledge)

☐ What is the procedure to dispose expired DD in your clinic?

(Practice: If no expired DD kept in the clinic, mark NA)

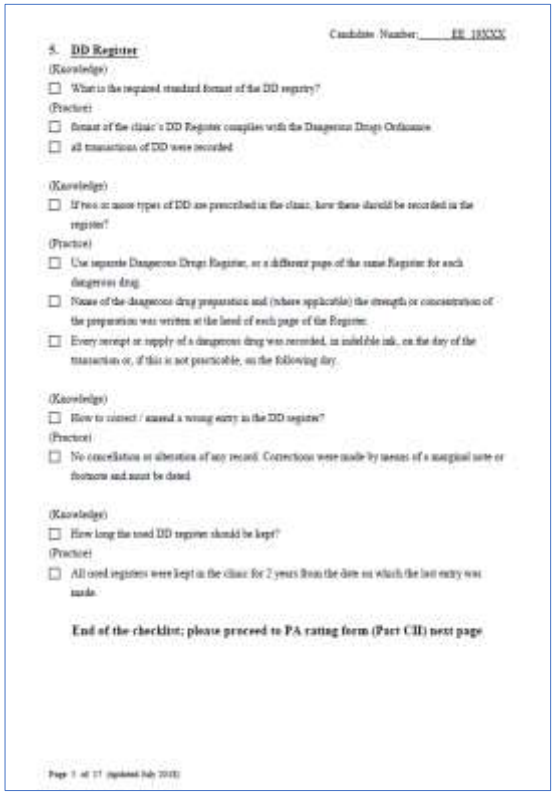
Check the expired DD kept in the clinic for

☐ stored in the receptacle

☐ recorded

☐ disposal

Continue on the next page→



Candidate Number: _____ EE 19XXX

5. DD Register

(Knowledge)

☐ What is the required standard format of the DD registry?

(Practice)

☐ Format of the clinic's DD Register complies with the Dangerous Drugs Ordinance

☐ all transactions of DD were recorded

(Knowledge)

☐ If two or more types of DD are prescribed in the clinic, how these should be recorded in the register?

(Practice)

☐ Use separate Dangerous Drugs Register, or a different page of the same Register for each dangerous drug

☐ Name of the dangerous drug preparation and (where applicable) the strength or concentration of the preparation was written at the head of each page of the Register.

☐ Every receipt or supply of a dangerous drug was recorded, in indelible ink, on the day of the transaction or, if this is not practicable, on the following day

(Knowledge)

☐ How to correct / amend a wrong entry in the DD register?

(Practice)

☐ No cancellation or alteration of any record. Corrections were made by means of a marginal note or footnote and must be dated

(Knowledge)

☐ How long the used DD register should be kept?

(Practice)

☐ All used registers were kept in the clinic for 2 years from the date on which the last entry was made.

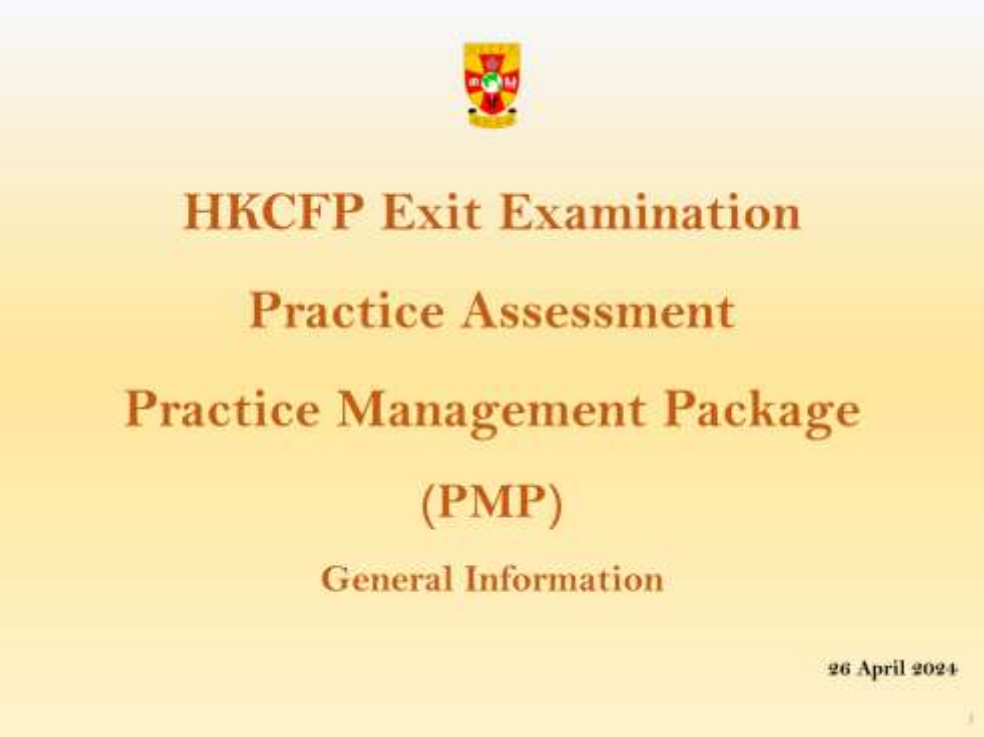
End of the checklist; please proceed to PA rating form (Part CII) next page

Part C II (Dangerous Drugs management)

For:

- the format of marking (same as PMP visit)
- some examiners' comments on candidate's performance in Part CII in the previous years

Please refers to:



Passing Part C II (Dangerous drugs management)

Candidate Number: EE XXXXX

Please mark and comment according to the "Checklist on Dangerous Drugs (DD) Management"

Part C II (Dangerous Drugs management)

		Knowledge	Practice
1.	**Authorized person***		
2.	**DD receptacle***		
3.	**DD: storage, check for expiry***	N/A	
4.	**Expired DD: storage, record, disposal*** (if DD in the clinic not expired → ask 'Knowledge'; 'Practice' mark N/A)		
5.	**DD register***		

Overall result

(must pass in both knowledge and practice to have overall pass here)

Pass		**Fail**	

Assess Medical Records (Part D and Part E)

candidate can show the basic layout of the medical records before start marking

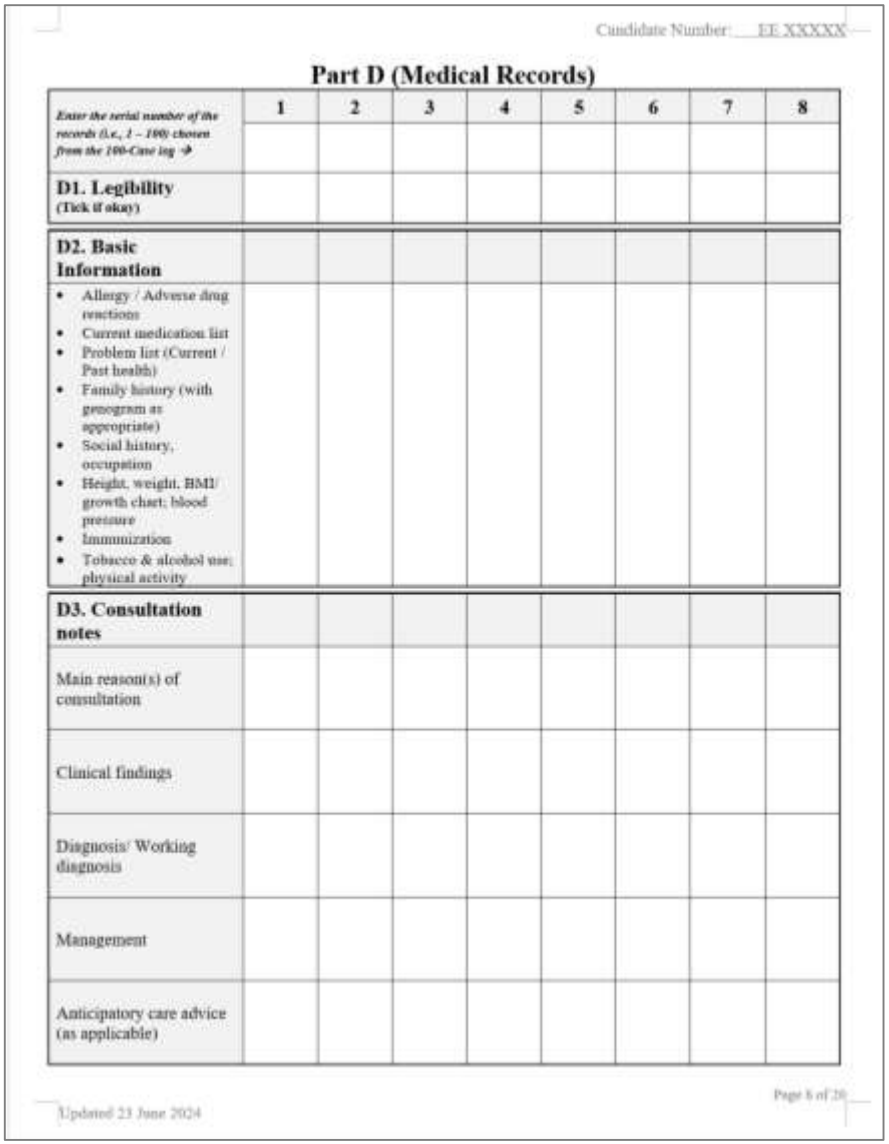
Prepare a room of adequate audio-visual privacy, for Examiners to assess your records

Assess the records in the room provided

Examiners mark independently

Part D
(Medical records)

Part D (Medical Records) Rating Form



Candidate Number: EE XXXXX

Part D (Medical Records)

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8
D1. Legibility (Tick if okay)								
D2. Basic Information								
• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate) • Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity								
D3. Consultation notes								
Main reason(s) of consultation								
Clinical findings								
Diagnosis/ Working diagnosis								
Management								
Anticipatory care advice (as applicable)								

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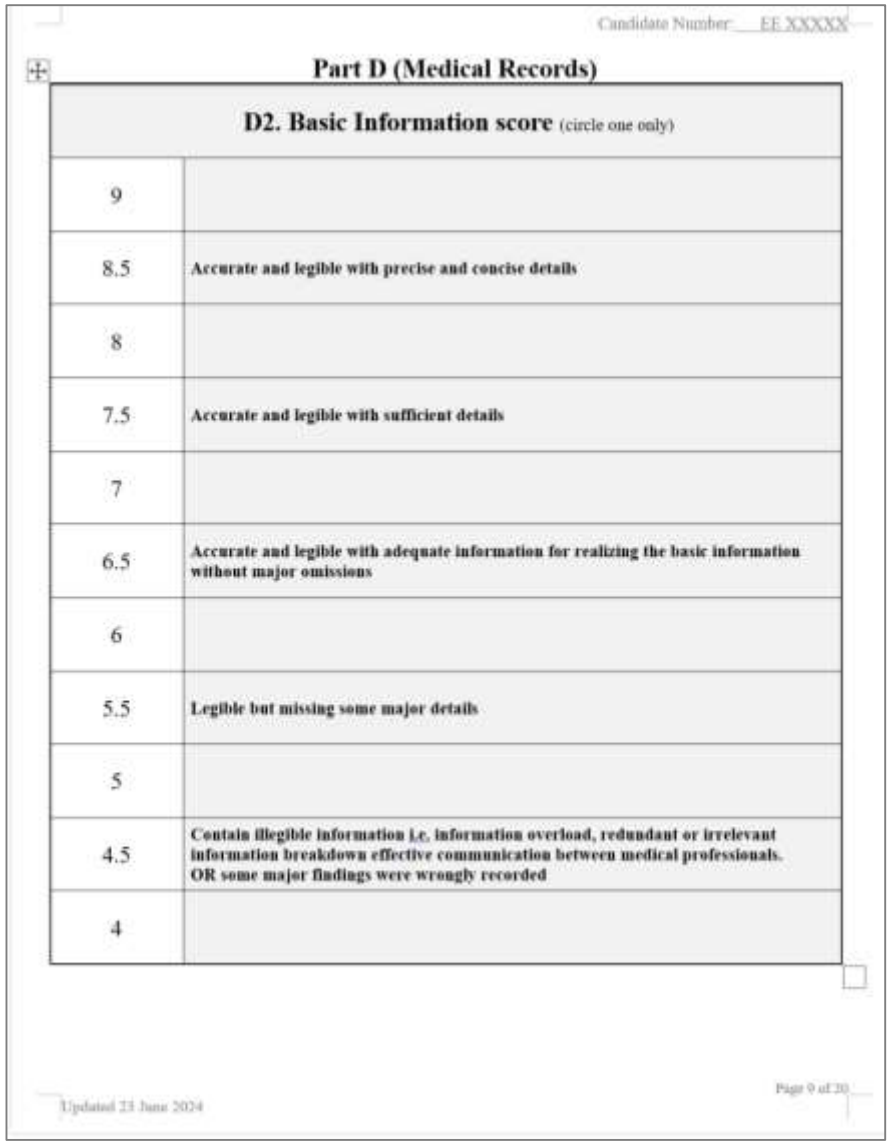

Candidate Number: EE XXXXX

Part D (Medical Records)

D2. Basic Information score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details**
8	
7.5	**Accurate and legible with sufficient details**
7	
6.5	**Accurate and legible with adequate information for realizing the basic information without major omissions**
6	
5.5	**Legible but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded**
4	

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Part D (Medical Records) Rating Form

Candidate Number: EE XXXXX

Part D (Medical Records)

D3. Consultation notes score (circle one only)	
9	
8.5	Accurate and legible with precise and concise details, with a relevant past medical / social history of an appropriate length
8	
7.5	Accurate and legible with sufficient details, with a relevant past medical / social history
7	
6.5	Accurate and legible with adequate information for realizing the whole consultations without major omissions
6	
5.5	Legible for the consultations but missing some major details
5	
4.5	Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded
4	

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Candidate Number: EE XXXXX

Part D (Medical Records)

Total score (Part D):

D2 score x 3.5	+	D3 score x 6.5	=	Total Score (Part D)

If D1 pro-rata mark deduction applicable

↓

Pro-rata deducted Total Score (Part D)

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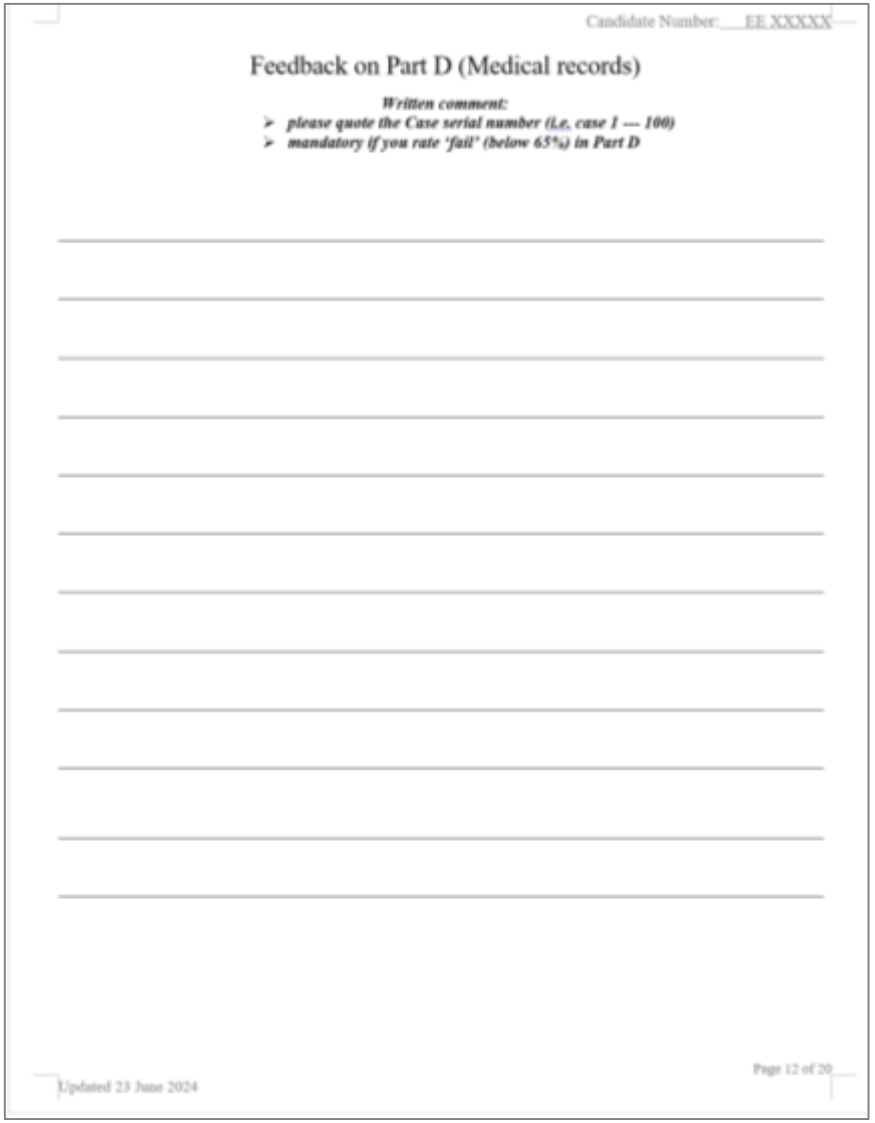
Part D (Medical Records) Rating Form



Candidate Number: EE XXXXX

Feedback on Part D (Medical records)

Written comment:

- ***please quote the Case serial number (i.e. case 1 — 100)***
- ***mandatory if you rate 'fail' (below 65%) in Part D***

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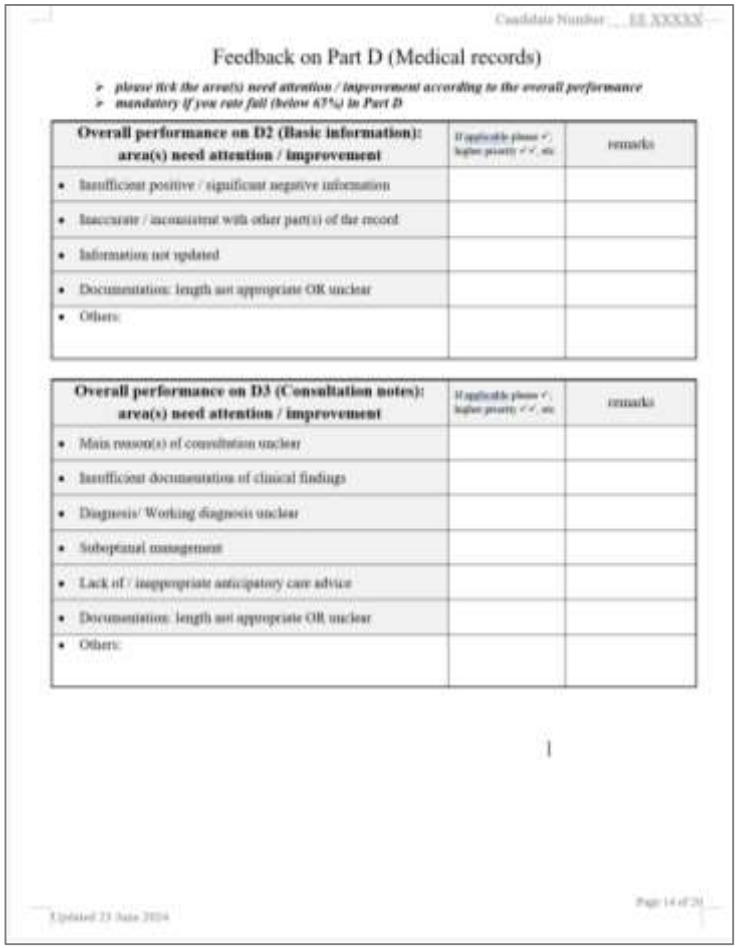

Candidate Number: EE XXXXX

Feedback on Part D (Medical records)

- ***please tick the area(s) need attention / improvement according to the overall performance***
- ***mandatory if you rate fail (below 65%) in Part D***

Overall performance on D2 (Basic information): area(s) need attention / improvement	If applicable please ✓, higher priority ✓✓, etc	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on D3 (Consultation notes): area(s) need attention / improvement	If applicable please ✓, higher priority ✓✓, etc	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

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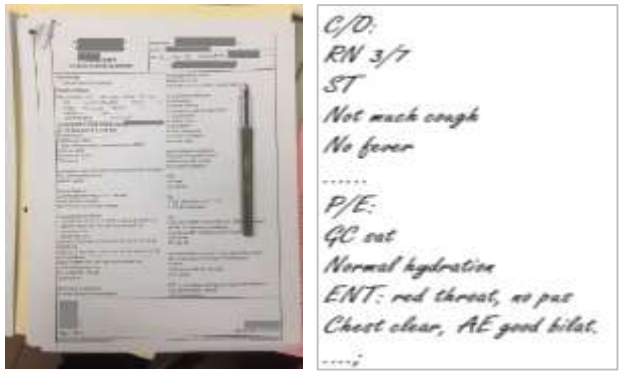
D1 (Legibility): marking

Enter the serial number of the records (i.e., 1 – 100) chosen from the 100-Case log →	1	2	3	4	5	6	7	8
	8	12	23	25	35	56	78	91

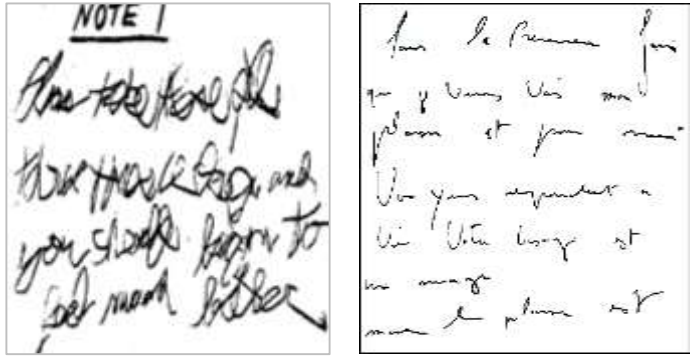
Please enter the Serial no. of the records i.e. 1 to 100 of the Attachment 12

D1 (Legibility): marking

D1. Legibility (Tick if okay)	√					X		



Examiners proceed to assess the medical record



the whole case will not be marked pro-rata mark deduction in Part D total score

D2 (Basic Information): marking

D2. Basic Information								
• Allergy / Adverse drug reactions • Current medication list • Problem list (Current / Past health) • Family history (with genogram as appropriate) • Social history, occupation • Height, weight, BMI/ growth chart; blood pressure • Immunization • Tobacco & alcohol use; physical activity								

Examiner would jot down the impression of each of the eight selected cases

Marking Scale for D2 (Basic information)

Examiner marks all the eligible medical records
Then give a global mark in Part D2 (basic information)

New in 2025 Exit

D2. Basic Information score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details**
8	
7.5	**Accurate and legible with sufficient details**
7	
6.5	**Accurate and legible with adequate information for realizing the basic information without major omissions**
6	
5.5	**Legible but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals.** **OR some major findings were wrongly recorded**
4	

D3 (Consultation notes)
Date of the consultation

Attachment 12

Serial no.	Patient record number	Patient initials	sex	age	diagnosis	Date of the consultation	Date of first attended the clinic
1	3216	NFK	F	25	URTI	20 May 2022	18 OCT 2010
2	8839	LKF	F	46	DEPRESSION	20 May 2022	25 JUL 2011
3	292	KPW	M	87	DM, HT, HYPERLIPIDEMIA	21 May 2022	18 SEP 1999
4	9932	STKM	F	1	URTI	21 May 2022	6 AUG 2011
5				12	ALLERGIC RHINITIS		
6			M	67	HT		
…	…	….	…	…	…	….	….
100	2323	LKH	M	38	URTI	29 June 2022	24 OCT 2011

If the assessor choose to assess this record

This consultation notes would be selected for assessment

D3 (Consultation notes): marking

D3. Consultation notes								
Main reason(s) of consultation								
Clinical findings								
Diagnosis/ Working diagnosis								
Management								
Anticipatory care advice (as applicable)								

Examiner would jot down the impression of each of the eight selected cases

D3 (Consultation notes): marking

D3. Consultation notes								
Main reason(s) of consultation								
Clinical findings								
Diagnosis/ Working diagnosis								
Management								
Anticipatory care advice (as applicable)								

NOT “Idea / Concern / Expectation of the patient”!

Marking Scale for D3 (Consultation notes)

Examiner marks all the eligible medical records
Then give a global mark in Part D3 (Consultation notes)

New in 2025 Exit

D3. Consultation notes score (circle one only)	
9	
8.5	**Accurate and legible with precise and concise details, with a relevant past medical / social history of an appropriate length**
8	
7.5	**Accurate and legible with sufficient details, with a relevant past medical / social history**
7	
6.5	**Accurate and legible with adequate information for realizing the whole consultations without major omissions**
6	
5.5	**Legible for the consultations but missing some major details**
5	
4.5	**Contain illegible information i.e. information overload, redundant or irrelevant information breakdown effective communication between medical professionals. OR some major findings were wrongly recorded**
4	

Part D (Medical Records): total score

Mark distribution:

D2 (Basic information): 35%

D3 (Consultation notes): 65%

Passing mark: Total score ≥ 65%

Total score (Part D):

D2 score x 3.5	+	D3 score x 6.5	=	Total Score (Part D)

If D1 pro-rata mark deduction applicable

↓

Pro-rata deducted Total Score (Part D)

Feedback on Part D (Medical records)

- ***please tick the area(s) need attention / improvement according to the overall performance***
- ***mandatory if you rate fail (below 65%) in Part D***

Overall performance on D2 (Basic information): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient positive / significant negative information		
• Inaccurate / inconsistent with other part(s) of the record		
• Information not updated		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on D3 (Consultation notes): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Main reason(s) of consultation unclear		
• Insufficient documentation of clinical findings		
• Diagnosis/ Working diagnosis unclear		
• Suboptimal management		
• Lack of / inappropriate anticipatory care advice		
• Documentation: length not appropriate OR unclear		
• Others:		

Part E
(Investigations)

Part E (Investigations) Rating Form

Candidate Number: EE XXXXX

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1. Investigation indication documentation										
E2. Justification										
E3. Results documentation										
E4. Follow up										

E2 mark *(circle one)*	*4*	*4.5*	*5*	*5.5*	*6*	*6.5*	*7*	*7.5*	*8*	*8.5*	*9*	*9.5*
E4 mark *(circle one)*	*4*	*4.5*	*5*	*5.5*	*6*	*6.5*	*7*	*7.5*	*8*	*8.5*	*9*	*9.5*

Total score (Part E):

E2 score x 5	+	E4 score x 5	=	Total Score (Part E)

If E3 pro-rata mark deduction applicable, please enter the adjusted mark

If E1 pro-rata mark deduction applicable

Pro-rata deducted score (Part E)

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Candidate Number: EE XXXXX

Please note:

- E1 (Investigation indication documentation): IF NOT shown in the record → cross the box; no need to mark the concerned case, apply pro-rata deduction to 'total score in Part E'
- E3 (Results documentation): IF report copy NOT available OR result NOT recorded in the 'follow up' medical notes → cross the box; no need to mark E4 of the concerned case; apply pro-rata deduction to 'E4 score'
- Assessment should be based on the medical records; but can consider score adjustment if the candidate offers appropriate additional information in the 'Comment' section, Attachment 13.

Reference for marking E2 (Investigation indication documentation) and E4 (Follow up)

Mark (Please circle one)	description
9	Consistently demonstrates outstanding performance in all components; criterion performance (outstanding)
8.5	
8	Consistently demonstrates mastery of most components and capability in all (Very Good)
7.5	
7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
6.5	
6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care *(Such omissions/ defects were seen in two or more of the Cases assessed)*
5.5	
5	Demonstrates inadequacies in several components with major omissions or defects
4.5	
4	Demonstrates serious defects; clearly unacceptable standard overall

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Part E (Investigations) Rating Form

Candidate Number: EE XXXXX

Feedback on Part E (Investigations)

- ***please quote the Case number (i.e. case 1 — 10)***
- ***mandatory if you rate 'fail' (below 65%) in Part E***

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Candidate Number: EE XXXXX

Feedback on Part E (Investigations)

- ***please tick the area(s) need attention / improvement according to the overall performance***
- ***mandatory if you rate fail (below 65%) in Part E***

Overall performance on E2 (Justification): area(s) need attention / improvement	If applicable please ✓, higher priority ✓✓, etc	remarks
• Insufficient clinical information		
• Inappropriate working diagnosis		
• The investigation not guiding the management		
• Not choosing appropriate test(s)		
• Test(s) not done at appropriate time		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on E4 (Follow up): area(s) need attention / improvement	If applicable please ✓, higher priority ✓✓, etc	remarks
• Follow up not done at appropriate time		
• Key findings documentation unclear		
• Not offering appropriate management according to the investigation results		
• Documentation: length not appropriate OR unclear		
• Others:		

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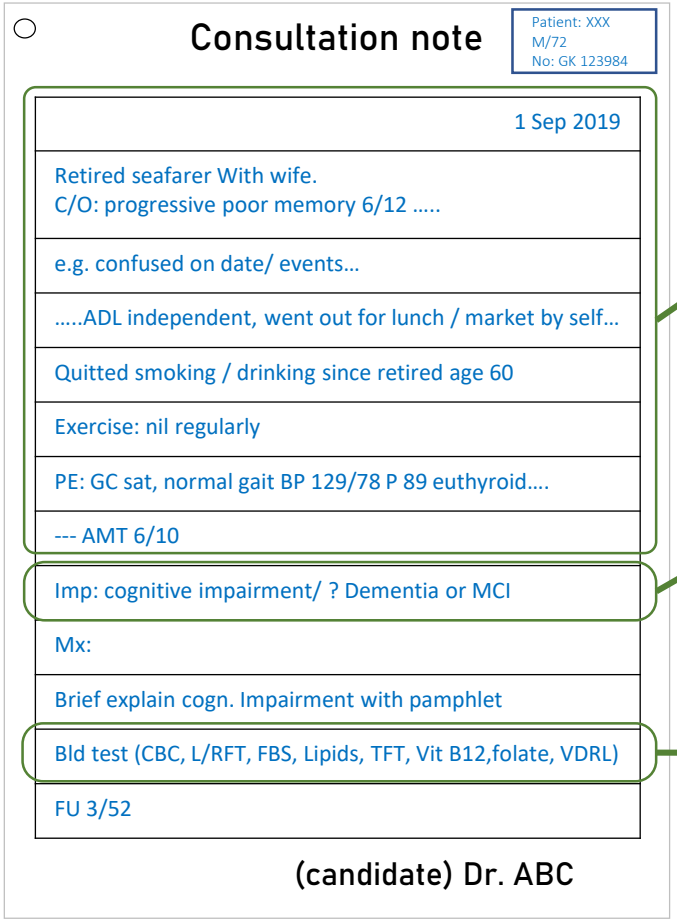
E1 (Investigation indication documentation)



Clinical information

Present in record

ICPC coded in Attachment 13

Provisional diagnosis / Chief condition requiring investigations

Present in record

Test(s) ordered

Present in record

Indication of the investigation documented (E1)

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

E1 (Investigation indication documentation): marking

Indication(s) of the investigation documented in record

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	✓									
E2 Justification										
E3. Results documentation										
E4. Follow up										

→ Examiners proceed to assess the record

Indication(s) of the investigation **cannot be found** in the record

Part E (Investigations)

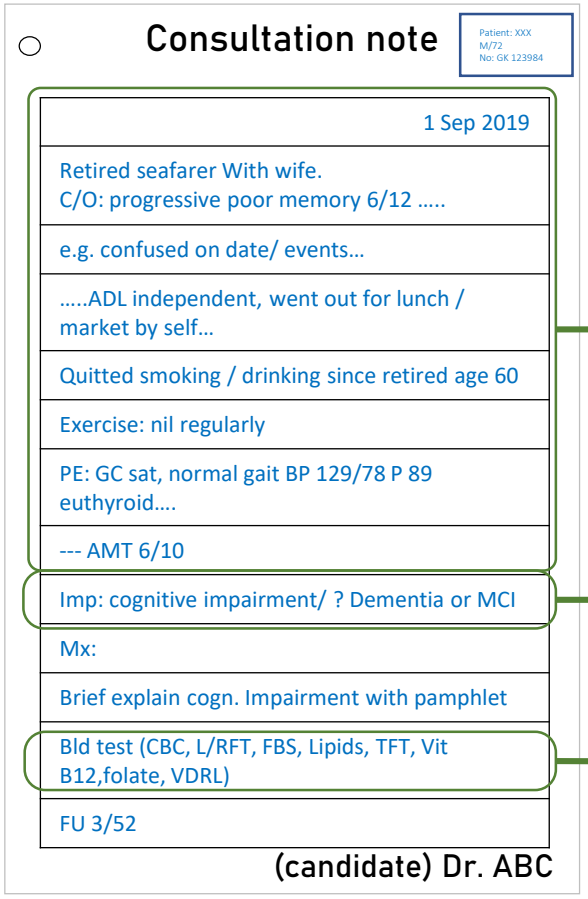
Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	X									
E2 Justification	X									
E3. Results documentation	X									
E4. Follow up	X									

Penalty!

→ the whole case will not be assessed

→ pro-rata mark deduction in Part E total score

E2 (Justification)



Consultation note

Patient: XXX
M/72
No: GK 123984

1 Sep 2019
Retired seafarer With wife. C/O: progressive poor memory 6/12 …..
e.g. confused on date/ events…
…..ADL independent, went out for lunch / market by self…
Quitted smoking / drinking since retired age 60
Exercise: nil regularly
PE: GC sat, normal gait BP 129/78 P 89 euthyroid….
--- AMT 6/10
Imp: cognitive impairment/ ? Dementia or MCI
Mx:
Brief explain cogn. Impairment with pamphlet
Bld test (CBC, L/RFT, FBS, Lipids, TFT, Vit B12,folate, VDRL)
FU 3/52

(candidate) Dr. ABC

Marking of E2 (Justification)
is the **Examiner's judgement** on the record's :

- Clinical information
- Provisional diagnosis / Chief condition requiring investigations
- Test(s) ordered

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E2 (Justification)

Examiner marks all the eligible medical records
Then give a global mark in Part E2 (justification)

Reference for marking E2 (Investigation indication documentation) and E4 (Follow up)	
Mark (Please circle one)	description
9	Consistently demonstrates outstanding performance in all components; criterion performance (outstanding)
8.5	
8	Consistently demonstrates mastery of most components and capability in all (Very Good)
7.5	
7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
6.5	
6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care *(Such omissions/ defects were seen in two or more of the Cases assessed)*
5.5	
5	Demonstrates inadequacies in several components with major omissions or defects
4.5	
4	Demonstrates serious defects; clearly unacceptable standard overall

E3 (Results documentation)

Consultation note

Patient: XXX
M/72
No: GK 123984

21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

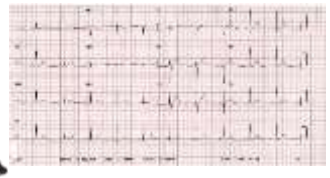
(candidate) Dr. ABC

Investigation results/ findings

documented in record

+

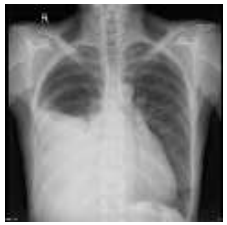
Copy of the investigation reports, e.g.



CT scan

Ultrasound scan

For plain X-Ray: : if report not available



film

OR

Present for Examiner's inspection

Results documented (E3)

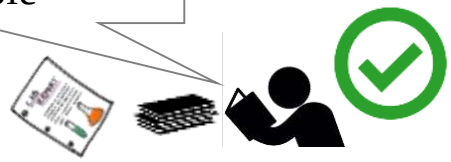
Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

E3 (Results documentation): marking

- The investigation results documented in the medical record
  AND
- The investigation/ laboratory report (copy) available

E3. Results documentation	✓									
E4. Follow up										

→ Examiners proceed to assess the record, E4 (follow up)



- The investigation results **NOT** documented in the medical record
  OR
- The investigation/ laboratory report (copy) **NOT** available

E3. Results documentation	X									
E4. Follow up	X									

Penalty!

→ "Follow up" of the case will not be assessed
→ pro-rata mark deduction in E4 (follow up) score

E4 (follow up)

Consultation note

Patient: XXX
M/72
No: GK 123984

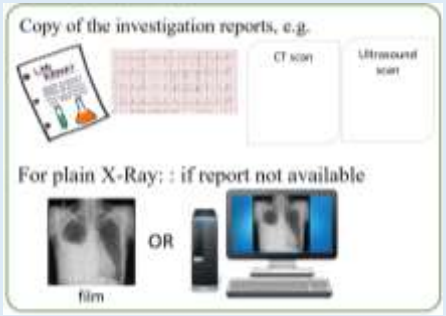
21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

(candidate) Dr. ABC

Marking of E4 (follow up)
is the **Examiner's judgement** on the record's:

Investigation results/ findings:

Documented in the Medical record &



Further clinical information elicited (if any)

Diagnosis

Management

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E4 (follow up)

Examiner marks all the eligible medical records
Then give a global mark in Part E4 (follow up)

Reference for marking E2 (Investigation indication documentation) and E4 (Follow up)	
Mark (Please circle one)	description
9	Consistently demonstrates outstanding performance in all components; criterion performance (outstanding)
8.5	
8	Consistently demonstrates mastery of most components and capability in all (Very Good)
7.5	
7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
6.5	
6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care *(Such omissions/ defects were seen in two or more of the Cases assessed)*
5.5	
5	Demonstrates inadequacies in several components with major omissions or defects
4.5	
4	Demonstrates serious defects; clearly unacceptable standard overall

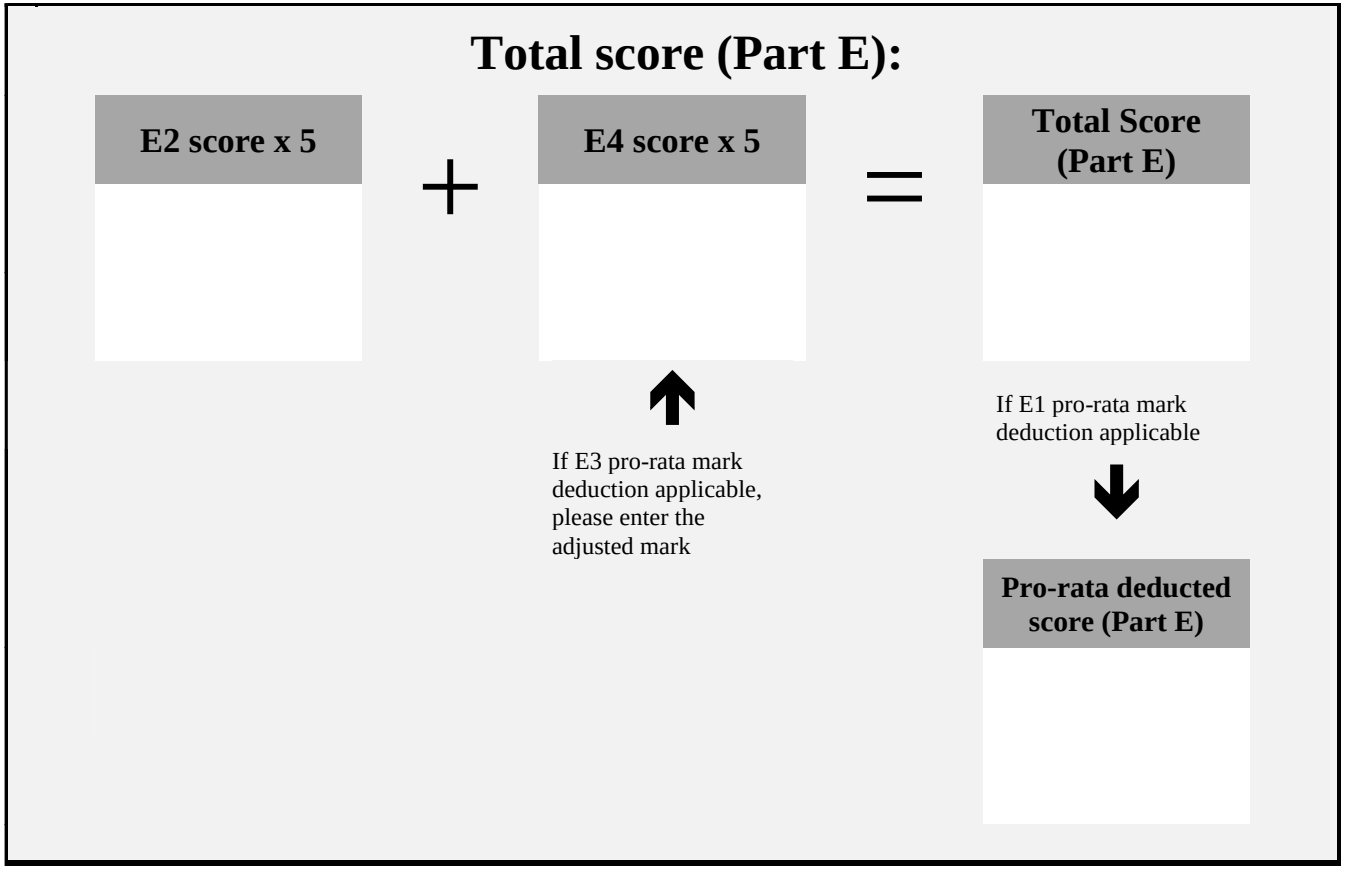
Part E (Investigation): total score

Mark distribution:

E2 (Justification): 50%

E4 (Follow up): 50%

Passing mark Total score ≥ 65%



Feedback on Part E (Investigations)

- ***please tick the area(s) need attention / improvement according to the overall performance***
- ***mandatory if you rate fail (below 65%) in Part E***

Overall performance on E2 (Justification): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Insufficient clinical information		
• Inappropriate working diagnosis		
• The investigation not guiding the management		
• Not choosing appropriate test(s)		
• Test(s) not done at appropriate time		
• Documentation: length not appropriate OR unclear		
• Others:		

Overall performance on E4 (Follow up): area(s) need attention / improvement	If applicable please ✓; higher priority ✓✓, etc.	remarks
• Follow up not done at appropriate time		
• Key findings documentation unclear		
• Not offering appropriate management according to the investigation results		
• Documentation: length not appropriate OR unclear		
• Others:		

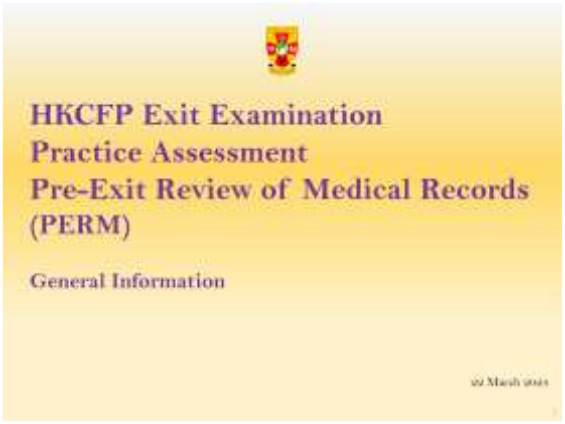
When the Exam ends

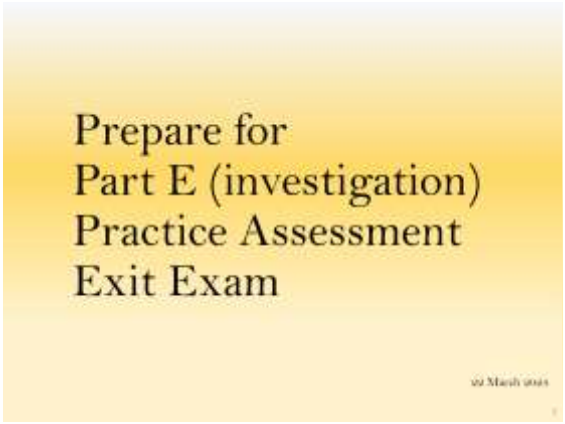
- The Examiners will call you back
- Please check with the Examiners that all the medical records had returned to you
- Confirm by signing on the note provided

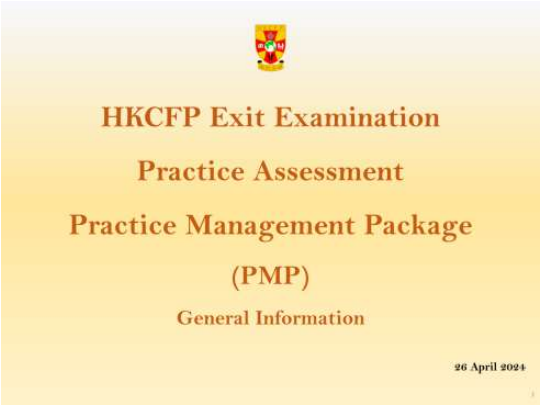
This is to confirm that all the medical records used in Practice Assessment today had returned to me.
Date
Candidate:
Signature:

Some observations, comments and recommendations in previous PA

Learn from the past!!







The presentation materials are available at the College *internet website:*

Hong Kong College of Family Physicians (hkcfp.org.hk)

(Education & Examinations > Exit Examination)

Pass / Fail

When Pass-fail discrepancy among Examiners' marking occur in

Random check, Part C II:

'Pass' = two or all the Examiners give passing grade

When Pass-fail discrepancy among Examiners' marking occur in

Part D, Part E:

Average of the three Examiners' Total Score will be considered:

Examiner 1	Examiner 2	Examiner 3	Average of the Total Score	Pass / Fail
Pass	Pass	Pass	*Not applicable*	**Pass**
Pass	Fail	Pass	Pass	**Pass**
Pass	Fail	Fail	Pass	by 4th Examiner
Pass	Pass	Fail	Fail	by 4th Examiner
Pass	Fail	Fail	Fail	**Fail**
Fail	Fail	Fail	*Not applicable*	**Fail**

4th Examiner

- The 4th Examiner may go to your clinic **in either Period A or Period B**
- 2-working-day notice in advance
- assesses the same set of materials seen by the previous three PA Examiners

All Candidate

- must keep all the examination materials seen by the previous PA Examiners; at least until the end of Period B

to pass the Exit Examination

Random check	Part CII	Part D	Part E
Grade ‘A’ or ‘C’	Pass in both Knowledge Practice	Score 65 % or above	Score 65 % or above

=

- Pass in Practice Assessment
- Pass in Consultation Skill Assessment
- \+ Pass in Research/ Clinical Audit

= Pass in Exit Examination

Fail in PA:
All the failed Part(s) need to be re-attempted as a set

Pass in PA:
Valid for five years; same as other individual Segments of Exit Examination

Candidate must have valid passes in all three Segments (CSA + PA + Research / Clinical Audit) at the same time in order to pass the Exit Examination

Enquiry

Specialty Board secretary:

alkyyu@hkcfp.org.hk

Tel: 2528 6618 (Alky or John)