

Please fax this form to 5456 8899 following your visit

Name of Practice Consultant:

Name of Practice Visited:

Date of Visit:..... **Length of Visit:**.....

Topic(s) covered:

- | | |
|---|--|
| <input type="checkbox"/> PIPs & SIPs | <input type="checkbox"/> Nurse-led clinics |
| <input type="checkbox"/> MBS Item Numbers | <input type="checkbox"/> EPC / CDM |
| <input type="checkbox"/> Recalls & Reminder | <input type="checkbox"/> GPMP / TCA |
| <input type="checkbox"/> MD Templates | <input type="checkbox"/> CAT |
| <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Resources given: | |

Names of Practice Staff in attendance (please include surname):

- | | |
|--------|--------|
| 1..... | 2..... |
| 3..... | 4..... |

What exactly did you do / accomplish?

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What changes would lead to an improvement in the practice?

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Are there any follow-up actions required by you or the Division?

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Additional Comments:

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