**HOSPITAL REVIEW FORM APPROVAL CHECKLIST**

To be completed by the RAPM/Independent Assessor(s) for each hospital providing the SIA in Pain Medicine

|  |  |
| --- | --- |
| **Name of Hospital:**  |  |
| **Faculty Tutor (Pain) Name & Qualifications:**  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes/No (where applicable)** | **Acceptable for provision of training? Yes/No** |
| **Is all the training for the SIA in Pain Medicine provided in one centre?**  |  |  |
| **Are the following staffing levels available:**  |
| Consultants |  |  |
| CNS |  |  |
| Psychologists |  |  |
| Physiotherapists |  |  |
| Others |  |  |
| **Number of outpatient consultation sessions per week:**  |
| Consultant sessions |  |  |
| CNS sessions |  |  |
| Psychology sessions |  |  |
| Physiotherapy sessions |  |  |
| Other sessions |  |  |
| **Ward rounds per week:** |
| Medical |  |  |
| CNS |  |  |
| Pharmacy |  |  |
| **Total number of intervention lists with image intensifier per week:**  |  |  |
| **Any specialised interventions carried out:**  |  |  |
| **Facilities including:** |
| Library |  |  |
| IT support |  |  |
| Administrative/secretarial staff support |  |  |
| Training and education |  |  |
| Formal teaching |  |  |
| MDTs |  |  |
| Audit |  |  |
| Safety training |  |  |
| **Access to written protocols/guidelines:** |  |  |
| **Access to PMP:** |  |  |
| **Number of PMP sessions per year:**  |  |  |
| **Access to MDT:** |
| Spinal |  |  |
| Headaches |  |  |
| Palliative Care |  |  |
| Rheumatology |  |  |
| Other (please specify) |  |  |
| **Service commitment: does the timetable demonstrate that trainees can spend daytime hours in pain clinics?**  |  |  |
| **Based on the timetable provided, are the current training arrangements provided acceptable?**  |  |  |
| **Is the statistical information for the last 12 months acceptable based on the number of patients and procedures for the SIA in Pain Medicine?**  |  |  |

**Is the centre suitable for the SIA in Pain Medicine?** **YES** [ ]  **NO** [ ]

If the centre is not suitable, please provide reasons in the box below:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **RAPM Name**:  | **Assessor Name:** |
| **RAPM Signature:** | **Assessor Signature:** |
| **Date:** | **Date:** |