***NATIONAL BOARD OF EXAMINATIONS***

***NEW DELHI***

***DEPARTMENT OF RADIODIAGNOSIS***

**LOG BOOK**

**DIPLOMATE OF NATIONAL BOARD**

**Name of P.G. Student:**

**Name of P.G. Guide**

**Name of hospital:**

**Department of Radiology**

**Certificate**

**This is to certify that Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is registered as a Resident in the Dept. of Radiology. All the entries in the Logbook have been checked and authenticated.**

**Signature Signature**

**Post – Graduate Teacher Head of the Department**

**Name: Name:**

**Date: Date:**

**INDEX**

|  |  |  |
| --- | --- | --- |
| **Sl. No.** | **Topic** | **Page No.** |
|  | **General Information** |  |
|  | **Clinical Postings** |  |
|  | **Log Of cases** |  |
|  | **Presentations** |  |
| * **Case Presentations Sessions**
 |  |
| * **Seminars**
 |  |
| * **Journal Club Meetings**
 |  |
| * **Basic Sciences Lecture for DNB**
 |  |
| * **CME / Workshop / Conference**
 |  |
| * **Inter Hospital Clinical Meetings**
 |  |
| * **Inter Departmental Meetings**
 |  |
| * **Other Meetings**
 |  |
|  | **Workshop, Seminars, Conference and Guest Lecture Attended** |  |
|  | **Scientific Papers presented at Conferences** |  |
|  | **Awards, Prizes and Certificates of Appreciation obtained.**  |  |
|  | **Publications in the Books & Scientific Journals** |  |
|  | **Resident evaluation** |  |

**GENERAL INFORMATION**

***Name:***

***Address:***

***Tel.No.:***

***E-mail ID:***

***Date of joining the course: Date of Completion:***

***Registered for: Registration Number:***

***Post-Graduate Teacher:***

**Under-Graduate and Post Graduate Qualification**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Degree/Diploma** | **College & University** | **Year of Passing** | **Attempt** | **Distinction & Prizes** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

 ***Signature of the Student***

***Signature of the HOD Signature of the Director Academics***

***Date with Stamp / DNB Program***

***Date with Stamp***

***CLINICAL POSTING***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Period** | **POSTING** | **Signature of Unit Incharge** |
| **From** | **To** |
| **1st Year** | **1st Month** |  |  |  |  |
|  | **2nd Month** |  |  |  |  |
|  | **3rd Month** |  |  |  |  |
|  | **4th Month** |  |  |  |  |
|  | **5th Month** |  |  |  |  |
|  | **6th Month** |  |  |  |  |
|  | **7th Month** |  |  |  |  |
|  | **8th Month** |  |  |  |  |
|  | **9th Month** |  |  |  |  |
|  | **10th Month** |  |  |  |  |
|  | **11th Month** |  |  |  |  |
|  | **12th Month** |  |  |  |  |
| **2nd Year** | **1st Month** |  |  |  |  |
|  | **2nd Month** |  |  |  |  |
|  | **3rd Month** |  |  |  |  |
|  | **4th Month** |  |  |  |  |
|  | **5th Month** |  |  |  |  |
|  | **6th Month** |  |  |  |  |
|  | **7th Month** |  |  |  |  |
|  | **8th Month** |  |  |  |  |
|  | **9th Month** |  |  |  |  |
|  | **10th Month** |  |  |  |  |
|  | **11th Month** |  |  |  |  |
|  | **12th Month** |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Period** | **POSTING** | **Signature of Unit Incharge** |
| **From** | **To** |
| **3rd Year** | **1st Month** |  |  |  |  |
|  | **2nd Month** |  |  |  |  |
|  | **3rd Month** |  |  |  |  |
|  | **4th Month** |  |  |  |  |
|  | **5th Month** |  |  |  |  |
|  | **6th Month** |  |  |  |  |
|  | **7th Month** |  |  |  |  |
|  | **8th Month** |  |  |  |  |
|  | **9th Month** |  |  |  |  |
|  | **10th Month** |  |  |  |  |
|  | **11th Month** |  |  |  |  |
|  | **12th Month** |  |  |  |  |

***LOG OF CASES – (A) RADIOLOGY – BARIUM / IVP / UROLOGY / OTHERS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (B) ULTRASOUND / COLOR DOPPLER – OBSTETRICS / GYNAE / ABDOMEN /***

 ***SMALL PARTS / OTHERS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (C) CT : NEURO / BODY / ANGIO / OTHERS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (D) MRI : NEURO / BODY / ANGIO / MRCP / MUSCULOSKELETAL / OTHERS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (E) MAMMOGRAPHY : BIOPSY***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (F) ANGIOGRAPHY: CEREBRAL / PERIPHERAL / RENAL / OTHERS***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (G) INTERVENTIONAL: DIAGNOSTIC / THERAPEUTIC***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (H) MISCELLANEOUS :***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***LOG OF CASES – (I) EMERGENCY RADIOLOGY & IMAGING :***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Sl.No.*** | ***DATE*** | ***NAME*** ***HOSP. NO.******AGE / SEX***  | ***PROCEDURE*** ***PERFORMED*** | ***CASE DISCUSSED WITH DOCTOR*** | ***REMARKS*** | ***NAME OF THE CONSULTANT & SIGNATURE*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***CASE PRESENTATION***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***CASE*** | ***SIGNATURE OF CONSULTANT / FACULTY / MODERATOR***  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***SEMINAR / REVIEW FOR DNB TRAINEES***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***TOPIC*** | ***SIGNATURE OF CONSULTANT / FACULTY / MODERATOR***  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***JOURNAL CLUB FOR DNB TRAINEES***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***TOPIC*** | ***SIGNATURE OF CONSULTANT / FACULTY / MODERATOR***  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***BASIC SCIENCES LECTURE FOR DNB TRAINEES***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***TOPIC*** | ***SIGNATURE OF CONSULTANT / FACULTY / MODERATOR***  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***CME / WORKSHOP / CONFERENCE FOR DNB TRAINEES***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***TOPIC*** | ***SIGNATURE OF CONSULTANT / FACULTY / MODERATOR***  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Signature of the Candidate***

***Signature of the Head of the Department***

 ***With Stamp***

***Inter- Hospital & Inter – Departmental Clinical Meetings Attended***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | **Title of the Case Presented** | **Signature Prof / Assoc. Prof /** **Lecturer** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Presentation at other Meetings***

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***Topic*** | ***Signature Prof / Assoc. Prof /******Lecturer*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**WORKSHOPS / SEMINARS / CONFERENCES / GUEST LECTURERS ATTENDED**

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.NO.*** | ***DATE*** | ***Workshop / Seminar / Conference /*** ***Lecturer*** | ***Signature Prof / Assoc.*** ***Prof / Lecturer*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SCIENTIFIC PAPERS PRESENTED AT CONFERENCES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***SL.******NO.*** | ***Date*** | ***Title of the paper*** | ***Conference*** | ***Signature Prof / assoc.******Prof / Lecturer*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**AWARDS, PRIZES**

**AND CERTIFICATES OF APPRECIATION**

|  |  |  |  |
| --- | --- | --- | --- |
| ***SL.******NO.*** | ***Date*** | ***Prize / Certificate*** | ***Signature Prof / assoc. Prof /*** ***Lecturer*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PUBLICATION IN BOOK & SCIENTIFIC JOURNALS:**

**RESIDENT EVALUATION**

**Name of Resident:**

**Below competence (BC) Competent (C) Above competence (AC)**

**BC CAC**

**Patient care** (*Residents should provide compassionate, appropriate, and effective patient care)*

1. Develop a clinical plan and proper technique based on radiologic findings and clinical Information.

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Medical Knowledge** (*Residents should be knowledgeable, scholarly, and committed to lifetime learning)*

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Recognize and describe relevant radio logic findings.

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Synthesize radiologic and clinical information and form as impression

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Utilize information technology to investigate clinical questions and for continuous self – learning

**Interpersonal / communication skills** *(Residents should communicate and teach effectively*)

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Show sensitivity to and communicate effectively with clinical colleagues and health care team

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Appropriately obtain informed consent

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Recognize, appropriately communicate, and documents in the patient record urgent or unexpected radiologic findings

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Produce radiologic reports that are accurate, concise, and grammatically correct

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Effectively teach residents, medical students and other health care professional

**Practice – based learning and improvement** *(Residents should investigate and evaluate Patient care practices, and appraises and assimilate scientific evidence in order to improve their practices)*

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Participate in QI (Quality improvement) / QA (Quality assurance) activities

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Recognize and correct personal errors

**Professionalism** *(Residents should be altruistic and accountable, and adhere to principles of medical ethics by respecting and protecting patient’s best interests)*

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Demonstrate a responsible work ethic with regard to conference attendance and work assignments

|  |  |  |
| --- | --- | --- |
|  |  |  |

1. Demonstrate acceptable personal demeanour and hygiene

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Overall performance:**

***Comments:*** *(An overall impression of below competence (BC) or above competence (AC) requires narrative comments).*

**Signatures / Date**